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:	Leopardstown Care Centre
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Ballyogan Road, Dublin 18
Type of inspection:	Unannounced
Date of inspection:	05 November 2024
Centre ID:	OSV-0008692
Fieldwork ID:	MON-0045146

About the designated centre

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

Leopardstown care centre is situated in south county Dublin and is in close distance to a local shopping area. It is a purpose built facility that is currently registered for 101 beds but can accommodate 150 residents in the future. It is a mixed gender facility catering for dependent persons aged 18 years and over, providing long-term residential care, respite, convalescence, dementia and palliative care. Care is provided for people with a range of needs: low, medium, high and maximum dependency. The registered provider is Mowlam Healthcare Services Unlimited. The person in charge of the centre works full time and is support by a senior management team and a team of healthcare professionals and care and support staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	82

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
Tuesday 5 November 2024	08:45hrs to 16:45hrs	Karen McMahon	Lead
Wednesday 6 November 2024	09:38hrs to 15:00hrs	Karen McMahon	Lead
Tuesday 5 November 2024	08:45hrs to 16:45hrs	Lisa Walsh	Support
Wednesday 6 November 2024	09:38hrs to 15:00hrs	Lisa Walsh	Support

What residents told us and what inspectors observed

This inspection took place in Leopardstown Care Centre, Ballyogan Road, Dublin18. The inspectors spent time observing and speaking with residents, staff and visitors to gain insight into the lived experience of residents living here. The overall feedback was that residents liked living here but that sometimes they found the day long due to lack of choice of stimulating social activities. The inspectors also followed up on the findings of previous inspections and relevant actions that the registered provider committed to taking in their submitted compliance plans. The inspectors found that while residents spoken with were happy within the designated centre significant improvements were required in the oversight and provision of care for some residents which will be further discussed within this report.

On arrival to the centre the inspectors were met by the person in charge. After a brief introductory meeting the person in charge accompanied the inspectors on a tour of the premises. The centre was a purpose built building and registered in 2023. It was split over three floors with currently only the ground floor and 1st floor registered for use.

Overall the centre was observed to be very clean and well maintained. Many residents were up and participating in the routines of daily living. Residents were well-presented and neatly-dressed. There was a generally calm atmosphere in the centre and the inspectors observed that staff were for the most part attentive and responsive to residents needs.

Residents' bedrooms were observed to be bright, spacious and comfortable. Many residents had personalised their rooms with photographs and personal possessions from home. All the rooms had a cosy and homely feel to them and each room was uniquely laid out to meet the needs of the residents living in them. All residents who inspectors spoke with expressed high satisfaction about their bedrooms and used words such as lovely, homely, spacious and beautiful to describe them.

There was a choice of communal spaces available to residents across all floors of the centre, as well as two enclosed well-maintained courtyards. Internal communal spaces included a large open plan sitting and dining room area, where group activities were observed taking place throughout both days of the inspection. There were also two other smaller sitting rooms available on each floor with large TV screen, electric fireplaces and comfortable seating. However, these rooms on the 1st floor were observed not to be used over the two days, with the lights switched off on both days of inspection, and were not as inviting or finished with decorative items, as seen on the ground floor. Inspectors observed all residents living on this floor were cohorted in the large sitting and dinning room space. This is discussed further within the report.

There were also quieter reflection spaces available to residents across the centre. While these spaces were observed to provide a quieter space for residents, who may

not like noisier areas in the centre or just want to sit in quiet reflection, the rooms were observed to be lacking in soft furnishings such as pictures or sensory items and did not provide an inviting space for residents to use. Staff reported that these spaces were predominantly observed to be used by visitors to visit their loved ones.

The inspectors observed the residents' lunchtime meal. Inspectors noted that the dining experience on the ground floor differed from that found on the 1st floor, which was known to staff and management in the centre as their "memory care unit". On the ground floor the inspectors observed that while many residents preferred to go to the dining room to eat their meals, some residents preferred to eat their meals in their bedrooms or the sitting rooms and their preferences were facilitated. The dining experience on this floor was a social and unhurried occasion for residents who generally sat in small groups of four chatting and interacting with one another. In comparison on the first floor the majority residents were seen to be facilitated in the dining room for meals. On the first day of inspection an extra dining table was observed by the inspectors to be dragged across the dining room floor to facilitate the large volume of residents residing on this floor to sit here. The noise levels were noted to be significantly noisier on this floor and lacked the calm atmosphere observed on the ground floor. The noise levels in this area were observed to be having a negative impact on some residents who displayed responsive behaviour (how people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).Staff appeared unaware of the potential reason for the behaviours and did not respond to the residents in a empathetic and positive manner.

Meals were home cooked on site and recent hot serving trolleys had been purchased for the 1st floor with a plan to purchase more for the rest of the centre, in response to residents reporting that the meals were not overly hot when being served. A menu was displayed on each dining table. On the first day of the inspection, residents were provided with a choice of meals which consisted of chicken a la king or salmon in dill sauce both served with mashed potatoes, carrots and green beans. Residents told inspectors that the food was nice but that the vegetables served were always carrots and green beans and many did not like the green beans. The inspectors again observed carrots and green beans being served as the vegetables of choice on the second day of inspection.

Activities were observed taking place in the large dining and sitting rooms of the centre throughout both days of the inspection, facilitated by carers on the ground floor and the activity co-ordinator on the 1st floor. These included mainly ball games and memory games. Small groups were observed to participate in these activities on the ground floor and the inspectors spoke with some residents on this floor who reported that they felt the activities on offer didn't always meet their cognitive ability and that they found them lacking in stimulation. These residents reported feeling the days sometimes long living here as a result of this. On the first floor in the memory care unit activities were observed to be taking place in large groups with between 20 to 23 residents on both days of the inspection sitting in a big circle in the large sitting come dining room area. Over the two days of inspection, three incidents were observed by inspectors on the first floor whereby residents displayed

responsive behaviours during the activities provided, expressing their lack of interest in the activity.

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

Capacity and capability

This inspection found, that although the provider aimed to provide a good service and support residents living in the designated centre to receive a good standard of care, little progress had been made to address the findings of the previous inspections. The provider would now need to take significant actions to come into compliance with the regulations, to ensure the service provided was safe, consistent and appropriately managed.

This was an unannounced risk inspection carried out to follow up on recent unsolicited information submitted to the office of the Chief Inspector and the compliance plan submitted after inspection in June this year. The inspection took place over two days. The registered provider of Leopardstown Care Centre is Mowlam Healtcare Services Unlimited Company.The inspectors found that although there were clear lines of accountability and responsibility in relation to governance and management arrangements for the centre there were still a number of senior clinical staff who had not yet taken up their positions. A number of clinical nurse manager roles had very recently been filled and these staff were currently undergoing training with the registered provider's quality and risk officer. The appointment included a mix of external and internal appointments. Two new assistant directors of nursing had also been appointed with one having oversight for patient flow and another commencing their induction programme on the first day of inspection. There was an ongoing recruitment plan to recruit two more clinical nurse managers and four senior staff nurses to ensure appropriate supervision 24 hours a day, seven days a week. However, at the time of inspection there was no positive impact evident from the appointment to these roles as many were still undergoing training and induction programmes.The lack of senior staff available to support and supervise nursing and care staff in their work was having a negative impact on the efficacy of the governance and oversight arrangements. Furthermore, the role of general manager had recently become vacant and had not yet been filled.

Inspectors identified a high incidences of falls in the centre, with 11 significant injuries occurring that required regulatory notifications to be submitted to the office of the Chief Inspector, since the previous inspection in June. Inspectors reviewed documentation regarding falls management over the two days of the inspection and were not assured there was adequate oversight or quality improvement plans regarding the high incidence of falls in the centre. This is further discussed under

regulation 23; Governance and management.

Over the two days of the inspection, inspectors found that there was sufficient staffing levels and skill mix in place. However, improvements were required around the supervision of staff to ensure residents' needs were met and that they were appropriately safeguarded and supported. This is further detailed under Regulation 16: Training and staff development.

The complaints log was made available to the inspectors for review. Inspectors identified that the complaints process was not always in line with the registered providers own policy on complaints and there was no detailed investigations into complaints available for review.

Regulation 15: Staffing

There were sufficient staff on duty to meet the needs of the current residents and taking into account the size and layout of the designated centre. There was at least four registered nurses on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised to ensure that they responded to residents who displayed responsive behaviours in a supportive and effective manner. The inspectors observed staff using inappropriate language and objects to restrict the movements of residents who walked with purpose and who did not wish to stay sitting in the communal areas. This was a recurrent finding.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management and quality assurance systems that were in place did not ensure the quality and safety of the service was effectively monitored. This was impacting on clinical effectiveness and residents' quality of life. For example;

- Disparities between the high levels of compliance reported in the centre's own care plan audits did not reflect the inspector's findings during the inspection. This will be detailed further under Regulation 5; Individual Assessment and Care plan.
- There was a high falls incidence in the centre resulting in a number of significant injuries. However, the audit in place did not identify trends in falls such as times or places of falls and there was not root cause analysis carried out into the high incidence of falls to inform a detailed action plan for quality improvement. As a result the incidence of falls remained high in the centre.
- The provider had failed to address the actions from compliance plans submitted to the Chief Inspector following the inspection carried out in June 2024 in relation to regulations 16, 23,24, 5 & 8. This is evidenced by the continued non-compliance's and recurrent findings of inspection.

The management structure that was in place did not support robust governance and oversight of the care and services provided for the residents. A number of senior management roles were still not in place on the days of inspection. These management roles had being identified as a staffing need in a staffing strategy submitted to the chief inspector when the registered provider applied to register the designated centre. For example:

- The staffing strategy identified a need for a whole time equivalent (W.T.E) of two clinical nurse managers for night duty. However on the day of inspection inspectors were informed that supervision on nights would be provided by all clinical nurse managers rotating into nights and supplemented by a plan to appoint four senior staff nurses, for which recruitment was currently ongoing, along with recruitment for two clinical nurse managers to reach their target of 6 W.T.E clinical nurse managers.
- The general manager had left their role and their was no plan in place to recruit for this role.
- There was only one activity co-ordinator in place on the days of inspection despite the identified need for two for the current number of residents living in the centre. This was having a negative impact on the choice of activities been offered to residents**.**

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Contracts in place, for a number of residents in receipt of additional funding, had not been updated to reflect the appropriate arrangements in place for the receipt of financial support towards the resident's care in the centre, despite commitment form the registered provider to do so following the findings of inspection in June 2024.

Judgment: Not compliant

Regulation 31: Notification of incidents

An incidence of financial theft had not been recognised as an incident requiring a notification to be submitted within three working days of its occurrence. It was submitted retrospectively after the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had failed to keep a record of the investigations into complaints made in the centre, in line with their own complaints policy. As a result of this inspectors were unable to review the investigations into two significant complaints and could not be assured they had been investigated appropriately. It also meant a review of the complaint could not be fully carried out, in the absence of the record of the investigation, if requested by the complainant.

Judgment: Not compliant

Quality and safety

Although inspectors found that the provider had taken some positive actions to improve the quality and safety of care provided for the residents in the designated centre these changes were not consistent and had not brought about sustained improvements. As a result inspectors were not assured that the systems in place to oversee the quality and safety of care and services promoted a good quality of life for the residents in which their safety and rights were promoted. More focus and effort were now required from the provider to bring the centre into compliance with the regulations, particularly in relation to managing behaviour that is challenging, assessment and care planning, residents' rights, and protection.

Overall, records showed that residents had access to medical care in line with their assessed needs. A general practitioner attended the designated centre weekly and as required. There was on site support from a physiotherapist three times a week. Appropriate medical and health care referrals were made to specialist services such as psychiatry, speech and language therapy, dietitians and community services such

as chiropody. Records evidenced that referrals were timely and residents received prompt support form these specialist services when needed.

The layout of the premises promoted a good quality of life for residents. There were suitable ancillary services throughout the building, including appropriate hand washing facilities. The centre was clean and well-maintained. Although the centre was well-maintained, there was a lack of soft furnishings in the quiet room and the smaller sitting rooms on the first floor, which did not provide an inviting space for residents to use.

Inspectors reviewed some records of recent discharges to the acute setting. Inspectors were told that the centre utilised the National Transfer Document. Inspectors reviewed the records which were maintained upon the residents' return to the centre, and saw there was review from the GP and the health care recommendations such as medicine review or outpatient appointment follow-up were received.

Residents' social and health care needs were assessed using validated tools; however, inspectors found that some were not completed appropriately and did not correlate with care planning information. This resulted in residents taking part in activities that they did not like or that were not appropriate to their assessed cognitive ability. Furthermore, a number of residents who had had some significant falls recently and were assessed as a high falls risk did not have their care plans updated to reflect there current falls risk or their current mobility assessments, carried out post falls. As a result the care plans did not effectively guide safe and appropriate care to minimise the risk of falls. Inspectors found compliance with care planning had decreased since the previous inspection findings.

The centre had a policy to guide the use of restraint and restrictive practices and maintained a register of restrictive practices in use in the centre. From a review of the risk registers, inspectors found that there was a low use of restraint within the centre. However, as found on the previous inspection, inspectors observed poor staff responses to those residents who display responsive behaviour. This is discussed further under Regulation 7; Managing behaviour that is challenging.

While, the provider had measures in place to safeguard residents from abuse and residents confirmed that they felt safe in the centre, a number of staff did not demonstrate an awareness of their reporting responsibilities and the reporting structures in the centre. Furthermore, two residents with a safeguarding risk did not have a care plan in place. The registered provider had also failed to put care plans in place for residents who were currently undergoing the process to have a decision making representative appointed under the Assisted Decision Making (Capacity) Act 2015, which they had committed to doing in their compliance plan following inspection in June this year.

Regulation 25: Temporary absence or discharge of residents

All relevant information was communicated through the national transfer document on the residents transfer to hospital or elsewhere. Changes to care, on return to the centre, were reflected in the care plans. Medical and nursing transfer letters accompanying the resident on return to the centre were available for review in the residents personal file.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure that assessments and care plans were reviewed and updated as required when there was a change in the resident's condition and that these correlated with each other to ensure that residents needs were met. For example:

- Not all assessments were completed appropriately and did not correlate with care planning information. This resulted in some residents taking part in activities that they did not choose or that were not appropriate to their assessed cognitive ability.
- Several care plans did not reflect the residents assessed needs. For example:
    - A number of residents who had had some significant falls recently were assessed as a high falls risk. However, they did not have their care plans updated to reflect there current falls risk.
    - Furthermore, a number of residents who had been seen by physiotherapy following a recent fall did not have all physiotherapy recommendations detailed in their care plan. As a result the care plans did not effectively guide safe and appropriate care to minimise the risk of falls.
    - A number of residents who had multiple falls did not have a care plan in place to support their mobility needs to guide staff on how to support them.
- Not all residents who were identified as a high risk of falls had assessed safety checks in place. For example, a resident who had multiple significant falls resulting in injuries requiring hospital treatment had been assessed as required additional supervision and safety checks due to the risk identified. However, records reviewed of safety checks in place had some gaps of up to four hours, on one occasion, when the resident had a safety check recorded.
- Two residents who were identified as having safeguarding needs did not have a care plan in place. Other residents who had safeguarding needs had a care plan in place, however, this was not based on a risk assessment and was not individualised to meet their care needs.

Judgment: Not compliant

Regulation 6: Health care

While residents had access to allied health care professionals the recommended treatment was not always reflected in resident's care plans and inspectors were not assured that the appropriate care in line with the medical practitioner's was provided to residents. For example;

- a number of residents who had been seen by physiotherapy following a recent fall did not have all physiotherapy recommendations recorded in their care plans and inspectors were not assured that care staff had the appropriate information to provide recommended care.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The oversight and management of residents with responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) required improvement. Residents had positive behaviour care plans in place. However, these detailed support for residents risk of falls and did not have accurate or clear direction for staff to ensure that responsive behaviour was managed or responded with the appropriate skills and knowledge to manage the behaviour. In addition, they did not detail options including a stepped approach to ensure that responsive behaviours were managed in a manner that is not restrictive or in accordance with the national policy. For example;

- One resident who had sensory issues was sitting in the dining room on the first floor waiting for their meal to be served. The dining room was full of residents and observed to be very busy and loud. The resident displayed responsive behaviours. While this was occurring staff pulled a table across the dining room and rearranged other tables which added to the noise and did not create a calm atmosphere to support the residents sensory needs or responsive behaviours.
- In addition, the resident was given a PRN (medicines only taken when the need arises) without any other alternatives trailed first. The resident did not have a care plan in place to ensure their needs were met. This resulted in staff not responding appropriately to a recorded incident and to an incident observed by inspectors on the day of inspection.

As identified on a previous inspection in June this year, inspectors were not assured that episodes where a resident displays responsive behaviours that poses a risk to the resident concerned or to other persons, was managed and responded to in a manner that is not restrictive. For example, on this a resident was observed wanting to leave the area they were sitting in. There was a table up against their legs which

they moved and tried to walk away. Staff redirected them to sit back down and pulled the table towards their legs again.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not taken all measures to protect residents from abuse. This was evidenced by;

- Two residents with a safeguarding risk of financial abuse did not have a care plan in place.
- Although staff had completed training in relation to the detection and prevention of and responses to abuse, a number of staff did not demonstrate an awareness of their reporting responsibilities and the reporting structures in the centre. For example, staff had failed to recognise an incident which occurred as safeguarding concern and had not reported it to the person in charge. This resulted in delayed action been taken to respond and prevent any further risk to residents.
- Nine residents were undergoing the process to have a decision making representative appointed under the Assisted Decision-Making (Capacity) Act 2015. They required additional measures in place to protect them from abuse due to impaired capacity in relation to certain decisions. In the compliance plan form the previous inspection the registered provider had committed to these residents having an individual care plan and risk assessment that clearly defines the areas of concern to the individual resident, including measures to be taken by staff to ensure these residents are protected. However, the registered provider had also failed to risk assess individual residents and put the required care plans in place to ensure that residents were safeguarded.

This is a third repeated non-compliance from two previous inspections this year.

Judgment: Not compliant

Regulation 9: Residents' rights

There was an activity programme available. However, on the two days of inspection there was only one activity co-ordinator for 81 residents, who were spread out between two floors. Health care assistants were observed to facilitating some activities on the ground floor, while the activity co-ordinator was mainly on the first

floor. The provision of activities on the ground floor did not ensure that all residents had an opportunity to participate in activities in accordance with their interests and capabilites. Some residents spoken with also said they felt the activities on offer didn't always meet their cognitive ability and that they found them lacking in stimulation. These residents reported feeling the days sometimes long living here as a result of this.

On the first floor in the memory care unit activities were observed to be taking place in large groups of residents in attendance on both days of the inspection. Some residents appeared to enjoy some of the activities. However, three incidents were observed by inspectors whereby residents displayed responsive behaviours during the activities provided, expressing their lack of interest in the activity.

Inspectors found that resident's ability to exercise choice in their daily routines was limited, in particular for residents on the first floor, which created a task-orientated culture for residents on the first floor.For example;

- On the first floor, the activities were provided to residents sitting in a big group in the large sitting come dining room area. Residents who were observed to not want to participate in the activity taking place were redirected to stay at the activity without alternative choices offered to them.
- Additional smaller sitting rooms and quiet rooms were available for residents to use on the first floor. However , these rooms were observed to have the doors closed and the lights off throughout both days of inspection and no television on to create an inviting alternative choice of routine for residents to enjoy.Inspectors observed residents who tried to leave the large communal area being redirected back to this space and residents were not encouraged or facilitated to use the alternative communal spaces.
- In addition, for residents on the first floor, when it was time for meals residents moved from one side of the room to the other side of the room which was laid out as the dining area.

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 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Leopardstown Care Centre OSV-0008692

Inspection ID: MON-0045146

Date of inspection: 06/11/2024

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 will provide all staff with enhanced education and training on the management of people with behaviours that are challenging. Since the most recent inspection, most staff have received further training on managing Behavioral and Psychological Symptoms of Dementia (BPSD), and we have worked with the trainers to use real life scenarios as the basis for effective learning to ensure that theory translates to practice. • The PIC has reviewed the rosters to ensure that staff with an expressed interest in working with people with a diagnosis of dementia are appropriately allocated to care for the residents who display BPSD, so that they will develop greater understanding of individual residents' behaviours, including triggers and the implementation of appropriate de-escalation strategies; they can ensure that walking with purpose is supported appropriately, using language that is connective and understanding the personal needs of individuals. • We will ensure that residents who require enhanced care to manage BPSD are cared for in one unit dedicated to the needs of people with behaviours that can be challenging. This will facilitate the provision of an enhanced level of care, supervision, appropriate skill and staff mix. This has been undertaken in consultation with residents and families to ensure all personal needs and preferences can be met. • We will provide education for all nursing staff on assessments and care planning.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:
• We have established a team to support the PIC to develop the new management team and ensure they are working effectively and cohesively to restore regulatory compliance in the centre. The team includes the Healthcare Manager, a Quality & Safety Coordinator, and the Director of Care Services. This team meets on a weekly basis to review progress on an agreed Quality Improvement Plan.
• Clinical Care Audit schedules have commenced to review all resident care plans. CNM's, ADON and DON are completing these audits to ensure the named nurse reviews all assessments, current medical and MDT reviews and reflects the interventions in the care plans.
• The PIC will ensure that each member of the management team understands the need to identify any non-compliant areas found during the audit process and to identify these as areas to be addressed in the associated Quality Improvement Plans (QIPs).
• A Falls Committee has been established within the centre, which will be chaired by the ADON who has previous experience of leading on Falls Prevention strategies. The ADON will attend the organisation-wide Falls Committee meetings. The aim of the centre's Falls Committee is to increase staff awareness of falls, educate staff residents and family members about effective falls prevention strategies and implement a culture in the centre where staff understand how to conduct a skilled observation of a resident in their environment; for example, ensuring that the call bell, table, drinks etc are within easy reach, that the residents is wearing appropriate footwear and that regular safety checks are completed.
• There is a focus on new admissions and their transition and residents who have had 2 or more falls within the month.
• Analysis of falls and trend identification are presented at these meetings. Learnings from falls such as the oversight of managers before and after lunchtime has been highlighted to reduce the number of falls at this peak time.
• The PIC will ensure that there is effective supervision of communal areas and regular safety checks of residents in their bedrooms.
• We will introduce a second sitting at mealtimes to allow for a calmer environment and also to facilitate closer supervision during times when residents are in transit between bedrooms and communal areas to dining areas, when the risk of falls is higher.
• We have introduced a supernumerary Night Supervisor which will enhance the supervision of the centre at night. The Night Supervisor will be an experienced Senior Staff Nurse.
• We now have 3 ADONs in post, all supernumerary. There are 4 supernumerary CNMs in post and we are recruiting 2 more CNMs in preparation for the registration of the remaining 50 beds.
• The General Manager role will be reviewed as we have outsourced many of the services that would have been within the remit of the General Manager, including Housekeeping, Laundry and Facilities. We will be outsourcing the catering service in early 2025. Most of the administrative functions have been centralized to the main Support Office. Management of the service contracts is overseen by the Chief Operations Officer, supported by the Healthcare Manager.
• We will appoint a General Services Manager (GSM) to oversee all non-clinical services and to liaise with external contractors, ensuring that service level agreements are implemented as planned. The GSM will monitor quality standards and provide on-site supervision and direction to non-clinical services in the centre. Until the GSM commences in post, supervision and operational support of non-clinical services will be provided on a

daily basis by the centre management team and there are area managers available who provide oversight to their respective services and employees. Employees of external contractors that are nased in the centre will be integrated into the overall operations team to ensure effective communication regarding meeting the needs of all residents and maintaining expected standards and complying with the centre's policies, procedures and guidelines.
• There are currently 2 Activity Coordinators (AC) in post, and we are in the process of recruiting another AC.
• The activities schedule will be enhanced by an online application called Altra to ensure the provision of a variety of interesting and engaging activities to residents every day of the week.

Regulation 24: Contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
• We will revise the contracts for the residents in the Assisted Decision-Making process to reflect the appropriate arrangements in place for the receipt of financial support towards the resident's care in the centre.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• Any incident of suspected theft from residents will be notified to the Authority as NF06 suspicion or allegations of abuse. The Authority, the Gardai and the HSE Safeguarding Team have been informed about the historic suspected thefts and a Safeguarding plan has been implemented to protect residents' property and valuables.
• The PIC will oversee all incidents and ensure that they are reported, recorded, investigated and resolved in accordance with the centre's policy on Safeguarding and Risk Management, and in accordance with legislative requirements.
• We will hold a weekly senior management team meeting with the Healthcare Manager to review current incidents and notifications to ensure that there are robust safeguarding plans in place.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The PIC will maintain a record of all complaints received and will ensure that all complaints are acknowledged, and a response sent to the complainant; complaint investigation records will be documented, investigated and resolved in accordance with the centre's Complaints Management Policy.
• We will provide staff with Complaints Awareness training and the management team will be educated in Complaints Management.

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:
• Clinical Care Audit schedules have commenced since the inspection to review all resident care plans. The PIC, with the support of the ADON and CNMs will complete these audits and will support the named nurse to review all assessments, current medical and Multidisciplinary (MDT) reviews and to reflects appropriate interventions in the care plans.
• The centre's Falls Committee has been established, which will be chaired by the ADON, who will also participate in the organisation-wide Falls committee meetings. A Falls Prevention strategy will be developed, including ensuring that skilled safety checks take place routinely, and raising awareness of falls risks among staff, residents and families.
• Actions from this group will be circulated to all clinical staff and members of the MDT to ensure responsibility is shared and also reflected in the care plans.
• The Night supervisor will also reviews all care plans that are revised after a change in a resident's baseline, such as return from a hospital admission, increase in care needs or following review by the MDT.
• Nurses will be assigned key residents to ensure the updates and the results of the audits are completed. CNMs will meet with nurses on their assigned unit each month to undertake clinical reflection, and to review the care plan audit findings and evaluation of the required quality improvement actions.
• Care plan training for nurses has commenced since the inspection, and all nurses will undertake training to improve their completion of care plans.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Physio review notes will be recorded in the appropriate MDT Section of the electronic care record for each resident, and also in the residents' care plans. All changes or adjustments recommended by MDT will be discussed with the CNM for each unit and at weekly MDT meetings. All changes will be discussed with all staff at handover meetings and Safety Pauses.
• The Physiotherapist will be invited to participate in the centre's Falls Committee.
• Education and training will be scheduled for all nurses to ensure that they include the recommendations of the allied healthcare professionals in the residents' care plans.
• The Night supervisor will review the care plans of residents who require review following a change in baseline, following discharge from hospital, change in mobility needs, nutritional status or following MDT reviews.
• Nurses will be assigned key residents and will be responsible for ensuring that all care plans and quality improvements following clinical care audits are implemented.
• CNMs will meet their allocated key nurse each month for clinical reflection, and during this meeting they will review the care plan audit findings and evaluations of the quality improvements.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• We will locate all residents with BPSD in a designated unit in the centre. This Memory Care Unit will be staffed by staff with an interest and/or experience of caring for residents with a diagnosis of dementia and associated responsive behavioural issues. Residents, staff and families will be consulted to ensure there is a good understanding of the purpose and function of this unit.
• Most of the staff have already received further training on managing BPSD and symptoms of dementia; the trainers use real-life scenarios to assist staff to gain insight into challenging behaviours and to encourage them to translate theory to practice. All staff who work in the Memory Care Unit will receive focused education on managing challenging behaviours, including how to identify triggers to behaviours and appropriate de-escalation techniques, all of which will be documented in the residents' care plans to ensure a consistent approach to care.
• The management team of the centre will receive attend a workshop focused on the role of managers in identifying, responding to, notifying/escalating safeguarding concerns, and will learn how to develop and implement safeguarding plans to protect all residents from harm or abuse.
• The ADON and CNMs, allocated to the Memory Care Unit will conduct daily quality and safety checks to monitor standards of care, ensure the appropriate management of BPSD and dementia symptoms, and that there is no inappropriate use of restrictive practice.

• A second sitting at mealtimes will be introduced to facilitate calmer, unhurried mealtimes that can be enjoyed by all residents and give those who need assistance sufficient time to enjoy their meals with due consideration to their dignity and privacy.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• We have appointed an ADON whose role focuses on Patient Flow: from the time of referral to discharge, the Patient Flow ADON will ensure that each resident is appropriately assessed, that the care needs of all residents admitted to the centre can be safely met, that all residents are protected from harm, including those residents who are going through the complex Assisted Decision-Making process. The Patient Flow ADON will oversee, support and ensure the development and implementation of all safeguarding plans for residents currently undergoing the decision-making process, including the referral to advocacy services and social worker.
• Residents undergoing the Assisted Decision-Making process have a point of contact, a solicitor, who is the person responsible for the decisions made on behalf of the residents and the Patient Flow ADON will ensure that there is effective communication and record-keeping regarding all aspects of the residents' care.
• We will ensure that all residents at risk of abuse have appropriate individual safeguarding care plans in place, based on their requirements. Individual residents will be risk assessed every 4 months or sooner should needs change and the care plan updated accordingly.
• We will ensure that all staff attend a Safeguarding workshop where real-life scenarios will be used as the basis for learning and to help them to apply theory to practice. The management team will also attend Safeguarding education sessions to ensure that they understand their role in recognising, reporting, escalating/notifying, investigating and resolving safeguarding issues.
• The PIC, with the support of the Healthcare Manager, will review all incidents and complaints every week to determine whether they include any suspicions or allegations of abuse, to heighten awareness of abuse and to promote a culture of resident protection.
• The management team will ensure that they provide oversight and support to staff to encourage them to ensure that resident protection is integral to the care planned and delivered to all residents in the centre.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• There are currently 2 full-time Activities Coordinators in post, and recruitment is under way to appoint a third.
• There is a variety of activities available in various areas throughout the building to encourage smaller groups and increase resident choice.
• For those residents who may be unable to attend the dining room, there is a weekly activities schedule provided on paper. There is also a weekly activities schedule displayed on the activities board.
• We will develop a Quiet Room within the Memory Care Unit which will be used to assist people with BPSD when behaviours are escalating, to assist them to reduce anxiety or agitation.
• Residents have access to TVs, newspapers and other media.
• There is an online application that is used by Activities Coordinators and Healthcare Assistants, which gives residents access to a wide range of meaningful activities and games. This application is used to enhance the activities programme.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/01/2025
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/03/2025
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	31/01/2025
Regulation 23(c)	The registered	Not Compliant	Orange	31/01/2025

	provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 24(2)(a)	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 services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.	Not Compliant	Orange	31/01/2025
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	31/12/2024
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on	Not Compliant	Orange	31/01/2025

	foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/01/2025
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Substantially Compliant	Yellow	31/01/2025
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and	Not Compliant	Orange	31/01/2025

	skills, appropriate to their role, to respond to and manage behaviour that is challenging.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	31/01/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	31/01/2025
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	31/01/2025