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:	Killeline Care Centre
Name of provider:	Killeline Nursing Home Limited
Address of centre:	Cork Road, Newcastle West, Limerick
Type of inspection:	Unannounced
Date of inspection:	19 October 2023
Centre ID:	OSV-0000423
Fieldwork ID:	MON-0041129

About the designated centre

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

Killeline Nursing Home is located in the town of Newcastle West on the Cork Road registered to provide care for 63 residents. There are 47 single bedrooms and eight twin bedrooms all with en-suite facilities. The centre accommodates both female and male residents with the following care needs: general care, dementia specific care and acquired brain injury. There is also a dedicated wing for Alzheimer's and a secured unit for Acquired Brain Injury for people with challenging behaviour. There is 24 hour nursing care available. A full assessment shall be completed within 24 hours of admission which will include any updated information and care needs identified to develop appropriate care plans. The care plans will be completed within the 48 hour time frame and additional information can be added appropriately. We operate an open visiting policy within Killeline Nursing Home. Facilities provided are: quiet room, Polly tunnel, hairdressing, dining rooms and sitting rooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	61

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 19 October 2023	08:55hrs to 18:55hrs	Rachel Seoighthe	Lead
Thursday 19 October 2023	08:55hrs to 18:55hrs	Fiona Cawley	Support

What residents told us and what inspectors observed

Overall, general feedback from residents of the quality of care and service provided in the centre was one of satisfaction. Inspectors heard positive comments such as 'where would you get comfort like this', and all residents who spoke with inspectors had high praise for staff. Residents were observed to be content and relaxed in the company of staff and inspectors found that staff were knowledgeable of residents care needs.

This was an unannounced inspection which was carried out over one day. The inspectors were met by the person in charge upon arrival to the centre. Following an introductory meeting, the inspectors walked through the centre which gave them the opportunity to meet with residents and observe their lived experience in the centre.

Killeline Care Centre provides long term and respite care for both male and female adults with a range of dependencies and needs. The centre is located in Newcastle-West, Co. Limerick. The designated centre is registered to provide care to a maximum of 63 residents. There were 61 residents living in the centre on the day of this inspection. The centre was a purpose-built, two storey facility and resident bedroom and communal accommodation was provided in three separate wings, known as Sunflower, Marigold and Violet.

Inspectors spent time walking through the centre and noted that the atmosphere was calm and friendly. The Violet wing provided accommodation to thirty five residents and resident bedroom accommodation was provided over two floors. Residents living in this wing were seen to frequent the communal areas on the ground floor, including a spacious reception which led to a number of distinct seating areas and a visitors room. This area was bustling with activity and it was well used by residents throughout the day of inspection. There was a constant staff presence and inspectors observed residents engaging with staff, while others were relaxed, reading and watching television.

Dementia-specific care was provided in a 14 bedded unit know as the Sunflower wing, located on the first floor of the centre. Resident accommodation was provided in twin and single bedrooms and the decor in this unit was designed to support and facilitate residents to move independently around the unit. Inspectors noted that resident bedroom doors were brightly painted to replicate front doors and there were memorabilia boxes which contained items of personal significance, placed at each bedroom door. Inspectors noted that residents had access to communal spaces such as a large day room, an activity room and a traditional style dining room. Residents living in the Sunflower wing were supported to attend other communal areas within the centre and inspectors were greeted by several residents on the afternoon of the inspection, as they departed to attend a party on the ground floor.

Inspectors also spent time on the Marigold wing which was a secure unit,

designated for use by a maximum of 13 male residents. Residents living in this unit had complex care needs and several residents were assessed as requiring continuous one-to-one supervision. Inspectors noted that there were adequate staffing levels in place, to meet residents health and social care needs. Inspectors spoke with staff who were working on this unit and they displayed a good knowledge of resident care needs and preferences. Residents living in the Marigold wing had access to their own dining room and sitting room, where the majority of residents were seen to spend time with staff throughout the day. Several residents were seen resting independently in their bedrooms. A secure courtyard could be accessed directly from the sitting room and residents had unrestricted access to this area. Inspectors noted that the the courtyard and surrounding areas were in a poor state of repair, as the ground surface was uneven in places and this posed a risk of falls.

Inspectors noted that many residents' bedrooms were personalised with items such as their photographs, artwork and ornaments. Residents' bedrooms had sufficient space to meet their needs including adequate wardrobe and storage space for their clothes and personal belongings. However, inspectors noted that the layout of some bedrooms impacted on the ability of residents' privacy and autonomy, as the location of wardrobes in several shared bedrooms meant that residents could not access their own clothing without entering the bed-space of another resident.

Inspectors observed residents attending a meal service in a spacious dining room on the ground floor, and it was a relaxed, sociable experience. The dining room was clean, bright and well furnished to accommodate residents. Inspectors noted that a large selection of hot and cold food was displayed at service counters in the dining room and there was a choice of three dishes for the lunch-time meal. Inspectors observed several residents being greeted warmly by catering staff when they arrived to the dining room. Residents' were noted to be chatting about the food on display at the counters and ordering their choice of meal directly from the catering staff. It was clear to inspectors that residents enjoyed this interaction. Residents who spoke with inspectors were complimentary of the food served in the centre and it was described by several residents as 'lovely' . Inspectors also spoke with a resident who had expressed that they had requested an alternative to the lunch time menu choices, and this was being arranged by the person in charge.

Visitors were observed being welcomed into the centre throughout the inspection. Residents met with their friends and loved ones in their bedrooms or communal rooms. Residents were satisfied with the arrangements that were in place to facilitate visits at the time of the inspection.

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

Capacity and capability

This was an unannounced 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. Inspectors also reviewed the actions taken by the provider to address issues of non-compliance identified during the last inspection in September 2022. The findings of this inspection indicated that while some action had been taken,the provider had failed to fully implement a compliance plan submitted following the inspection in September 2022. This included the oversight of the premises and management systems such as record management and contracts of care.

Killeline Nursing Home Limited was the registered provider for the designated centre. There were two directors, who were both part of the management strucutre of this centre. One of these directors was the named provider representative and there was evidence that they were actively involved in the day to day operation of the centre. The provider employed a director of quality and safety who provided operational and clinical support to the person in charge. There was a clearly defined management structure in place, with identified lines of authority and accountability. The person in charge was supported in the centre by two assistant directors of nursing (ADON), three clinical nurse managers (CNM) , and a team of nurses, health care assistants, maintenance, cleaning, catering and administration staff.

There were 61 residents accommodated in the centre on the day of the inspection. Inspectors' observations were that staffing levels on the day of the inspection were sufficient to meet the assessed needs and dependencies of residents. Communal areas were appropriately supervised. Residents who required enhanced supervision were well supported. Staff who spoke with inspectors demonstrated an understanding of their roles and responsibilities. There was a training programme in place for staff, which included mandatory training and other areas to support provision of quality care. Inspectors found that staff had competed training in the areas appropriate to their role. Staff who spoke with the inspector demonstrated good knowledge of residents needs.

There were management systems in place to monitor the quality of care and service provided. The management team collated clinical data such as antibiotic usage, controlled medication usage, resident wounds and nutritional care. Records viewed by inspectors demonstrated that a weekly analysis of key clinical performance indicators was completed. There was an audit schedule in place to support the management team to measure the quality of care provided to residents. Inspectors viewed a sample of audits relating to incidence of resident falls, call bell response times and medication management. A review of clinical audits found that quality improvement plans were developed following audits completed. While there was management oversight of the service, inspectors found that deficits identified by the management team were not always addressed in a timely manner. For example, this inspection found repeated non-compliance in relation to premises, resident contracts, written policies and procedures and record management.

An electronic record of accidents and incidents was maintained in the centre. Records evidenced that incidents were investigated and preventative measures were recorded and implemented, where appropriate.The person in charge informed the

Chief Inspector of notifiable events, in accordance with Regulation 31.

The provider maintained a suite of written policies and procedures as set out in Schedule 5 of the regulations. However, inspectors found that frequency of risk evaluation, as detailed in the centres risk management policy, was not implemented in practice. This is a repeated finding. Furthermore, although there was a complaints policy and procedure in place, it was not reviewed and updated in line with changes to the regulation. A record of complaints viewed by inspectors demonstrated that the management of complaints was not in line with the requirement of Regulation 34; Complaints procedures.

There were contracts of care in place for all residents, however inspectors found that the information contained in contracts for resident attending the centre for respite care, did not clearly describe what services were included in the service fee. This is discussed under Regulation 24; Contracts for the provision of care.

Inspectors viewed a sample of staff files and found that they contained all of the information required by Schedule 2 of the regulations. Inspectors found that records were not safe and accessible. The issues relating to the storage of records is a repeated finding.

A directory of residents was maintained by the registered provider, however, it did not include all of the requirements of Regulation 19. For example, there were incomplete details in relation to admissions and deaths.

An annual report on the quality of the service had been completed for 2022 and had been completed in consultation with residents . The annual review set out the service's level of compliance with the regulations, as assessed by the management team.

Regulation 15: Staffing

There were sufficient numbers of staff with the appropriate skill mix to met the assessed needs of the residents. There were at least two registered nurses on duty at all times in the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

Training records reviewed demonstrated that staff were facilitated to attend training in fire safety, moving and handling practices and the safeguarding of resident. Staff also had access to additional training to inform their practice which included, restrictive practices, infection prevention and control, falls prevention, dementia, and

cardio pulmonary resuscitation (CPR) training.

Judgment: Compliant

Regulation 19: Directory of residents

A review of the directory of residents found that the information specified in Paragraph3(h) of Schedule 3 was not entered into the directory for all residents as follows;

- the name and address of any authority, organisation or other body which arranged the resident's admission to the designated centre.
- where a resident died at the centre, the date, time and cause of death.

Judgment: Substantially compliant

Regulation 21: Records

A sample of staff duty rosters reviewed found that roster information was incomplete and and did not reflect the management hours worked. The positions held by each member of the management team, including the person in charge, were not recorded on the rosters.

Although inspectors were assured that residents had frequent access to physiotherapy services, there were limited records of treatment plans and recommendations made following physiotherapy reviews.

Not all residents' records were held in a safe and accessible manner. Inspectors found a box of residents' information stored openly on the floor in the nurses station in the Sunflower wing. A storage cabinet containing resident medical records was also unlocked. The door to the nurses station was open and records were accessible to any visitor in the centre. This is is a repeated finding.

Judgment: Not compliant

Regulation 23: Governance and management

The management systems in place did not provide full assurance that the service was safe and consistent. This was evidenced by

- inadequate oversight of complaints management.

- poor risk management
- inadequate oversight of residents access to healthcare services
- repeated non-compliance found in relation to record management, written policies and procedures and contracts for the provision of services

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A sample of residents contracts were reviewed and they did not comply with the requirements of the regulations. For example;

- The provider charged residents an additional weekly service charge. However, the contract of care for residents admitted to the centre for a period of respite, did not clearly indicate the services which were included in this weekly fee.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints policy and procedure did not reflect the requirements of Regulation 34 and did not provide assurances that there were arrangements in place to effectively manage complaints. For example;

- complaints records reviewed did not include a written response to the complainants, to advise if a complaint was upheld, the reasons for that decision, any improvements recommended and details of the review process.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The inspection found that the centres risk management policy was not adopted and implemented as follows;

- Risks identified in the centre were not reviewed in line with the centre's own risk management policy, which stated that risks identified would be reviewed on a monthly basis. This is a repeated finding.

Judgment: Not compliant

Quality and safety

Inspectors found that the standard of care which was provided to residents living in this centre was of a satisfactory quality. Residents who spoke with inspectors said that they were well cared for by staff in the centre. Inspectors found that the provider had addressed non-compliance in relation Regulation 8; Protection, found on the previous inspection in September 2022. However, the inspectors found that the non-compliant issues in relation to Regulation 17; Premises in relation to maintenance and storage had not been addressed. In addition, action was required to bring the centre into full compliance with fire precautions, infection control, and health care.

A review of resident care records demonstrated that each resident had a comprehensive assessment of their health and social care needs carried out prior to admission, to ensure the centre could provide them with the appropriate level of care and support. Following admission, a range of clinical assessments were carried out, using validated assessment tools to identify areas of risk specific to each resident. The outcomes of these assessments were used to develop an individualised care plan for each resident which addressed their individual abilities and assessed needs. Care plans were initiated within 48 hours of admission to the centre, and reviewed every four months or as changes occurred, in line with regulatory requirements. Inspectors reviewed a sample of nine residents' files and found that each resident had a care plan in place which reflected each individual's needs. Daily progress notes demonstrated good monitoring of residents' care needs.

Records demonstrated that residents were referred to allied health specialists such as tissue viability nurses, dietitian and speech and language therapist. A physiotherapist was employed in the centre and residents were referred to occupational therapy if required. Although the majority of residents had timely access to their general practitioners (GPs), records showed that a small number of residents were not allocated a GP. This arrangement did not ensure that residents timely access to medical service. This is discussed under Regulation 6; Health care.

The centre promoted a restraint-free environment, and there was appropriate oversight and monitoring of the incidence of restrictive practices in the centre. There were a number of residents who requested the use of bedrails. Records reviewed showed that appropriate risk assessments had been carried out in consultation with the multidisciplinary team and resident concerned.

Overall, the premises was clean and well-maintained. However, there were areas where walls, skirting boards and door surfaces were in a poor state of repair . Inspectors also noted that safety grab rails were not in place in multiple resident bathrooms. Furthermore, the function of an art room was reassigned to store linen supplies, which was not in line with the statement of purpose submitted by the

centre in September 2023. Further findings are described under Regulation 17; Premises.

Inspectors observed that there were good infection prevention and control practices and procedures in place. However, the segregation and storage of supplies in one sluice room did not ensure that good standards for infection prevention and control were maintained. This finding is discussed under Regulation 27; Infection control.

There were measures in place to protect residents against the risk of fire. These included regular checks of means of escape to ensure they were not obstructed, and checks to ensure that equipment was accessible and functioning. Staff had received fire safety training and regular fire drills had been completed to ensure that resident could be evacuated in a safe and timely manner. However, the recorded drills did not provide assurance that residents could be safely evacuated to a place of safety in a timely manner when there were lower levels of staffing on duty such as night duty. Additionally, inspectors found that some of the fire doors did not provide assurance of effective containment of smoke and fire in the event of a fire safety emergency. This is addressed under Regulation 28; Fire precautions.

Residents were free to exercise choice about how they spent their day. Residents had the opportunity to meet together and discuss management issues in the centre including privacy, nutrition, communication, call bells and activities. Residents' satisfaction surveys were carried out and feedback was acted upon. Residents had access to an independent advocacy service. There was a schedule of activities which included bowling, exercise and music. Residents' wishes in relation to their preferred religious practices were recorded and respected. A local priest attended the centre on a regular basis to celebrate Mass. Other religious and pastoral services could also be made available, if required.

Measures were in place to safeguard residents from abuse. Staff had completed up-to-date training in the prevention, detection and response to abuse. The provider acted as pension agent for seven residents and, all pensions were paid into a separate resident bank account. Records showed that a ledger was maintained detailing each resident's payments and surplus amounts was available to review. Records viewed by inspectors demonstrated that there was a system in place to transfer the funds in the residents account, to pay for resident care provision.

Inspectors found that the registered provider had ensured that visiting arrangements were in place for residents to meet with their visitors as they wished.

Regulation 11: Visits

Visiting was facilitated in an unrestricted manner and inspectors observed many visitors being welcomed to the centre throughout the day of the inspection.

Judgment: Compliant

Regulation 17: Premises

There were areas of the building that did not meet the requirements under Schedule 6 of the regulations. For example;

- The surface around the wheels on some commodes were rusted.
- A number of doors, skirting and walls were visibly damaged in resident bedrooms.
- Safety grab rails were not fitted at the sinks in multiple resident en-suite bathrooms..
- The layout of several shared bedrooms did not enable residents to access their own wardrobes without entering the bed space of another resident.
- Some surface areas of the external grounds and the courtyard leading from the marigold unit were rugged and uneven.
- There were several holes in the ceiling surface of the laundry room.

There was a lack of suitable storage in the centre;

- Inspectors found that the function of an art room on the ground floor was been reassigned for the storage of clean linen supplies and the art room was relocated to another area of the centre. This was not in line with the detail of the centres' statement of purpose and floor plans of the centre, submitted by the Provider in September 2023.

Judgment: Not compliant

Regulation 27: Infection control

The provider did not fully ensure that procedures consistent with the standards for the prevention and control of health-care associated infections published by the Authority were implemented. This was evidenced by:

- The clinical and general waste area was kept in an unsecured area, which was open to the public.
- There was no equipment drying rack available in the sluice room.
- House-keeping trolleys, chemicals and catering supplies were being stored in the sluice room. This arrangement posed a risk of cross contamination.
- Used bed linen was stored in open laundry skips along corridors in resident accommodation areas. This arrangement posed a risk of cross infection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required by the provider to ensure adequate precautions were in place to protect residents and others from risk of fire and to bring the centre to bring the centre into full compliance with Regulation 28: Fire Precautions, as follows;

- A record of simulated emergency evacuation drills was not available to provide assurances regarding residents' timely evacuation to a place of safety from the centres' largest fire compartment in the event of a fire in the centre with night time staffing levels.
- Directional signage was missing along one fire exit route, to direct and illuminate the route of escape, in the event of a fire evacuation at night-time.
- Inspectors found a number of gaps between the floor and the bottom of some cross corridor and doors. This could impact on the effectiveness of the fire doors to contain fire, smoke or fumes.
- A residents' designated smoking area was located on the opposite side of a final fire exit door. This arrangement could cause an obstruction in the event of a fire safety emergency.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A comprehensive assessment was in place for each resident prior to or on admission to the centre. The care plans reviewed were individualised, and reflected residents' needs and the supports they required to maximise their autonomy and quality of life.

Judgment: Compliant

Regulation 6: Health care

Inspectors were not assured that residents living in the centre had access to appropriate medical care. For example,

- Records viewed by inspectors demonstrated that two residents who were admitted to the service did not have access to a general practitioner (GP) of their choice and they had not been seen by a general practitioner in over a

year.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The provider promoted a restraint-free environment in the centre, in line with local and national policy. The provider had regularly reviewed the use of restrictive practises to ensure appropriate usage.

Judgment: Compliant

Regulation 8: Protection

Inspectors found that measures were in place to protect residents from abuse. Training was provided to staff to guide them in recognising and responding to actual, alleged or suspected incidents of abuse. Safeguarding incidents were investigated and safeguarding care plans were developed where appropriate.

Judgment: Compliant

Regulation 9: Residents' rights

Privacy curtains found in several shared bedrooms did not provide sufficient cover to ensure privacy and dignity for residents sharing that 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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Killeline Care Centre OSV-0000423

Inspection ID: MON-0041129

Date of inspection: 19/10/2023

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: • The Designated Centre's directory of residents was updated to include all the information specified in Schedule 3 of Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Completed on 15th November 2023. • Ensure the inclusion of the name and address of any authority or body arranging resident admissions, and details of deaths, including date, time, and cause. • Every quarter the directory of residents will be reviewed by the Person in charge (PIC) to ensure compliance with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • The Designated Centre will ensure that resident records are maintained in a manner that is safe and secure. A review to ensure correct storage has been carried out and all files are now to be kept in locked presses at all times. All staff made aware of proper file storage and reminded at the start of each shift. • Revise the staff duty roster system to ensure it accurately reflects management hours worked and the positions held by each management team member, including the person in charge. This revision completed. • Implement a regular review process to verify the accuracy and completeness of rosters, with the first review scheduled for December 1st, 2023. • Develop and implement a system for detailed recording of physiotherapy treatment plans, recommendations, and reviews. Completion of system implementation by	

November 30th , 2023.
• Train physiotherapy staff and care coordinators in documenting and maintaining these records, with training to be completed by November 30th , 2023.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Revise and strengthen the complaints management process to ensure timely and effective handling of all complaints. This revision to be completed by November 30th , 2023.
• Reevaluate and reinforce the risk management policy, ensuring it is fully implemented and adhered to. Completion of this re-evaluation by November 30th , 2023.
• Review and improve systems to guarantee residents have regular and appropriate access to healthcare services, including access to GPs. This review to be finalized by November 30th , 2023.
• Conduct a comprehensive audit of all records and written policies to identify areas of non-compliance. Audit to be completed by January 31st, 2024.
• Revise and update all records and policies to ensure they comply with regulatory requirements, with revisions to be completed by March 31st, 2024.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
• Conduct a thorough review of all resident contracts, focusing specifically on those for respite care. This review will aim to identify and rectify any ambiguities or omissions regarding the services included in the weekly service charge. The review and initial revisions to be completed by January 31st, 2024.
• Ensure that each contract clearly outlines all services covered under the weekly fee, with an itemized breakdown for transparency. Implementation of revised contracts for new admissions by January 31st, 2024.

Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • The complaints policy and procedure has been reviewed and is in line with the regulations, to include written responses to complainants, detailing the outcome and review process. Training on the new policy has been provided to all nurses and the in-house management team to enhance their understanding of complaints and the actions to take. Completed – 15th November 2023.	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • Immediate initiation of the risk management policy as documented, focusing on the regular review of identified risks. The first comprehensive risk review to be completed by January 31, 2024. • Establish a strict schedule for risk reviews, adhering to the centre's policy. This schedule will start in February 2024 and continue on an going basis. • Develop a system for documenting and tracking all risk reviews, ensuring transparency and accountability in the risk management process. Implementation of this documentation system by February 28th , 2024. • Regular audits of the risk review documentation to be conducted quarterly, starting in March 2024, to ensure compliance with the policy. • We acknowledge the gaps in our written policies and procedures and are in the process of updating them to align with the latest regulatory standards. These updates will be completed, and staff training on the new policies will be conducted by March 2024.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Meeting with Maintenance Manager, DON and RPR on 16th November to review the findings of the inspection with regards the premises. Maintenance schedule updated and works commenced to address findings from inspection to be completed by 31st July 2024 • Inspect all commodes and repair or replace those with rusted surfaces, particularly around the wheels. This task to be completed by February 28th , 2024. • Implement a regular maintenance schedule for commode inspection and repair,	

starting March 2024.
• A painting and decorating contractor has been engaged and work has commenced on painting and decorating throughout the care centre. This will include painting doors, walls and skirting boards. Completion targeted for March 31st , 2024.
• Reconfigure layouts of shared bedrooms to ensure that all residents can access their wardrobes without infringing on another resident's bed space. This reconfiguration to be completed by February 28th, 2024.
• Regularly review room layouts during bi-annual resident satisfaction surveys, starting March 2024.
• Repair uneven surfaces in external grounds and courtyards, particularly around the Marigold unit. Completion of these repairs by July 31st , 2024.
• Schedule regular grounds maintenance to ensure safety and accessibility, starting August 2024.
• Repair holes in the ceiling surface of the laundry room. This repair work to be completed by July 31st , 2024.
• Implement a building integrity check every six months to identify and rectify similar issues, commencing January 2024.
• Reallocate the storage of clean linen supplies to a designated storage area.
• Conduct an audit of all storage spaces to ensure they align with the centre's statement of purpose and submitted floor plans. This audit to be completed by March 31st, 2024.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Immediately relocate the clinical and general waste area to a secured, non-public space. This relocation and securing of the waste area will be completed by March 2024.
• Implement a routine monitoring system to ensure that the new waste area remains secure and inaccessible to unauthorized individuals, starting March 2024.
• Install equipment drying racks in the sluice room to facilitate proper drying and storage of cleaning and medical equipment. The installation is scheduled to be completed by April 30th, 2024.
• Conduct regular inspections, starting December 2023, to ensure that the drying racks are used effectively and maintained properly.
• Reorganize the storage in the sluice room to remove house-keeping trolleys, chemicals, and catering supplies, thereby minimizing the risk of cross-contamination. Completed.
• Establish a regular audit system, beginning in November 2023, to ensure that only appropriate items are stored in the sluice room and to maintain the separation of cleaning and catering supplies.
• Modify the storage of used bed linen by providing closed laundry skips or containers to prevent cross-infection. This change will be implemented by April 30th, 2024.
• Initiate monthly checks from May 2024 to ensure that used linen is consistently stored in a manner that mitigates the risk of infection.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Immediate implementation of a comprehensive record-keeping system for all simulated emergency evacuation drills. This system will provide clear evidence of the Centre's capacity to evacuate residents safely, particularly during night-time staffing levels. Completions to this system and its integration into routine practice is targeted for November 30th, 2023.
• Regular reviews of evacuation drill records every quarter to ensure effectiveness and readiness, starting from January 2024.
• Installation of missing directional signage along the identified fire exit route to ensure clear illumination and direction for escape during night-time evacuations. This installation will be completed by January 2024.
• Ongoing maintenance checks of all signage to be conducted monthly, beginning January 2024.
• Conducting a comprehensive assessment of all fire doors, specifically targeting gaps that could compromise their effectiveness in containing fire, smoke, or fumes. This assessment to be completed by January 31st, 2024.
• Following the assessment, necessary repairs or replacements of fire doors will be undertaken with completion deadline of June 30th, 2024.
• Immediate relocation of the residents' designated smoking area to ensure it does not obstruct any final fire exit doors. This relocation to be completed by December 20th 2023.
• Regular monitoring and assessment of the new smoking area's compliance with fire safety standards, starting January 2024.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Immediately review the medical care access for all residents, with a focus on ensuring that each resident has access to a GP of their choice. This comprehensive review to be completed by November 20, 2023.
• For residents who do not currently have a GP or have not seen a GP in over a year, arrange GP appointments and establish ongoing care plans. This process to be initiated by November 30th, 2023, with all affected residents having seen a GP by January 31, 2024.
• Develop and implement a system for the allocation of GPs to new residents upon their admission to the Centre. This system should ensure that residents can choose their preferred GP or be provided with access to a GP if they do not have a preference.

Implementation deadline: January 31st, 2024.
• Regular monitoring and updating of the GP allocation system to ensure it remains responsive to residents' needs, with reviews conducted quarterly starting February 2024.
• Establish a protocol for regular health reviews for all residents, including scheduled GP visits, to ensure continuous and appropriate medical care. The first round of health reviews to be completed by April 30, 2024.
• Maintain detailed records of these health reviews and GP visits, with a system in place for follow-up actions as necessary.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Conduct a thorough assessment of all privacy curtains in shared bedrooms to determine their adequacy in providing sufficient privacy and dignity. This assessment will be completed by January 30th, 2023.
• Based on the assessment, replace privacy curtains that are found to be inadequate. The procurement and installation of new curtains will be completed by March 31st, 2024.
• Implement a regular monitoring system to ensure that privacy curtains continue to provide adequate cover, starting in April 2024. This will involve routine checks by the care team and feedback from residents about their privacy experiences.
• Incorporate resident feedback on privacy and dignity into monthly care meetings to continually assess and improve the living conditions in shared bedroom.

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	31/07/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	04/12/2023
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.	Not Compliant	Orange	30/11/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to	Not Compliant	Orange	04/12/2023

	be safe and accessible.			
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	31/03/2024
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Substantially Compliant	Yellow	31/01/2024
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 implemented by staff.	Substantially Compliant	Yellow	30/04/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/01/2024
Regulation	The registered	Substantially	Yellow	31/01/2024

28(1)(e)	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.	Compliant		
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/06/2024
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	30/11/2023
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out	Not Compliant	Orange	28/02/2024

	in Schedule 5.			
Regulation 6(2)(a)	The person in charge shall, in so far as is reasonably practical, make available to a resident a medical practitioner chosen by or acceptable to that resident.	Substantially Compliant	Yellow	31/01/2024
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	31/03/2024