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:	Carnew Nursing Home
Name of provider:	Genesis Healthcare Ltd
Address of centre:	Gorey Road, Carnew, Wicklow
Type of inspection:	Unannounced
Date of inspection:	18 September 2024
Centre ID:	OSV-0008471
Fieldwork ID:	MON-0040469

About the designated centre

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

Carnew Nursing Home is a new 90 bed creatively designed, spilt-level building, built to a high specification. The centre has three units - Oak, Birch and Rowan.The centre had three twin en-suite rooms in Birch unit and the remaining 84 rooms are single en-suite. Each level has its own access to internal courtyards. The centre is located in the countryside, on the outskirts of Carnew village, situated approximately 16 kms from the town of Gorey Co. Wexford and 15 km from the town of Bunclody, Co. Wexford. Carnew Nursing Home delivers care to residents over the age of eighteen with varying and complex needs ranging from lower dependency individuals to maximum dependency requirements. The centre also cater for residents who require general care, including residents with dementia, physical disabilities, chronic physical illness, psychiatric illness, frail elderly, and those requiring palliative care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	51

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 18 September 2024	09:00hrs to 17:20hrs	Mary Veale	Lead
Thursday 19 September 2024	09:00hrs to 17:15hrs	Mary Veale	Lead

What residents told us and what inspectors observed

This was an unannounced inspection which took place over two days. Over the course of the inspection the inspector spoke with residents, staff and visitors to gain insight into what it was like to live in Carnew Nursing Home. The inspector spent time observing the residents daily life in the centre in order to understand the lived experience of the residents. The inspector spoke in detail with 10 residents and 5 visitors. Residents and visitors expressed improvements in communication of care needs and attention to personal care since July 2024.

Carnew Nursing Home is a split level two storey purpose built designated centre registered to provided care for 90 residents on the outskirts of the village of Carnew, in County Wicklow. The centre was registered as a designated centre in June 2023. There were 51 residents living in the centre on the days of inspection. The centre had three units. Oak unit and Birch units were on the ground floor. Rowan unit was on the lower level and there were no residents living on this floor on the days of inspection.

The design and layout of the premises met the individual and communal needs of the residents. The building was well lit, warm and adequately ventilated throughout. Residents had access to dining rooms, sitting rooms, and activities rooms. Residents had access to a visitors room and a hairdressing room.

There were 28 single bedrooms on Oak unit with en-suite wash hand basin, toilet and shower facilities. There were 20 single bedrooms and three twin rooms on Birch unit with en-suite wash hand basin, toilet and shower facilities. An assisted bath was available to residents in the Rowan unit. Resident's bedrooms were clean and tidy. Bedrooms were personalised and decorated in accordance with resident's wishes. Lockable storage space was available for all residents and personal storage space comprised of a locker, double wardrobes and a set of drawers. All bedrooms were bright and enjoyed natural light. Bedrooms at the rear of the centre had a panoramic view of the Wicklow hills. The inspector observed that residents had access to call bells on the days of inspection.

Residents had access to a courtyard between Oak and Rowan units. The courtyard was tastefully decorated, had level paving and comfortable seating. There was a designated smoking area in this courtyard. Residents were observed enjoying the sunshine in the courtyard over the days of the inspection.

Residents spoken with were very mostly complimentary of the home cooked food and the dining experience in the centre. Most residents' stated that the quality of food was excellent, however a small number of residents said that they were not offered choice at tea time. The menus for all daily meals and snacks were displayed in the dining rooms on each table and in the reception area. Water dispensers were available on each unit. The inspector observed the dining experience on Oak unit at dinner time on the first day of inspection and on Birch unit at dinner time on the

second day of inspection. The dinner time meal was appetising, well present and the residents were not rushed. The dinner time experience was a social occasion where residents were seen to engage in conversations and enjoying each others company.

Residents' spoken with said they were very happy with the activities programme and told the inspector that the activities suited their social needs. The monthly activities programme was displayed in each resident's bedroom. The inspector observed staff and residents having good humoured banter throughout the days and observed staff chatting with residents about their personal interests and family members. The inspector observed many residents walking around the corridor areas of the centre. The inspector observed residents reading newspapers, watching television, listening to the radio, and engaging in conversation. Visits and outings were encouraged and practical precautions were in place to manage any associated risks.

Visitors were observed attending the centre throughout the days of inspection. The inspector spoke with five family members who were visiting. All visitors told the inspector that they were dissatisfied with the medical care provided and aspects of nursing care their relatives received. Visitors told the inspector that they had found it difficult to communicate with staff about their loved ones care needs and felt they had not been listened too. Visitors told the inspector that they felt their complaints had been ignored and were dismissed previously. However; visitors acknowledged that there had been improvements in communication and care practices since August 2024.

A residents' committee had been established and resident's views and opinions were sought through resident meetings. Residents said that they could approach the person in charge if they had any issue or problem to be solved. Residents stated that there had been improvements in the communication of their care needs and that the person in charge was very good at communicating changes, particularly relating to their nursing and social care needs.

A significant number of residents were living with a cognitive impairment and were unable to fully express their opinions to the inspector. These residents appeared to be content, appropriately dressed and well-groomed on the days of the inspection. Residents were observed engaging in a positive manner with staff and fellow residents throughout the days and it was evident that residents had good relationships with staff. Many residents had build up friendships with each other and were observed sitting together and engaging in conversations with each other. There were many occasions throughout the days in which the inspector observed laughter and banter between staff and residents. The inspector observed staff treating residents with dignity during interactions throughout the inspection. Residents' told the inspector that they felt safe and trusted staff.

The centre provided a laundry service for residents. All residents' whom the inspector spoke with on the days of inspection were happy with the laundry service.

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

Capacity and capability

Overall improvements were required in the management of the service to ensure safe effective systems were in place to support and facilitate the residents to have a good quality of life. This was an unannounced inspection which took place over two days. On this inspection, the inspector found that actions were required by the registered provider to comply with:

- Regulation 3: Statement of Purpose,
- Regulation 5: Individual assessment and care planning
- Regulation 6: Healthcare,
- Regulation 21: Records,
- Regulation 23: Governance and Management, and
- Regulation 31: Notification of incidents.

Areas of improvement were required in Regulation 9: Residents rights, Regulation 12: Personal possessions, Regulation 16: Training and staff development, Regulation 25: Temporary absence or discharge of residents, and Regulation 27: Infection prevention and control.

The registered provider was Gensis Healthcare Limited. The company had three directors, one of whom was the registered provider representative. There had been a change in the person in charge since the previous inspection. The person in charge worked full-time five days a week in the centre and at the time of inspection was supported by two clinical nurse managers who were supernumerary in the role to provide clinical supervision and oversight of residents care needs. The post of assistant director of nursing (ADON) had been vacant since August 2024, a person had been recruited to the ADON position and was due to commence the week following the inspection. In addition the person in charge was supported by a team of staff nurses, healthcare assistants, housekeeping, activities co-ordinators, a rehabilitation assistant, catering, administration, laundry and maintenance staff.

There were sufficient staff on duty to meet the needs of the residents living in the centre on the days of inspection. The centres staffing levels were in line with the whole time equivalents (WTE) as set out in the statement of purpose which Gensis Healthcare Limited was registered against. The inspector was informed that staff turnover had significantly reduced and the centre had not utilised agency staff since June 2024.

There was an ongoing schedule of training in the centre and the person in charge had good oversight of mandatory training needs. An extensive suite of mandatory training was available to all staff in the centre and training was mostly up to date. There was a high level of staff attendance at training in areas such as fire safety, manual handling, safeguarding vulnerable adults, medication management, and infection prevention and control. Staff with whom the inspector spoke with, were knowledgeable regarding fire evacuation procedures and safeguarding procedures.

Dementia, safeguarding, manual handling and cardio-pulmonary- resuscitation (CPR) training were scheduled to take place in the weeks following the inspection. However; further improvements were required to ensure staff were appropriately supervised, this is discussed further in this report under Regulation 16: Training and staff development.

Records maintained in the centre were in paper and electronic format. Garda vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available for staff. Improvements were required in the centre's staff personnel files which is discussed further under Regulation 21: records.

Improvements were required in the management systems in place to monitor the centre's quality and safety. There were regular management meetings and audits of care provision. Records of clinical governance meetings, quality and safety meeting, head of department meetings and staff meetings which had taken place since the previous inspection were viewed on this inspection. Quality and safety meetings had commenced in August 2024, governance meetings and head of department meetings took place monthly, and staff meetings took place quarterly in the centre. Since the previous inspection falls audits, call bell audits, care planning audits, and restrictive practice audits had been completed. A review of the centres audit system was required this is discussed further under Regulation 23: Governance and Management.

The annual review for 2023 was available during the inspection. It set out the improvements completed in 2023 and improvement plans for 2024.

There was a record of accidents and incidents that took place in the centre. Some notifications were submitted appropriately to the office of the Chief Inspector of social services. However, there were a number of three day notifications that were not submitted. Subsequent to the inspection these notifications were submitted retrospectively. This is discussed further in this report under Regulation 31.

The management team had a good understanding of their responsibility in respect of managing complaints. The inspector reviewed the records of complaints raised by residents and relatives and found they were appropriately managed. Residents spoken with were aware of how to make a complaint and whom to make a complaint to.

Regulation 15: Staffing

On both inspection days, staffing was found to be sufficient to meet the residents' needs. There was a minimum of two registered nurses and three health care assistants on duty in the centre at all times for the number of residents living in the centre at the time of inspection.

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 behaviours that are challenging 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. There was lack of supervision of staff relating to care planning, medication management, identification of deteriorating residents and the management of residents with behaviours is challenging. This is discussed further in this report.

Judgment: Substantially compliant

Regulation 21: Records

The registered provider did not ensure that the records set out in Schedule 2, 3 and 4 were kept in the designated centre and made available for review by inspector. For example:

- Documents as outlined in schedule 2 were not available for the person in charge on inspection.
- In a sample of four staff files viewed, three of the files did not have a satisfactory history of gaps in employment in line with schedule 2 requirements.
- One staff file did not include a reference from the person's most recent employer.

Judgment: Not compliant

Regulation 22: Insurance

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

Judgment: Compliant

Regulation 23: Governance and management

The overall governance and management of the centre was not fully effective. Management systems were not sufficiently robust to ensure the service was safe, appropriate, consistent and effectively monitored. For example:

- There were inadequate systems of oversight in place to monitor and respond to issues of concern found by the inspector, particularly in relation to communication with residents and families, residents access to a medical care, information provided to receiving hospital from the centre and medication safety. Theses issues are discussed further under Regulations 6: healthcare, and Regulation 25: Temporary absence or discharge of residents.
- The centres audit system and processes required review to ensure it was effective. For example: High levels of compliance had been achieved in recent audits such as care planning, call bell response time and residents property audits. This did not reflect in the findings on this inspection. A review of the call bell response audit found that residents were waiting up to 15 minutes for their call bell to be answered and a personal item belonging to a resident was found stored in the control drug press. The high level of compliance achieved in care planning audits did not reflect the findings on this inspection, this is discussed further under Regulation 5: Individual assessment and care planning.
- The system for assessment of a resident with behaviour that is challenging was not managed in accordance with the centre's policies.
- There was a lack of oversight and monitoring of incidents and accidents which required review. Notifications were not submitted in accordance with the requirements of Schedule 4 of the regulations. For example, a number of allegations of abuse of residents and an allegation of misconduct by a member of staff were not submitted.
- Actions were required to ensure medication management systems were safe. A significant number of medication errors were recorded which posed a risk to the safety of residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose did not contain all the information required under Schedule 1 and required review in respect of:

- The statement of purpose did not include the information set out in the certificate of registration.
- The complaints procedure was not in line with Regulation 34: Complaints procedure.

- The statement of purpose had not been reviewed and revised since June 2023.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of the records in relation to incidents in the centre showed that there were incidents as set out in Schedule 4 of the regulations that were not notified to the office of the Chief Inspector within the required time frames. The person in charge was requested to submit these notifications following the inspection, relating to safeguarding concerns and an allegation of misconduct by a member of staff.

Judgment: Not 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. These nominated persons had received suitable training to deal with complaints. The complaints procedure outlined how a person making a complaint could be assisted to access an independent advocacy service.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the provider was, in general, delivering a good standard of nursing care; however, the gaps in oversight, as mentioned in the Capacity and Capability section, impacted on the quality of life for the residents living in the centre. The findings of this inspection are that further action was required to come into compliance with care planning and health care. Areas of improvements were required in resident's rights, personal possessions, transfer documentation and infection control and prevention.

The inspector viewed a sample of residents' electronic nursing notes and care plans. There was evidence that residents were comprehensively assessed prior to

admission, to ensure the centre could meet their needs. Care plans viewed by inspector were generally person- centred. However, a review of a sample of care plans found that there was insufficient information recorded to effectively guide and direct the care of these residents. Details of issues identified are set out under Regulation 5.

The centre was clean and tidy. A schedule of maintenance works was ongoing, ensuring that the décor of the centre was consistently maintained to a high standard. Communal spaces and bedrooms were homely. Alcohol gel was available, and observed in convenient locations throughout the building. Sufficient housekeeping resources were in place. Housekeeping staff were knowledgeable of correct cleaning and infection control procedures. Intensive cleaning schedules had been incorporated into the regular cleaning programme in the centre. There were infection prevention and control (IPC) policies which included COVID-19 and multi-drug resistant organism (MDRO) infections available to staff. Improvements were required in relation to infection prevention and control which are discussed further under Regulation 27: Infection control.

The provider had effective systems in place for the maintenance of the fire detection, alarm systems, and emergency lighting. There were automated door closures to all bedrooms and compartment doors, and the doors were seen to be in working order. All fire safety equipment service records were up to date and there was a system for daily and weekly checking, of means of escape, fire safety equipment, and fire doors to ensure the building remained fire safe. Fire training was completed annually by staff and records showed that fire drills took place regularly in each compartment with fire drills stimulating the lowest staffing levels on duty. Records were detailed and showed the learning identified to inform future drills. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation methods applicable to individual residents and staff spoken with were familiar with the centres evacuation procedure. There was evidence that fire safety was an agenda item at meetings in the centre.

There was a centre-specific policy on the protection of the resident from abuse. Staff were supported to attend safeguarding training. Staff were knowledgeable of what constituted abuse and what to do if they suspected abuse. All interactions by staff with residents were observed to be respectful throughout the inspection. However; further improvements were required to the systems in place to safeguard residents and protect them from the risk of abuse. This is discussed under Regulation 8: Protection.

Mealtimes were facilitated in the dining and communal rooms. Some residents preferred to eat their meals in their bedrooms and residents said that their preferences were facilitated. The inspector observed that residents were provided with adequate quantities of food and drink. Residents were offered choice at mealtimes and those spoken with confirmed that they enjoyed the meals provided. Residents on modified diets received the correct consistency meals and drinks, and

were supervised and assisted where required to ensure their safety and nutritional needs were met.

Activity schedules were displayed and activities were available from Monday to Sunday. The inspector observed that residents had sufficient opportunities to participate in activities in accordance with their interests and capacities. Residents had access to radio, television, newspapers and other media such as the use of mobile computer devices. Mass took place in the centre weekly which residents said they enjoyed. Access to independent advocacy was available. Notwithstanding the good practices in the centre, areas for action were identified to ensure that all residents in the centre could exercise choice and had their privacy and dignity maintained.

Regulation 12: Personal possessions

While residents were supported to keep their own belongings in their bedrooms, the inspector observed a personal item belonging to a resident inappropriately stored in the centres control drug press. Action was required to ensure that a robust system was in place for the safe keeping of residents personal valuable items.

Judgment: Substantially compliant

Regulation 17: Premises

The premises was appropriate to the needs of the residents and promoted their privacy and comfort.

Judgment: Compliant

Regulation 18: Food and nutrition

A validated assessment tool was used to screen residents regularly for risk of malnutrition and dehydration. Residents' weights were closely monitored and there was timely referral and assessment of residents' by the dietician. Meals were pleasantly presented and appropriate assistance was provided to residents during meal-times. Residents had choice for their meals and menu choices were displayed for residents.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

A copy of a transfer record for a resident who was transferred for acute care assessment was available. However; information provided from the centre did not contain all reasonable information about the resident in relation to skin care, incontinence needs or communication needs. Lack of information could lead to errors in care delivery.

Judgment: Substantially compliant

Regulation 27: Infection control

The inspector observed practices that were not in line with the National standards and guidance for the prevention and control of associated infections. Oversight in this area required improvement as evidenced by the following:

- Storage practices had the potential for cross-contamination. For example: Boxes were stored on the floors of the pharmacy rooms on Birch and Oak units which meant that the floors in these rooms could not be effective cleaned. Clinical waste bins were observed to be inappropriately placed in a number of bedrooms for residents who did not have an active infection.
- Sharps bins containers in the pharmacy rooms did not have temporary closures in place, which posed a safety risk to staff.
- The inspector was informed that the contents of urinals and urinary catheters were manually decanted into residents' toilets. This practice could result in an increase environmental contamination and cross infection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Measures were in place to ensure residents' safety in the event of a fire in the centre and these measures were kept under review. Fire safety management servicing and checking procedures were in place to ensure all fire safety equipment was operational and effective at all times. Daily checks were completed to ensure fire exits were clear of any obstruction that may potentially hinder effective and safe emergency evacuation. Each resident's evacuation needs were regularly assessed and the provider assured themselves that residents' evacuation needs would be met with completion of regular effective emergency evacuation drills. Staff had

completed annual fire safety training and were provided with opportunities to participate in the evacuation drills.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- A resident did not have a care plan to reflect and support their recent infection status.
- A resident did not have a care plan to reflect their mouth care needs for a gum infection and jaw infection.
- A resident did not have a care plan to support the management of a wound.
- A resident did not have a care plan to support administration of crushed medication.
- All of the sample of residents nursing records viewed, none had an oral care assessment completed.
- A sample of care plans viewed did not all have documented evidence to support if the resident or their care representative were involved in the review of their care in line with the regulations.

Judgment: Not compliant

Regulation 6: Health care

Significant improvements were required in healthcare. For example:

- Further assurances was required to ensure residents had timely access to appropriate medical care. Over the days of inspection the inspector was told by visitors, staff and residents conflicting information in regard to when medical practitioners attended the centre to see residents. The inspector was informed that some medical practitioner visits were driven by nursing instructions. A sample of medical notes viewed confirmed this. This was a repeated finding on the previous inspection.
- A number of fluid balances charts viewed for residents who had indwelling urinary catheters were not accurately calculated to make an assessment of the residents hydration status.
- The inspector was informed on inspection that there had been an incident in which a deteriorating resident had not been identified nor was their care managed appropriately.

- A resident who displayed behaviours that were challenging particularly in the evening time had not been referred to an appropriate medical practitioner. This residents' behaviour was having an impact on the well-being of some of the other residents living in the centre.

Judgment: Not compliant

Regulation 8: Protection

While it was evident that the registered provider had some safeguarding measures in place, further action was required to ensure all reasonable measures were taken to protect residents from abuse. For example; residents who displayed responsive behaviours such as entering other residents' bedrooms and who were verbally abusive towards other residents, these incidents had not been recognised as safeguarding incidents. ?

Judgment: Substantially compliant

Regulation 9: Residents' rights

While the registered provider had many good practices in relation to upholding residents' rights, there were fundamental gaps seen on the inspection in residents' rights to privacy and choice. For example:

- A small number of residents who could not access a shower told the inspector that they were not offered a choice to have a bath.
- A small number of residents spoken with said they were not offered choice at tea time.
- Furthermore, the inspector was informed by residents and visitors that a number of residents were exposed to episodes of responsive behaviours displayed by a resident which had impacted on their privacy and safety. Residents told the inspector that they felt afraid and vulnerable.
- There had been one resident meeting since the previous inspection, the statement of purpose which Gensis Healthcare Limited was registered against outlines a meeting will take place every alternative month.

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	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Carnew Nursing Home OSV-0008471

Inspection ID: MON-0040469

Date of inspection: 19/09/2024

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
We are committed to ensuring the highest standards of care and have developed a comprehensive compliance plan to address the areas identified for improvement.

Training and Development:
We acknowledge and appreciate the positive feedback regarding our staff training programs. Our ongoing training schedule ensures that all staff members receive relevant and up-to-date training in areas such as fire safety, safeguarding, managing challenging behaviours, and infection prevention and control. We have assigned a member of the administration team to take charge of all training schedules and training matrix.

Supervision and Support:
To address the identified lack of supervision in specific areas, we are implementing the following actions:

Enhanced Supervision Structure:
A structured supervision framework will be developed to ensure consistent oversight of staff in critical areas such as care planning, medication management, and the management of challenging behaviours. This will be led by the ADON who will conduct regular supervisory sessions and provide ongoing support to staff.
The new supervision structure will be implemented within four weeks.

Regular Audits and Feedback:
Conduct regular audits of care plans, medication management practices, and the management of residents with challenging behaviors.
The management team will develop a feedback mechanism to provide staff with constructive feedback and identify areas for improvement.
Audits will be conducted monthly and reviewed by the clinical and governance management team monthly.

Focused Training Sessions:
Management will provide targeted training sessions to address specific gaps identified in supervision, particularly concerning the identification of deteriorating residents and managing challenging behaviours.
Management have engaged with external experts to deliver specialised training workshops and enhance staff skills in these critical areas. We have implemented an online training platform for ongoing training needs.

Monitoring and Evaluation:
Management will establish a monitoring and evaluation system to assess the effectiveness of the new supervision and training initiatives. The ADON will oversee this. Key performance indicators (KPIs) will be set up to track improvements in care planning, medication management, and behaviour management.
The monitoring system will be implemented within eight weeks and review progress quarterly.

Commitment to Continuous Improvement:
We are dedicated to continuous improvement and will ensure that all staff are adequately supervised and supported in their roles. Our management team will oversee the implementation of this compliance plan and provide regular updates to HIQA on our progress.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Below is our compliance plan to ensure full adherence to the requirements outlined in Schedules 2, 3, and 4.

Availability of Records:

Management will ensure that all records required under Schedules 2, 3, and 4 are maintained and readily available for inspection in the designated centre.
Management will conduct a comprehensive audit of all required records to verify completeness and accessibility. Implement a centralised filing system to ensure records are organised and easily retrievable. A designated member of the administration team has been assigned to oversee the implemented.

Staff Files and Employment History:

All staff files will be reviewed and updated to ensure compliance with Schedule 2 requirements, specifically addressing gaps in employment history.
The administrator has developed a standardised checklist for staff files to ensure all necessary documentation, including detailed employment history, is obtained and recorded. All staff files will be reviewed and updated within the next 4 weeks.

References from Previous Employers:

Management will ensure that all staff files include a reference from the most recent employer, as required by Schedule 2.
We will implement a policy requiring verification of references before employment is finalised. A review will be conducted of current staff files to obtain any missing references.
Ongoing Monitoring and Compliance:

Management will establish a regular review process to ensure ongoing compliance with record-keeping requirements.
A quarterly audit will be conducted of records and staff files, ensuring any discrepancies are addressed promptly.

Commitment to Improvement:

We are dedicated to maintaining the highest standards of record-keeping and compliance. Our management team will oversee the implementation of this compliance plan and provide regular updates to HIQA on our progress.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Below is our action plan to address the identified issues:

Governance and Management:
We will enhance our governance structure by appointing a dedicated external consultancy firm – they will oversee and ensure adherence to all regulations. This role will include regular monitoring and reporting on compliance measures. They will be on site once a week for the next 8 weeks.
During this period, weekly governance meetings will be instituted to review operational effectiveness, with a focus on communication, medical care access, and medication safety. These meetings will be attended by the Provider also.

Communication:
A new protocol will be implemented to improve communication with residents and families, ensuring timely updates and responses to concerns. Each wing has been assigned a CNM to oversee all aspects of care. This includes improved communication with residents and families. This will be monitored closely by the ADON, each fortnight, there will be a clinical governance management meeting where all CNM's, ADON, PIC and provider will attend.

Audit System and Processes:
Our audit processes will be thoroughly reviewed and revised to ensure accuracy and reliability. External auditor through a Consultancy firm will be engaged quarterly to provide an objective assessment of our compliance levels.
Immediate retraining of staff will be conducted to ensure adherence to care planning standards and prompt call bell responses.

Behavioural Assessment and Care Planning:
We will conduct a comprehensive review of our policies on managing challenging behaviours and ensure all staff are trained accordingly.
Regular audits will be implemented to ensure compliance with individual assessment and care planning regulations.
Incident and Accident Oversight:
We will establish a robust incident and accident monitoring system, including a dedicated team responsible for timely notifications as per Schedule 4 requirements.
Staff will receive additional training on incident reporting protocols to prevent future lapses.

Medication Management:
A thorough review of our medication management systems will be conducted, and corrective actions will be taken to prevent errors.
We will implement regular training sessions for staff on medication safety and establish a double-check system for medication administration.
We have moved pharmacy as of the 1st Oct 2024, this will hopefully reduce the occurrence of medication errors.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Inclusion of Information from the Certificate of Registration:
We will immediately revise our statement of purpose to include all necessary information as outlined in our certificate of registration. This will ensure that the document accurately reflects our registration status and operational capacity.

Complaints Procedure:
Our complaints procedure will be thoroughly reviewed and updated to align with Regulation 34: Complaints procedure. This will include clear guidelines on how complaints are received, managed, and resolved, ensuring transparency and accessibility for all residents and their families.
We will ensure that the updated complaints procedure is clearly outlined in the statement of purpose and communicated to all staff, residents, and families.

Regular Review and Revision of the Statement of Purpose:
To maintain the relevance and accuracy of our statement of purpose, we will establish a bi-annual review process. The document will be revised as needed to reflect any changes in our operations, services, or regulatory requirements.
The next review will be conducted immediately, with subsequent reviews scheduled every six months, or sooner if significant changes occur.

We are dedicated to ensuring that our statement of purpose meets all regulatory requirements and accurately represents our commitment to providing high-quality care.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Following the inspection, we have submitted all outstanding notifications related to safeguarding concerns and the allegation of misconduct by a member of staff to the office of the Chief Inspector. We confirm that these notifications are now up to date.

Review and Update of Reporting Procedures:
We are conducting a thorough review of our incident reporting procedures to ensure they meet all regulatory requirements. This includes revising our internal protocols to facilitate timely and accurate reporting of all incidents.

Training and Education:
We will implement a comprehensive training program for all staff members, with a focus on the importance of incident reporting and adherence to Schedule 4 requirements. This training will cover the process for identifying reportable incidents and the timelines for submission.

Enhanced Monitoring and Accountability:
A new monitoring system will be introduced to track all incidents and their reporting status. This system will include regular audits and checks to ensure ongoing compliance. The person in charge will be tasked with overseeing this system, ensuring that all incidents are reported within the required timeframes, and that any barriers to compliance are promptly addressed.
Our incident reporting procedures will be reviewed quarterly to ensure they remain effective and aligned with regulatory expectations.

We are fully committed to ensuring that our reporting processes are robust and compliant, thereby safeguarding the well-being of our residents and maintaining transparency with regulatory bodies.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
We are committed to ensuring that all residents' personal belongings are stored safely and appropriately. Below is our action plan to address this non-compliance:

Immediate Rectification:
The personal item observed in the controlled drug press has been immediately removed and returned to the resident. We have conducted a thorough check to ensure no other personal items are stored inappropriately.

Review and Update of Storage Policies:
We are reviewing our current policies and procedures regarding the storage of residents' personal belongings to ensure they are robust and comprehensive.
A new protocol will be implemented to clearly outline the appropriate storage locations for personal items and to prevent any future occurrences of inappropriate storage.

Resident Engagement:
- We will engage with residents to ensure they are aware of the procedures in place for the safekeeping of their belongings and to encourage them to report any concerns they may have.

Ongoing Review and Improvement:
- Our policies and procedures regarding personal belongings will be reviewed regularly to ensure they remain effective and aligned with best practices.

We are dedicated to maintaining a safe and respectful environment for all residents and appreciate your guidance in helping us achieve this.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
We recognise the importance of providing comprehensive information to ensure continuity and quality of care. Below is our action plan to address this non-compliance and prevent future occurrences:

Review and Update of Transfer Protocols:
We are revising our transfer protocols to include a detailed checklist that ensures all

critical aspects of a resident's care needs, including skin care, incontinence, and communication, are documented and communicated effectively during transfers.

Staff Training and Education:
We will conduct mandatory training sessions for all staff nurses involved in resident transfers. This training will focus on the importance of detailed documentation and effective communication to ensure the safety and well-being of residents during transfers.
Staff will be trained on the use of the updated transfer checklist to ensure consistency and completeness in the information provided.

We are committed to ensuring that all residents receive the highest standard of care, both within our facility and during any necessary transfers.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
We are committed to implementing corrective actions to address issues around infection control. Below is our comprehensive action plan:

Storage Practices:
All boxes stored on the floors of the pharmacy rooms in Birch and Oak units have been relocated to appropriate shelving to ensure that floors can be effectively cleaned. We are revising our storage policies to ensure compliance with infection control standards and to prevent potential cross-contamination.

Clinical Waste Bin Placement:
Clinical waste bins have been removed from bedrooms where they are not required, specifically for residents without active infections.
Review of Waste Management Practices: We are conducting a review of our waste management practices to ensure appropriate placement and usage of clinical waste bins throughout the facility.

Sharps Bin Safety:
Immediate Correction: Temporary closures have been activated on all sharps bins containers in the pharmacy rooms to eliminate safety risks.
We will implement regular checks to ensure that all sharps bins are used correctly and have temporary closures in place when not in active use.

Management of Urinals and Urinary Catheters:
Practice Change: We have discontinued the manual decanting of urinals and urinary catheters into residents' toilets. Instead, we will use designated disposal equipment that minimises environmental contamination and cross-infection risks.

Staff Training: All relevant staff will be trained on the new procedures and the importance of adhering to infection control protocols.

Oversight and Monitoring:
We are establishing an Infection Control Committee to provide ongoing oversight and to conduct regular audits of infection prevention practices. This committee will be responsible for ensuring compliance with national standards and for addressing any identified issues promptly.

Continuous Improvement:
We are committed to a culture of continuous improvement and will regularly review and update our infection control policies and practices to ensure they reflect current standards and best practices.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
We are committed to addressing the issues outlined to ensure that each resident's needs are thoroughly assessed and appropriately met. Below is our action plan to rectify these non-compliances:

Development and Review of Care Plans:

Immediate Action: We have initiated the development of comprehensive care plans for all residents identified as lacking them. This includes care plans for infection status, oral care needs, wound management, and administration of crushed medication.

Regular Updates: Care plans will be reviewed and updated regularly to reflect any changes in a resident’s condition or care needs. This will ensure that all care plans are current and relevant.

Oral Care Assessments:

Implementation: We have introduced a mandatory oral care assessment for all residents. This assessment will be conducted upon admission and reviewed periodically to ensure oral health needs are identified and managed effectively.

Resident and Representative Involvement:

Documentation: We will ensure that all care plans include documented evidence of resident or care representative involvement in the review process. This will be achieved by updating our care planning procedures to include a section for recording discussions

and agreements with residents and their representatives.

Communication: We will enhance our communication strategies to ensure residents and their representatives are actively involved and informed about care planning and reviews.
Staff Training and Development:

Training Sessions: We will conduct training sessions for all nurses to reinforce the importance of comprehensive assessments and care planning. This training will cover the development, implementation, and regular review of care plans.

Ongoing Education: We will establish an ongoing education program to keep staff updated on best practices and regulatory requirements concerning care planning and resident assessments.

Monitoring and Quality Assurance:

Regular Audits: We will implement a system of regular audits to ensure compliance with care planning standards. These audits will help identify any gaps and facilitate continuous improvement.

Feedback Mechanism: We will establish a feedback mechanism for residents and their representatives to provide input on their care plans and the care planning process.

We are committed to ensuring that all residents receive personalised and comprehensive care that meets their individual needs.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
We are committed to implementing significant improvements in our healthcare practices to ensure the highest standard of care for our residents. Below is our detailed action plan to address the identified non-compliances:

Timely Access to Medical Care:
For a number of our residents who their previous GP has refused to care for them at the nursing home, we have applied to the HSE medical card section outlining their choice of GP to take care of them. This is being processed currently. In the interim we have a GP who is willing to visit the nursing home bi-weekly to review any residents who need medical attention.
Clear Communication Protocols: We will establish clear communication protocols to ensure consistent and accurate information is provided to staff, residents, and visitors regarding medical practitioner attendance.
Regular Review Meetings: We will conduct regular meetings with medical practitioners and nursing staff to review and plan medical visits based on residents' needs, ensuring

that visits are driven by clinical assessments rather than solely nursing instructions.

Accurate Fluid Balance Monitoring:
Staff Training: We will conduct immediate training sessions for all relevant staff on the accurate calculation and documentation of fluid balance charts, particularly for residents with indwelling urinary catheters.
We will implement regular audits of fluid balance charts to ensure accuracy and to identify any training needs or procedural improvements.

Identification and Management of Deteriorating Residents:
Early Warning Systems: We are introducing an early warning system to help staff identify and respond to signs of deterioration in residents promptly. This will include training on recognising early signs of deterioration and appropriate escalation procedures.
Incident Review Process: We will review and enhance our incident management process to ensure that all incidents are thoroughly investigated and that lessons learned are implemented to prevent recurrence.

Management of Challenging Behaviours:
Referral Protocols: We will establish clear referral protocols to ensure that residents displaying challenging behaviours are promptly referred to appropriate medical practitioners or specialists for assessment and management.
Behavioural Support Plans: We will develop individualised behavioural support plans for residents with challenging behaviours, involving input from multidisciplinary teams to ensure comprehensive management.
Staff Training: Staff will receive training on managing challenging behaviours and on understanding the impact of such behaviours on other residents, promoting a supportive and harmonious living environment.

Oversight and Continuous Improvement:
Healthcare Committee: We are forming a Healthcare Committee responsible for overseeing the implementation of these improvements and for ensuring ongoing compliance with healthcare standards.
Feedback and Evaluation: We will establish mechanisms for obtaining feedback from residents, families, and staff to evaluate the effectiveness of changes and to drive continuous improvement.

We are dedicated to addressing these issues promptly and effectively to enhance the quality of care provided to our residents.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
We are committed to ensuring the safety and well-being of all residents and recognise the importance of addressing and improving our safeguarding practices. Below is our

action plan to address the identified non-compliances:

Recognition and Reporting of Safeguarding Incidents:
We will continue to provide comprehensive training to all staff on recognising and reporting safeguarding incidents, including those involving responsive behaviours such as entering other residents' rooms or verbal abuse. This training will emphasise the importance of viewing such incidents through a safeguarding lens.
Clear Reporting Protocols: We will establish clear and accessible reporting protocols to ensure that all safeguarding incidents are promptly reported, documented, and addressed. This will include revising our current policies to explicitly categorise incidents involving responsive behaviours as potential safeguarding issues.

Enhanced Monitoring and Supervision:
Increased Supervision: We will implement increased supervision in areas where residents are more likely to exhibit responsive behaviours, such as communal spaces and corridors near bedrooms.
Individualised Support Plans:
We will conduct thorough assessments of residents who display responsive behaviours to understand the underlying causes and triggers. This will inform the development of individualised support plans.

Resident and Family Engagement:
We will enhance our communication with residents and their families to ensure they are informed and involved in safeguarding practices and behaviour management strategies.
We will establish feedback mechanisms to allow residents and families to express concerns or suggestions regarding safeguarding and responsive behaviours, ensuring their voices are heard and acted upon.

Continuous Review and Improvement:
We will conduct regular audits of safeguarding practices and incident reports to identify trends, measure the effectiveness of interventions, and make necessary adjustments.
We will establish a Safeguarding Committee responsible for overseeing the implementation of this action plan, reviewing safeguarding practices, and ensuring ongoing compliance with best practices and regulatory requirements.

We are dedicated to creating a safe and supportive environment for all residents and will take all necessary steps to strengthen our safeguarding measures.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
We are committed to upholding the rights of all residents, ensuring their privacy, choice, and safety. Below is our comprehensive action plan to address the identified non-compliances:

Enhancing Access to Personal Care Choices:
Shower and Bath Accessibility: We will conduct an immediate review of our bathing facilities to ensure all residents have access to both showers and baths. We will communicate with residents to understand their preferences and offer choices accordingly.

Improving Meal Choice Options:
We will review our meal planning process to ensure a variety of options are available at each mealtime, particularly at tea time. Residents will be consulted to incorporate their preferences and feedback into the menu.

Addressing Responsive Behaviours
We will develop and implement individualized behavioural support plans for residents displaying responsive behaviours. This will involve input from a multidisciplinary team to ensure comprehensive management.
Increased Supervision and Support: We will enhance supervision in areas where responsive behaviours are likely to occur and provide additional support to residents affected by these behaviours to ensure their privacy and safety.

Regular Resident Meetings
Adherence to Meeting Schedule: We will adhere to the commitment outlined in our statement of purpose to hold resident meetings every alternate month. These meetings will provide a platform for residents to voice their concerns and suggestions.
Feedback from these meetings will be documented and used to inform continuous improvements in resident care and services.
Continuous Monitoring and Improvement:
We will establish regular feedback mechanisms, such as suggestion boxes and informal check-ins, to ensure residents have multiple avenues to express their needs and concerns.
We will establish an oversight committee to monitor the implementation of these actions, ensuring ongoing compliance with residents' rights and identifying areas for further improvement.

We are dedicated to addressing these issues promptly and effectively to enhance the quality of life for our residents.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	04/11/2024
Regulation 16(1)(c)	The person in charge shall ensure that staff are informed of the Act and any regulations made under it.	Substantially Compliant	Yellow	01/01/2025
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	Not Compliant	Orange	01/12/2024

	the Chief Inspector.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	01/12/2024
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.	Substantially Compliant	Yellow	04/11/2024
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	04/11/2024

	implemented by staff.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Not Compliant	Orange	04/11/2024
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Not Compliant	Orange	04/11/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	04/11/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	04/11/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4	Not Compliant	Orange	31/01/2025

	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.			
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 Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	31/01/2025
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.	Not Compliant	Orange	31/01/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	04/11/2024

Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	04/11/2024
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	04/11/2024