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:	Sugarloaf Care Centre
Name of provider:	Spridale Limited
Address of centre:	Kilmacanogue South, Kilmacanogue, Wicklow
Type of inspection:	Unannounced
Date of inspection:	10 October 2024
Centre ID:	OSV-0008793
Fieldwork ID:	MON-0044316

About the designated centre

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

Located at the foot of the majestic Sugarloaf mountain in the village of Kilmacanogue, the Sugarloaf Care Centre can provide comprehensive care for 119 residents, accommodating both male and female residents. The centre can provide care for residents ages 18+. Each room is thoughtfully designed to create a warm and welcoming atmosphere. The units are named appropriate to its surroundings as follows : Lower Ground Floor is named Powerscourt accommodating 18 residents. 15 single en-suite, 1 single accessible en-suite and 1 twin en-suite. Ground Floor is divided into two units Glendalough and Mount Usher accommodating a total of 49 residents. Glendalough: 17 beds comprising of 15 single en-suite, 1 twin ensuite. Mount Usher: 32 beds comprising of 29 single en-suite, 3 single accessible en-suite First Floor is divided into two units Silver Strand and Laragh accommodating a total of 52 residents. Silver Strand: 17 beds comprising of 15 single en-suite, 1 twin ensuite Laragh: 35 beds comprising of 32 single en-suite, 3 single accessible en-suite. Sugarloaf Care Centre is designed to meet the health & social care needs and risk assessment of residents of all dependency levels. There are currently no limits or restrictions on the care needs the centre is intended to meet, and all prospective and current residents are assessed using a standard assessment, the Barthel Assessment Tool. Staffing levels are determined by the management of the centre having reviewed the resident's current dependency levels.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	33

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 10 October 2024	07:50hrs to 17:35hrs	Helena Budzicz	Lead

What residents told us and what inspectors observed

Overall, there was a pleasant atmosphere in Sugarloaf Care Centre, and residents were relaxed and comfortable in their surroundings. Residents who spoke with the inspector gave mixed feedback about their experience living in the centre. While residents were complimentary of the staff who provided them with care and support in a caring and respectful manner, they expressed discontent with the quality of social care they received over the weekends and the quality of food provided in the centre.

Sugarloaf Care Centre is a newly built designated centre located in Kilmanogue Village, overlooked by the Great Sugar Loaf Mountain. The centre has sufficient parking spaces for residents and visitors at the front and back of the building, including disabled access spaces.

The centre was registered for 119 beds in July 2024. On the day of the inspection, there were 32 residents in the centre, with one resident in the hospital. Residents were accommodated on the ground floor and lower ground floor units. The lower Ground Floor unit is named Powerscourt, accommodating 18 residents. The Ground Floor is divided into two units, Glendalough and Mount Usher, with a capacity of up to 49 residents.

The centre appeared bright and well-ventilated, and the communal areas were beautifully furnished. The centre also features a coffee dock where residents can meet together or with their friends and family. Residents were seen spending time reading and watching television in some of the communal spaces, and other residents were observed enjoying the company of staff. The inspector observed that residents were well-groomed and appropriately dressed in their preferred clothing.

The premises were well-maintained, and the inspector observed some areas of good practice in preventing and controlling infection. Staff were observed to practise good hand hygiene techniques, and clinical hand wash basins were available on each floor. However, the cleanliness of the centre requires review, which will be further outlined under Regulation 27: Infection Prevention and Control.

All bedrooms had en-suite facilities and had been decorated and furnished to a high standard. Residents' bedrooms were clean, warm and comfortable. There was adequate storage space for residents' personal possessions and properties, including lockable storage for valuable items.

There was a nature-rich garden area featuring wild flowering plants and other garden features. However, access to these areas was restricted with key-pad codes, which meant that accessing safe outdoor spaces was not readily available to residents. In addition, the inspector observed that there was no garden furniture available for residents on the Lower Ground floor unit.

Residents were engaged in activities throughout the day. The social activities calendar in the centre was very important to the residents. The inspector observed residents interacting and enjoying the activities provided during the day. There were many occasions throughout the day of inspection in which the inspector observed laughter and banter between staff and residents. The inspector spoke with a number of residents, and while the feedback regarding the activities and staff providing the activities was very positive, the residents voiced that 'sometimes there is not much to do during the weekend' when the activity staff is not working.

During the inspection, a significant disparity in mealtime experiences was observed between residents on the Lower ground floor unit, where mainly residents with a diagnosis of dementia were living and those on the Ground floor unit and residents who received meals in their bedrooms. Residents on the Ground floor unit were served freshly prepared breakfast and lunch from the bain-marie by the kitchen staff and chef. However, residents on the Lower Ground floor unit had their meals pre-plated with limited choices available. At lunchtime, residents in the dining room on the Ground floor were treated to a delightful dining experience, complete with tablecloths and decorations, and a chef asking them about their choice of meal and serving the meals. In contrast, those on the Lower ground floor unit had their meals pre-plated, and some of the tables were not appropriately dressed for serving the meals. In addition, the inspector observed some delays in serving meals to residents in their bedrooms during lunchtime with some residents being served their lunches more than one hour later than the other residents. Residents who spoke with the inspector said they were not always happy with the quality and quantity of the food. The inspector also observed that the food being served to the residents was not in line with the written menus provided to the inspector for review. Further details are discussed under Regulation 18: Food and Nutrition and Regulation 23: Governance and Management.

Residents had access to radios, television and internet services. Arrangements were made for residents to access advocacy services. A Roman Catholic priest from the local parish visited the centre once a week.

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 on the quality and safety of the service being delivered. The levels of compliance are detailed under the individual regulations.

Capacity and capability

Overall, while there were management systems in the centre to ensure oversight of care and service provided to the residents, they were not effective at ensuring the quality and safety of the service was maintained at all times. There was an unstable governance and management team, and in the three months since the centre was registered, there had been three people in charge appointed to this role. There was

a new person in charge who started to work in the centre at the start of the week of the inspection. They have extensive experience in the care of older people in designated centres. They were able to identify some areas for quality improvements in the centre and demonstrated a good knowledge of the regulations.

This was an unannounced one-day inspection by an inspector of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The inspector also reviewed notifications and unsolicited information received by the office of the Chief Inspector in relation to the governance and management oversight of the centre and the quality and safety of care provided to residents. The findings of this inspection validated some of the concerns received and showed that actions were necessary to ensure that the governance oversight and the management systems were enhanced to enable safe, appropriate, consistent and effective care.

Sugarloaf Care Centre is owned and operated by Spridale Limited Limited, which is the registered provider and part of the Silver Stream Healthcare Group. The company is comprised of three directors. From a clinical perspective, care in the centre was directed by the person in charge (PIC). They were supported by one Assistant Director of Nursing (ADON) and one clinical nurse manager (CNM) who were responsible for overseeing the work of a team of nurses, health care assistants, an activity coordinator, maintenance, housekeeping and catering staff. At a senior level, the person in charge is supported by the Person participating in management (PPIM), the Director of Clinical Governance, who visits the centre regularly.

There were sufficient staff on duty on the day of the inspection to meet the residents' needs. However, the inspector found that the organisation and management of the staffing resources were not always effectively allocated within the centre. This is evidenced under Regulation 9: Residents' rights, Regulation 18: Food and nutrition and Regulation 23: Governance and management. Staff had access to appropriate training and development to support them in their respective roles, and a training schedule was in place. Records reviewed by the inspector confirmed that training was up-to-date.

A sample of five staff records reviewed by the inspector identified that the requirements of the regulations were met. Each staff had completed An Garda Síochána (police) vetting prior to joining the service, and registered nurses held an active registration with the Nursing and Midwifery Board of Ireland (NMBI).

The management systems in place did not ensure that the service provided was appropriate, consistent or effectively monitored. Although the provider completed weight loss audits, the information relating to weight loss management and feedback regarding the quality and quantity of food had not been identified or analysed, and as a result, an effective quality improvement plan was not developed. Based on the findings from this inspection, the inspector requested that an appropriate nutritional analysis be completed. Following the inspection, the provider

submitted evidence of improvements in the food menu, nutritional oversight, and mealtime experience.

The complaints policy and procedure were established and aligned with the regulations. The complaints procedure was visibly displayed in the centre. Although complaints in the centre were documented, there were some areas in complaints management that needed improvement to fully comply with Regulation 34: Complaints procedure.

During the inspection, the inspector identified that a notifiable incident had occurred and which had not been appropriately notified to the Office of the Chief Inspector. However, the inspector was assured that the new person in charge had identified and implemented safeguarding precautions to ensure that all residents were protected from reoccurring incidents.

Regulation 14: Persons in charge

There was a new person in charge who was full-time in post. They had the necessary experience and qualifications as required by the regulations. They demonstrated good knowledge regarding their role and responsibility and their regulatory remit.

Judgment: Compliant

Regulation 15: Staffing

On the day of inspection, the number and skill-mix of staff was appropriate to the assessed needs of residents, and the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

A training matrix was maintained in the centre, and mandatory training for all staff was in date. There was a plan in place to ensure all new staff received training, and there was evidence of an ongoing training schedule for training according to staff roles and responsibilities.

Judgment: Compliant

Regulation 21: Records

A sample of staff files was examined and contained the information required under Schedules 2 and 4 of the regulations.

Judgment: Compliant

Regulation 22: Insurance

A contract of insurance was available for review. The certificate included cover for public indemnity against injury to residents and other risks, including loss and damage to residents' property.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider did not ensure that the designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. For example:

- The allocation of staff resources required review as the inspector observed instances where residents were left unsupervised for a long time in the communal areas on the ground floor when no activities were going on.
- There was only one activity staff working five days a week, and there was a lack of evidence that there were any staff members allocated to provide activities for residents outside of the usual day allocation. Feedback from residents confirmed that there were no activities carried out during the weekend.
- The assistance at mealtimes for residents who chose to have their meals in their bedrooms was significantly delayed, as further outlined under Regulation 18: Food and nutrition.
- Residents' outdoor spaces were not equipped with appropriate equipment and furniture to enable them to enjoy these spaces and avail of opportunities for summer activities.

The management systems in place to ensure that the service was consistently monitored were not fully effective. This was evidenced by:

- While there was an auditing system in place, there was no clear action plan documented and outlined to inform a quality improvement plan. For example,

the weight loss audit completed in September 2024 did not identify the findings from this inspection or any areas for learning. The residents had voiced a number of complaints during residents' meetings regarding the quantity and quality of food and the fact that there was no protein served at tea time. There was no evidence that these complaints were adequately addressed or followed up. In addition, there was no quality improvement plan developed to ensure residents' nutritional care needs and nutritional risks were appropriately identified, monitored, and managed. The inspector was so concerned that they requested an urgent nutritional needs review to be completed by the person in charge on the day of the inspection. The inspector acknowledges that adequate assurances were received following the inspection.

- The oversight of the complaints management system had not identified that all complaints were not managed in line with local policy and regulatory requirements, as detailed under Regulation 34: Complaints.
- There was insufficient oversight of cleaning practices relating to infection prevention and control and the overall standard of cleaning was not adequate.
- Environmental restrictive practices, such as free access to garden areas and communal spaces, were not monitored sufficiently in line with local and national policy.
- The inspector noticed that door wedges and a chair were being used to keep fire doors open in communal areas. These practices posed a fire safety risk, and the inspector requested to be addressed on the day of the inspection. Oversight of fire management systems required to be strengthened.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector identified one notifiable incident of an allegation of a potential safeguarding issue; however, the Chief Inspector had not received the appropriate notification within three working day as required by the regulation. The new person in charge submitted the required notifications retrospectively.

Judgment: Not compliant

Regulation 34: Complaints procedure

A complaints log was maintained, but there was a lack of evidence to show that:

- All complaints had been acknowledged in writing within 5 days from the receipt of the complaint as per the centre's policy.

- Investigated and concluded within 30 working days.
- The provision of a written response informing the complainant whether or not their complaint had been upheld with the reason for the decision and the improvements recommended was not consistently included, as required by the regulation and complaints process.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that improvements were required to ensure that residents were supported to live a good quality of life in this centre in an environment that promoted their safety and promoted residents' well-being. Nothwithstanding some of the positive findings outlined in the compliant regulations, there were significant concerns in respect of the food and nutritional needs and how these impacted the overall quality of care and quality of life for the residents living in the centre. While there were opportunities for social engagement on the day of inspection, and staff interacted with the residents respectfully and kindly, further review of the provision of meaningful activities over the weekend was required. The inspector identified the following areas for improvement such as the management of care planning, residents' rights and social activities, infection control, restrictive practices, and premises.

A review of residents' records found that residents had access to a general practitioner (GP) of their choice, as requested or required.

The inspector reviewed a sample of residents' care plans and daily care records. Residents' assessments were undertaken using a variety of validated tools, and care plans were developed following these assessments within 48 hours of the resident's admission to the centre. Care planning documentation was available for each resident in the centre. However, it was found that some care plans were not updated in line with the changing needs of the residents. Additionally, some residents did not have their wound, nutritional, and infection control care plans updated to guide safe care delivery as required by Regulation 5: Individual assessment and care plan.

Environmental restrictive practices required action as they were not managed in accordance with the national restraint policy and guidelines and the centre's policy. Doors leading to outside spaces were locked, and staff said that was to prevent residents with dementia from going outside. This was brought to the attention of the new person in charge, who provided assurances to the inspector that all door locks were unlocked to ensure that residents had free access to all communal areas in the centre. This is discussed in the report under Regulation 7: Managing behavior that is challenging.

During the inspection, the inspector observed how residents were dining and being served. It was noted that not all residents had a satisfactory mealtime experience during breakfast and lunch and were not given the support needed for a dignified meal experience. There were significant disparities between the dining experience for the residents on the Ground floor and those on the Lower Ground Floor. These findings are outlined under Regulation 18: Food and Nutrition.

There was a cleaning schedule in place. Staff were seen to adhere to guidelines for the use of personal protective equipment (PPE), and there was a good stock of this available for staff, including enhanced PPE should there be an outbreak of infection in the centre. Further opportunities for improvement in environment and equipment management were identified as detailed under Regulation 27: Infection Prevention and Control.

The current activities program and activity staff allocation did not guarantee that all residents had equal opportunities to participate in social activities that aligned with their preferences and abilities every day of the week. This will be further discussed under Regulation 9: Resident's Rights.

Regulation 17: Premises

There was no garden furniture provided for residents in the garden on the Lower ground floor to sit down and enjoy the surroundings. In addition, premises were not clean in all areas.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The inspector observed that the mealtime experience for residents required review to come into compliance with the regulations with regard to the following:

All residents were not offered a choice at mealtimes:

- Residents on the Lower ground floor had their meals pre-plated, with staff routinely pouring orange juice into their glasses without offering an alternative. The lack of choice was further evident in the absence of tablecloths, menus, and decorations on some tables, as well as the non-availability of extra sauce for those who might have preferred it.

Residents were not provided with adequate quantities of food and drink:

- The daily menu provided to the inspector on the day of the inspection and the one available in the Governance and Management folder and used as

supporting evidence in the management of complaints did not outline the option for modified food, especially at tea time. The staff members who spoke with the inspector said that the residents were served tea and biscuits in the morning, afternoon tea, and at supper time. They mentioned that soup was sometimes provided at tea time, with a selection of sandwiches. Staff were not clear about the modified menu meal provided for residents with additional nutritional needs, and they were not clear on what food, except yoghurt, was available for these residents in case they became hungry at night or were not able to sleep. The inspector brought these findings to the management of the centre and requested an analysis of the nutritional needs of the residents.

Food was not properly served in some of the units:

- The breakfast meal on the Lower ground floor, such as porridge and fried eggs, were served pre-plated on plates covered with foil. Residents' meals were observed left on the trolley in the communal room for more than 2 hours as some residents were still in their bedrooms. This practice did not adhere to accurate food and safety guidelines.

An adequate number of staff were not available to assist residents when meals were served:

- The inspector observed that one resident on the Ground floor unit who stayed in their bedroom was calling out, looking for their meal, and appeared distressed. The inspector brought this to the staff's attention, and they said they were assisting other residents with meals in their bedrooms. Consequently, lunch for this resident was served one hour after the meal started.

The inspector was not assured that the dietary needs of the residents were met. This was evidenced by:

- From the residents' records reviewed, some residents' care plans for nutrition did not accurately reflect the needs of the residents when they lost their weight unintentionally and did not identify interventions in place to support residents when identified as being at risk of malnutrition. Additionally, there was a lack of evidence provided that the dietary intake was observed for three days and that additional therapeutic interventions were sought as per the centre's policy. There was no mention of the Malnutrition Universal Screening Tool (MUST) scoring at risk in residents' care plans for an evidence-based approach to care planning. In one instance, the Malnutrition Universal Screening Tool (MUST) was not correctly calculated, and a 9% weight loss was not identified since admission.

Judgment: Not compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27: Infection Control and the National Standards for Infection Prevention and Control in Community Services (2018); however, further action in respect of the management of the environment and equipment was required to be fully compliant. For example;

- The treatment rooms on the Lower ground floor and Ground floor were not kept clean. For example, the floor was stained with tags and other debris lying around. The access to the hand-washing sink was blocked by the bins. The cabinets and medication trolleys were stained.
- The management of sharp boxes was not in line with best practice as in one of the treatment rooms, sharp boxes were observed left on the floor and not secured to the wall. In addition, the contact details for traceability purposes were not consistently completed.
- A number of single-use dressings were seen left open in order to be re-used at a later stage, which could pose a cross-contamination risk. The staff who spoke with the inspector were not familiar with the risks and did not understand the principles of single-use.
- The doors on the corridors, including the glass parts, were visibly stained.
- The kitchenettes on both floors, including the fridges, were observed to be unclean.
- The dining room and sitting room on the Lower ground floor were observed to be unclean, with food left on the floor. The armchairs, including the cushion seating area, were observed to be stained.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure assessments and care planning were completed in line with regulatory requirements; examples are as follows:

- Care plans were not sufficiently detailed to guide the care provided. For example, the care plans for residents with a history of diabetes mellitus did not specify the Blood sugar (BLS) monitoring schedule. Also, they did not specify details of actions in case the resident experiences unplanned weight loss and its risks and actions associated with insulin dependency.
- Specific information relating to residents' infection or colonisation status was not consistently recorded in resident care plans to effectively guide and direct the care of residents with a history of MDROs, including Vancomycin-Resistant Enterococci (VRE) and Methicillin-resistant Staphylococcus aureus (MRSA). This posed a risk to health and safety.

- While the skin integrity assessment recorded a number of skin integrity issues, one wound care plan was not updated to reflect the plan for care provided for the resident.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner (GP) who attended the centre as required or requested. There was evidence that following a nursing assessment for pressure ulcers, appropriate referrals were sent to the tissue viability nurse, requesting a resident review.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The inspector observed that all doors leading into the garden areas were locked with a key-padded lock, and the code to disable these doors was not readily available. The staff members and residents who spoke with the inspector confirmed that this was a common practice. In addition, one of the doors in the dining room leading to the corridor on the Lower ground floor unit was locked. The staff confirmed that this is to prevent residents living with dementia and wandering behaviour from using this door. These restrictive practices, did not reflect a rights-based approach to care.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had measures in place to protect residents from abuse. All staff received mandatory training in how to recognise and respond to any incidents or concerns in relation to abuse and safeguarding concerns. Staff who spoke with the inspector were aware of their role in keeping residents safe and demonstrated appropriate knowledge in recognising and reporting abuse. The provider was not acting as a pension-agent for any residents.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights were not consistently upheld in the centre. For example;

- While there was an activity schedule in place for seven days, it was not always followed up. The activity staff members worked only five days a week, and the residents and staff members who spoke with the inspector confirmed that the activity schedule was not always followed up at the weekend.
- There was a lack of orientation signage for residents living with dementia and cognitive impairment in the centre.
- Residents with dementia living in the Lower ground floor did not enjoy the same quality of mealtime experience as those residents accommodated on the Ground floor.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Sugarloaf Care Centre OSV-0008793

Inspection ID: MON-0044316

Date of inspection: 10/10/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The allocation of staff has been reviewed to ensure all available resources required are used so residents are not left unsupervised for a long time in the communal areas on the ground floor when no activities are taking place. This is completed daily by the CNM/ADON on duty. • The activity timetable and staff allocation to activities have been reviewed and a new timetable is now in place which will cover 7 days a week. The activity timetable will be reviewed with residents during their committee meetings and if action required it will be taken. • The PIC has completed a full review of the meal time needs of their residents to ensure those that choose to have their meal in their room are not delayed. Feed back sought through surveys and resident committee meeting. Staff now allocated to supervise and assist meals in bedrooms. • Additional Garden furniture is now in place to enable residents to enjoy these spaces and avail of opportunities for outdoor activities. • To further enhance the management systems in place and to ensure that the service is consistently monitored and are effective, the following is now in place : Audits completed by the PIC and team wich include, Care planning, IPC, Wound care, Restraint, Dining experince ,Medication Managemmet.Theses audits are reviewed and vervified by members of the RPR team.Any actions required and learnings commujicated back to team. • All complaints are now reviewed weekly with the PIC by the RPR Clinical team and followed up as per policy. • A detalied quality improvemmet plan has been developed to ensure residents' nutritional care needs and nutritional risks are appropriately identified, monitored, and managed. • A full Cleaning and IPC audit has taken place and additional hours and processes introduced to ensure compliance for both clinical and non-clincal staff . This will be followed up and monitored by the RPR team.	

• All garden door have been released to ensure free access for residents and family.
• The oversight of fire safety management has been further enhanced by the introduction of a Fire Stafety check list for the centre. This will be managed locally by the homes MO and PIC. The RPR team will review monthly during our inspection and support visit. Staff have been reminded again of the fire training where it is clearly staed not to wedge open doors.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
To ensure compliance the Person in Charge will have the following implemented and actioned as required
• All incidents will be reviewed with the PIC to ensure notifications are submitted as required and within the time frame. This process will be supportrred by the RPR Compliance team

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• All complaints are now reviewed weekly with the PIC by the RPR Clinical team and followed up as per policy.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Additional garden furniture is now in place for all garden areas to facilitate residents to sit down and enjoy the surroundings.
• A full cleaning review has taken place and additional hours and processs have been introduced to ensure all areas are clean. This will be reviewed monthly by the RPR team.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
To ensure compliance the Person in Charge will have the following implemented and actioned as required
• To ensure all residents are offered a choice at meal times the PIC has completed a full nutrional review of all residents. The Dining experince and environment has also been reviewed. Follow up with residents through survey and audits and Resident committtee meetings.All preferrences are recorded in their care plan.
• The Residents on the Lower ground floor now have their meals servred directly by the Kitchen Manager/Chef from the Ban Maire.
• Residents are asked at each serving what drink they would like.
• Table clothes are now in place with appropriate menu and decorations.
• Addional condiments are now availalable.
• To ensure Residents are provided with adequate quantities of food and drink the PIC has completed a full review with each residents, documenting their likes/dislikes and food serving size preferrences. This has been recorded in their care plans and communicated to staff.
• All meal options now include a modified diet options.Addional support and training given to Kitchen staff to support.
• A full review of the menu has taken place and there are now seven defined opportunities through out the day for residents to be served food. Addionally staff can access the kitchen for anything else a resident may request at any time.
• The PIC has completed a full meal service review and breakfast is serverd to residents once they request it.
• The Staff allocation sets out the support that staff are required to give their residents during meal times. This is supervised daily with the staff nurses.
• The weight audit is completed monthly and after weight loss is noted on an indivdual audit is completed to ensure the full follow up is actioned and in place. The finding of this audit are then followed up as per policy. The RPR team is overseeing this process with the PIC.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• A full cleaning review has taken place with our external cleaning company and all areas found through this inspection have been reviewed and a plan is now in place to ensure areas are kept to a clean standard. This includes the treatment rooms on the Lower ground floor and Ground floor.

• The access to the hand-washing sink is now clear and the bins have been repositioned.
• The cabinets and medication trolleys that were stained are now clean and a cleaning schedule is now in place.
• All staff nurses have been trainied again in the management of sharps to ensure best practice as per policy.The contact details for traceability purposes is now consistently completed.
• All single-use dressings are now discardred after use. All staff nurses have been trained re same.
• The doors on the corridors, including the glass parts, were are now clean. This has been reviewed with our external cleaning company to ensure ongoing complinace.
• Our cleaning schedule have been updated to ensure the kitchenettes on both floors, including the fridges, are clean.
• A full review has taken place with our external cleaning compancy to ensure all areas of the home are clean to an acceptable standard. The cleaning will be audited monthly by the RPR team.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• The PIC is in process together with her ADONs to ensure all care plans are sufficiently detailed to guide the care provided. This will include any changes in condition such as weight loss or medication needs example insulin.
• The PIC has a register now indicating the specific information relating to residents' infection or colonisation status was not consistently recorded in resident care plans to effectively guide and direct the care of residents with a history of MDROs, including Vancomycin-Resistant Enterococci (VRE) and Methicillin-resistant Staphylococcus aureus (MRSA).
• The PIC and their nursing team will review wounds and ensure the care plans are updated to reflect the care being provided.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
To ensure compliance the Registered Provider and Person in Charge will have the following implemented and actioned as required

• All doors leading to the garden areas are enabled now to open when pushed thus allowing free access to residents to the protected garden areas.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The activity timetable and staff allocation to activities have been reviewed and a new timetable is now in place which will cover 7 days aweek. The activity timetable will be reviewed with residents at their resident ciommitttee meetings. Local links have also been estbalished to further enhance the activity experience for residents.
• The Additional signage required for the unit for residents living with dementia will be put in place once sourced.
• The Residents with dementia now have their meals served directly by the Kitchen Manager/Chef from the Ban Maire.
• Residents are asked at each serving what drink they would like.
• Table clothes are now in place with appropriate menu and decorations.
• Addional condiments are now available.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	18/11/2024
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	18/11/2024
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Not Compliant	Orange	18/11/2024
Regulation 18(1)(c)(ii)	The person in charge shall ensure that each	Not Compliant	Orange	18/11/2024

	resident is provided with adequate quantities of food and drink which are wholesome and nutritious.			
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Orange	18/11/2024
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Not Compliant	Orange	18/11/2024
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.	Not Compliant	Orange	18/11/2024

Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	13/12/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	18/11/2024
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	18/11/2024
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later	Substantially Compliant	Yellow	18/11/2024

	than 30 working days after the receipt of the complaint.			
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	18/11/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/12/2024
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the	Substantially Compliant	Yellow	18/11/2024

	Department of Health from time to time.			
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Substantially Compliant	Yellow	18/11/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	18/11/2024