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:	Ratoath Manor Nursing Home
Name of provider:	Ratoath Nursing Home Limited
Address of centre:	Ratoath, Meath
Type of inspection:	Unannounced
Date of inspection:	07 September 2021
Centre ID:	OSV-0000152
Fieldwork ID:	MON-0034116

About the designated centre

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

Ratoath Manor Nursing Home is set in the village of Ratoath in County Meath. The two-storey premises was originally built in the 1820's and is located on landscaped gardens. It now provides accommodation to 60 male and female residents over 18 years of age. Residents are admitted to the centre on a long-term residential, respite and convalescence care basis. The service provides care to residents with conditions that affect their physical and psychological function. Residents of all dependency levels are provided for. Residents are accommodated in single and twin bedrooms across three units; St Oliver's Unit, St Patrick's Unit and Ground Floor Unit. A proportion of these bedrooms have en-suite sanitary facilities. Communal shower rooms, bathrooms and toilets are available throughout the building. A variety of communal rooms are provided for residents' use across both floors, including sitting, dining and recreational facilities and an oratory. A number of outdoor areas are also available, including large gardens on the ground floor and two internal courtyards on the first floor. The registered provider employs a staff team consisting of managers, registered nurses, care assistants, activity co-ordination, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	48

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 7 September 2021	09:00hrs to 17:45hrs	Helena Budzicz	Lead
Tuesday 7 September 2021	09:00hrs to 17:45hrs	Marguerite Kelly	Support

What residents told us and what inspectors observed

Inspectors met a number of residents and spoke with residents who were willing and able to converse. The feedback from residents was that they were well looked after by the staff and felt that the staff knew them well. However, inspectors observed that some routines and practices needed to be reviewed to ensure that all residents were protected from the risk of infection cross-contamination and that care was person centred.

Inspectors arrived at the centre in the morning to conduct an unannounced risk inspection. At the time of the inspection, the centre had an outbreak of COVID-19. Additionally, two unsolicited concerns had been received prior to this inspection in relation to infection prevention and control practices and compliance with COVID-19 guidance, staffing and the standards of care delivery.

During this outbreak, 29 residents and 10 staff members tested positive for COVID-19, and all residents had completed their required period of isolation. It was evident that residents and staff in the designated centre have been through a challenging time. Residents acknowledged that staff and management had their best interest at the forefront of everything they did during the outbreak.

The assistant director of nursing (ADON), who deputised in the absence of the person in charge, facilitated the inspection on the day. Following an opening meeting, the inspectors took a tour of the premises accompanied by the ADON. This is a two-storey facility with resident accommodation on both floors, with lift and stairs access to the first floor. The centre is registered to accommodate 60 residents, and there were 48 residents living in the centre on the day of inspection. The centre is divided into three areas, the Ground Floor and two units on the first floor, St. Patrick's Nursing Unit and St Oliver's Nursing Unit. Through walking around the centre, the inspectors observed that small groups of residents were sitting in the communal rooms or reading newspapers in their rooms. Some residents were observed mobilising independently or with the assistance of staff around the centre, and they could access any of the centre's two enclosed outdoor courtyards on the first floor. However, the access to the garden on the ground floor was secured with the key-pad. Inspectors were informed that this was for residents' safety as the garden was not enclosed. Residents were therefore always accompanied by staff to access the garden area.

Inspectors observed that residents' bedrooms were personalised with possessions that were meaningful to the residents and reflected their life experiences. There was adequate storage available in the bedrooms. Inspectors observed that each resident had a manual handling chart (a personalised information sheet on how to safely mobilise the resident based on their needs) and a personal evacuation plan in their rooms. However, not all manual handling charts reflected the current resident's mobility status, and consequently, the personal evacuation plan was not completed

correctly.

Inspectors observed the interaction between residents and staff and noted a kind, patient and positive approach on the day of the inspection. Residents which the inspectors encountered were well presented in their appearance. Staff were observed to have a relaxed manner, and there were cheerful exchanges of conversation with residents. Staff accompanied residents and were available if the residents required help. Call bells were answered promptly. Inspectors spoke with staff, who confirmed they were aware of the complaints procedure. A resident who spoke with inspectors said that any concerns or complaints they had were dealt with, and they were confident of highlighting issues to staff members. A review of residents' meeting records found that the meetings had been completed regularly, and the meeting notes reflected the feedback from residents.

The inspectors were not able to meet with any family members as there were no visitors in the centre on the day of the inspection. Staff assisted residents with video and telephone calls to maintain contact with families. They mentioned that families were kept up-to-date with what was going on in the centre and any change in the resident's medical condition. Compassionate visits were facilitated at all times throughout the outbreak. Systems were in place to ensure that visitors were screened appropriately prior to entering the centre and were provided with appropriate personal protective equipment.

The next two sections of the report will discuss the governance and management of the centre and the quality and safety of care. The findings will be reported under the relevant regulations in each section.

Capacity and capability

The current management systems in place at the time of the inspection did not ensure that a good standard of service was provided for residents. The systems in place to monitor the quality, safety and oversight of the service failed to ensure compliance with the regulation. The centre has a good history of compliance, with findings on the previous inspection being mostly compliant with the exception of infection control and premises. While there was evidence that the provider was implementing various supports for residents and staff, the lack of effective leadership in the centre had resulted in inadequate practices, and therefore, the overall risks in the centre were not promptly identified and addressed. The inspectors issued an immediate action plan on the day in respect of fire safety management arrangements, as detailed under Regulation 28: Fire precautions. In addition, a cautionary provider meeting was arranged following the inspection to provide further assurances to the Chief Inspector of action taken to address the findings of the inspection and safeguard the residents.

The centre is owned and operated by Ratoath Nursing Home Limited, which is part of a larger private care group. The provider has, therefore, access to a national

support network that includes human resources, finance, administration and practice development. The person in charge reports to a clinical governance and operations manager. An operations meeting was held monthly. At the time of inspection, the assistant director of nursing was the nurse in charge of the centre. She was supported by a clinical nurse manager who worked as a staff nurse. Further strengthening of the management team was needed to ensure effective oversight and that safe and effective practices were in place.

Furthermore, an additional review of the staffing levels for the activity coordinators was required to ensure that all residents would have sufficient access to social and recreational activities seven days a week. The review of the household hours was also necessary as detailed under Regulation 15: Staffing.

There was a varied training programme in place to ensure staff were appropriately skilled. All mandatory training was up-to-date, which included fire safety, safeguarding vulnerable adults, manual handling, and online infection prevention and control training. The centre was asked to consider face-to-face infection prevention and control training from qualified infection prevention and control specialist.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each resident's condition and any changes noted. Additionally, the staff were encouraged to complete an infection prevention control safety pause at the beginning of each shift.

The provider had in place a preparedness and contingency plan for COVID-19; however, the contingency plan was not updated regularly and did not reflect current resources on how to manage the scale of the outbreak in the centre. The management team had liaised closely with the public health and the outbreak control team to discuss resources and the management of the current outbreak in the centre.

The registered provider had audit and monitoring systems in place to oversee the service. However, the audit system was not effective as it had failed to identify areas for improvement in respect of infection prevention and control practices issues which resulted in the issuing of an urgent action plan to the provider. For example, inspectors reviewed the environmental audit completed in September. This audit had assessed the cleanliness and hygiene standards of various locations in the centre, including bathrooms, bedrooms and sluice rooms. This audit scored 95%, which was not reflected in what inspectors observed on the day. As a result, the inspectors issued an urgent action plan in respect of environmental cleaning and infection prevention and control as outlined under Regulation 23: Governance and management.

Complaints were well managed in the centre. A clear policy was available to guide complaint management, and records were maintained separately from any resident file or information.

The annual review of the quality and safety of the service delivered to residents in 2020 was completed in consultation with residents.

Regulation 15: Staffing

The centre had two clinical nurse managers who were working as staff nurses without any managerial hours allocated to their duties. In addition to their nursing responsibilities, they were expected to complete the monthly checklists and audits for weights, air mattress, restraint, falls and care plans and assessments.

The centre did not have an adequate number of household staff to ensure the centre was cleaned to an appropriate standard, as evidenced in Regulation 27: Infection control. The inspectors found numerous gaps in the housekeeping rostered hours throughout the outbreak. With the exception of four days, over the last two weeks, there had been only two cleaners working across the three units of the designated centre. Given the spread and layout of the centre, this number was insufficient to clean the centre to an appropriate standard.

Activities co-ordinators were available four or five days a week. Inspectors were informed that the activities in the absence of activities co-ordinators were allocated to be provided by care staff who were expected to take on an additional role. However, there was no extra staff rostered.

Judgment: Not compliant

Regulation 16: Training and staff development

Observations made by inspectors on the day found that staff were not implementing the centre's policies and procedures and were not consistently adhering to correct infection prevention and control guidance. Although staff had access to a wide range of training resources, there was a lack of oversight in staff practices, as further exemplified under Regulation 27: Infection Control, Regulation 17: Premises, Regulation 29: Fire precautions, Regulation 23: Governance and management and Regulation 5: Individual assessments and care plans.

Staff supervision to ensure that this training was implemented required strengthening. It was unclear who held responsibility for the monitoring and supervision of cleaning practices of the centre.

Judgment: Not compliant

Regulation 21: Records

Improvements required in relation to records included:

- Turning charts were not regularly recorded as directed in the resident's care plan. Personal preferences if the resident did not wish to be turned were also missing.
- All records were not safely filed and stored as inspectors found records of personal emergency evacuation plans and manual handling assessments in empty bedrooms of previously discharged residents.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that the current management and oversight systems did not ensure that care and services were effective and appropriate and that there were sufficient resources available to deliver the service in line with the centre's statement of purpose. This was evidenced by:

- Risks identified on this inspection were not adequately managed as per the centre's risk register as outlined under Regulation 28: Fire precautions, Regulation 27: Infection control and Regulation 17: Premises.
- The management systems in place to monitor care, such as audits, did not include a documented quality improvement plan as shown to the inspectors on the day of the inspection. Some audits were in the format of a checklist or report printed from the electronic system. There was no evidence that these reports were followed up with an action plan, and on the format, there was no person identified to address the findings with an appropriate improvement plan.
- There was also no management personnel rostered to work over the weekend to ensure continued oversight and support to staff.
- Recent infection prevention and control audits had not identified infrastructural and maintenance issues identified during this inspection.
- Weekly care quality indicators reports were not completed since the week of 26 July 2021. Inspectors were informed that this was because one of the staff responsible for completion was on annual leave. While there was a clear management structure in place, there were no clear arrangements that identified the roles and responsibilities for all areas of care provision.
- The process for the review and management of residents' individual care plans required further oversight.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints log was computerised. When complaints were logged, then all stakeholders were notified. This ensures all procedures were taken and that complaints could be followed up and closed when resolved. All staff were trained in the system, and the complaints policy was displayed clearly in the centre's reception area.

Judgment: Compliant

Quality and safety

Necessary restrictions impacted residents' life and well-being during the COVID-19 outbreak. Dedicated staff working in the centre were committed to providing quality care to residents. Throughout the inspection, inspectors observed that staff treated residents with respect and kindness.

There was good access to health care services, including dietician, speech and language, tissue viability, dental, ophthalmology and chiropody services. Inspectors saw evidence that the centre maintained regular contact with hospitals and families during times when residents were admitted, and that updates from hospital staff were recorded in daily care notes. Nevertheless, some improvements were required in providing in-house access to a general practitioner.

The nursing assessment process involved the use of a variety of validated tools. However, inspectors found some inconsistencies in the correct and timely completion of the assessments and individualised care plans, which did not provide sufficient detail to effectively guide care in line with residents' current needs.

The procedures in place for the prevention and control of infection were found to be ineffective. Arrangements for the upkeep and maintenance of the centre were not correctly organised and addressed. The practices were unsafe, and the environment was not maintained to an appropriate standard which directly affected an effective implementation of infection and control measures. This is outlined under Regulation 27: Infection control and Regulation 17: Premises.

Fire safety measures were reviewed. Records were seen relating to preventive maintenance of fire safety equipment such as fire extinguishers, the fire alarm system and emergency lighting. Inspectors found that significant improvements in fire safety were necessary as detailed under Regulation 28: Fire precautions.

A comprehensive programme for activities had been set up. Given the layout of the centre and the fact that some resident's stayed in the bedrooms, the review of the

documentation of individual resident's engagement in activities and activity provision on the days when the activities co-ordinators were absent, especially over the weekend, were required.

Regulation 10: Communication difficulties

Inspectors reviewed the care plan for a resident experiencing communication difficulties due to the resident's lack of understanding and speaking English language and found that the care plan was generic and did not fully support the resident and effectively guide the staff in how to communicate with the resident. Additionally, appropriate care plans were not in place to guide staff on supporting identified communication needs for residents living with cognitive impairment and difficulties in expressing themselves effectively. Furthermore, inspectors noticed that the communication difficulties were not clearly outlined in the resident's personal emergency evacuations plans.

Judgment: Not compliant

Regulation 11: Visits

At the time of the inspection there were no visits due to an active outbreak of COVID-19. However, the staff accommodated all visits on compassionate grounds. Prior to the outbreak the provider informed inspectors that they were adhering to the most current Health Protection Surveilance Centre (HPSC) visiting guidance.

Judgment: Compliant

Regulation 13: End of life

Inspectors viewed a number of care plans and noted gaps in the care planning arrangements for residents at the end of life. Not all residents had a care plan in place documenting their expressed wishes and preferences for their future care needs, including their end-of-life care and support. Moreover, the religious and cultural needs of the residents have not been reflected clearly in the care plans.

Judgment: Substantially compliant

Regulation 17: Premises

Inspectors observed that there were a number of issues with the premises that required action:

- Grabrails were missing in the communal bathroom.
- Emergency call bell was not accessible in the resident's toilet.
- There were not adequate and suitable storage facilities in the centre.
- The bed-pan washer on the first floor was faulty on the day of inspection.
- The centre was not in good state repair in some areas. Inspectors observed that there was a leakage on the walls and around some windows. Missing and broken roof tiles were also observed.
- The radiator cover in the communal bathroom was not securely fixed to the wall.
- There were no suitable treatment rooms in two units of the centre, and the sink was missing in the treatment room on the first floor.
- Facilities for and access to staff hand-wash sinks required review.

Judgment: Not compliant

Regulation 26: Risk management

There was a risk management policy in place which reflected the requirements of the regulation. The provider had comprehensive risk register in place for clinical risks, health and safety risks and COVID-19 specific risks.

Judgment: Compliant

Regulation 27: Infection control

Systems and resources in place for the oversight and review of infection prevention and control practices required an urgent review. Inspectors observed practices that were not consistent with national standards for infection, prevention and control in the community services. This was evidenced by:

- The COVID-19 Contingency plan was completed and seen during the inspection and the plan for replacement staff suggested looking for staff from the 'Ireland on call campaign', which was not an appropriate plan at this stage in the pandemic.
- Many areas of the centre were not cleaned to an acceptable standard, the floors and surfaces were not clean and very sticky all around the centre.
- There was inadequate housekeeping procedures to guide staff to clean the centre. The current system was a list of rooms in the centre which staff would tick once cleaned.

- Deep cleaning procedures and enhanced terminal cleaning procedures were not available and, based on the observations of inspectors, were not being completed.
- The centre used a colour coding cloth and mop system; however, this was not correctly implemented. Mop heads were observed to have a number of different colour tags attached. Staff were, therefore, unable to identify where these mops should be used. For example, bathroom mops should only have a red tag so that staff know only to use those particular mop heads in a bathroom and not in a day room or dining room which may increase the risk of cross-contamination from a high-risk area to a low-risk area. String mops were also in use.
- The cleaning equipment was inappropriately stored in the sluice room.
- The laundry systems and processes in place did not support uni-directional flow from dirty to clean. The laundry equipment required review to ensure and support effective cleaning.
- Linen skips used in the centre did not have a lid to cover the contents, potentially leading to a risk of cross-contamination.
- Inspectors observed inappropriate arrangements for storage of equipment, nutrient drinks, in use sharps boxes and clean dressings all in the same store cupboard. Personal protection equipment (PPE) and residents mattress was stored in the communal bathroom.
- Storage of boxes with PPE was stored in the shed located in the waste compound in the centre's courtyard.
- Extractor fans in the bathrooms were dusty and unclean.
- Residents' equipment such as raised toilet seats and shower chairs were observed to be rusty and therefore could not be effectively cleaned.
- Equipment cleaning schedules required review. Inspectors found that hoists, wheelchairs, weight scales, smoking aprons for residents who smoke were not on the daily cleaning schedule, and there was no system in place to identify when the equipment had been cleaned, sanitised and was ready for use or whether they were being cleaned between residents, as per infection prevention and control guidance.
- There was no system to ensure that medical equipment such as blood glucometers was cleaned after use.
- Some of the armchairs in communal rooms were upholstered with a material that made them difficult to be effectively cleaned.
- Alcohol hand gel dispensers platforms were observed to be visible unclean.
- The inspectors saw a very unclean resuscitation bag stored on the floor containing sterile equipment out of date since 2012.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors reviewed the documentation in relation to fire safety in the centre and

found that significant improvements were required in relation to fire safety included:

- The fire risks in the centre were not appropriately risk assessed, actioned and included in the centre's risk register. For example, inspectors saw exposed electrical wires in two storage rooms. There were holes in the walls beside the electrical socket. Paper boxes were stored beside warm electrical boxes. There was no call bell available for residents in the smoking shelter on the first floor.
- Personal emergency evacuation plans (PEEPs) required improvements to ensure that accurate and up-to-date information is available in the fire safety folder and in the residents' bedrooms with appropriate aids suitable to evacuate the resident safely and to ensure these were updated regularly.
- There was no cautionary signage in place to alert people of the risks associated with oxygen cylinders or concentrators. Additionally, eight oxygen cylinders were stored inappropriately outside the boiler house. This was immediately addressed on the day.
- Emergency escape routes, the fire evacuation equipment and fire extinguishers were blocked by residents' equipment, cleaning trolley or furniture.
- Inspectors observed that the emergency lighting signs were missing on the designated escape routes as outlined on the evacuation plans displayed in the centre.
- Fire evacuation chairs were stored in the storage rooms underneath stairs or were freely standing on the corridor on the ground floor level. As a result, the equipment was not easily accessible for use in case of a fire emergency.
- Fire drills had not been completed with night time staffing levels to ensure all residents could be safely evacuated with reduced staffing levels. A drill report was submitted following the inspection of a full compartment evacuation, and further drills were required to ensure the competency of all staff in this area.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Improvements were required to ensure that care plans clearly set out current needs and preferences of the resident. For example:

- Inspectors reviewed residents' wound care records and noted that while the wound assessment was completed, the care plans supporting residents' skin integrity needs were not always in place. The wound care plans which were in place lacked details about the wound progress and measures to promote wound healing. The care plan's evaluation records also required a review.
- Inspectors found that not all residents had meaningful activity assessments to guide the completion of activity care plans. These care plans were seen to be generally completed but lacked the person-centredness to reflect individual resident's preferences for activities or therapeutic activities for individual

residents.

- From a review of the records available, inspectors found that a number of care plans had not been formally reviewed with the resident or, where appropriate, with the resident's family every four months, as required by the regulation. As a result, some care plans were not up-to-date and did not reflect the resident's current needs.
- In the case of one resident, the ADON confirmed that the resident required a standing hoist for their transfer and was mobilising with a rollator. Their chart and personal evacuation plan stated the resident required the assistance of two and wheelchair during the day and night, and there was no date when was the evacuation plan last time completed.
- Inspectors found that COVID-19 care plans for residents were generic and did not reflect individual residents' changing needs during the COVID-19 outbreak.

Judgment: Not compliant

Regulation 6: Health care

Inspectors were not assured that residents received a high standard of evidence-based practice in line with their assessed needs. For example, the inspectors reviewed five residents who experienced weight loss from March 2021 till August 2021. They found that the weight loss noted was not actioned, the weight loss was not correctly reflected in the Malnutrition Universal Screening Tool (MUST), and no further action to their weight loss had occurred. In addition, there was no supporting care plan to prevent the weight loss in place.

Judgment: Not compliant

Regulation 9: Residents' rights

Admission and advocacy arrangements required review to ensure that younger residents with complex health issues would receive the appropriate care and support to effectively meet their needs. There were four residents under 50 years of age living in the centre at the time of inspection.

Opportunities for participation in daily social activities were limited to five days per week when the designated activity coordinator was on.

Inspectors reviewed files and care plans for residents with different religious denominations and noted that there was no discussion documented regarding resident's opportunities to express their belief or their future care planning in line

with their faith, for example, in end-of-life care planning.
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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Not compliant
Regulation 11: Visits	Compliant
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ratoath Manor Nursing Home OSV-0000152

Inspection ID: MON-0034116

Date of inspection: 07/09/2021

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 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The registered provider and PIC to ensure compliance have implemented the following :
• The Home's Clinical Nurse Managers will be allocated appropriate time and audits to complete on a monthly basis. They will be supported to complete these audits by the homes PIC and ADON.
• A monthly Team review will be put in place to agree the actions required following the Audits and ensure actions are completed within the required timeframes. This will take place with the CNM's, PIC and ADON.
• On a monthly basis the Clinical Governance and Compliance team will review and verify that the actions are completed in a timely manner.
• A new corporate governance structure will be in place from Q1 2022 which will see the separation of the Current Operations/Clinical Governance to create the post of Director of Operations and a Director of Clinical Quality, Safety and Risk Management with sole responsibility for all matters of compliance

Following the closure of the COVID outbreak and all staff have returned to work.
• There are 3 household staff allocated per day to cleaning duties.
• Monthly cleaning reviews are now in place with further supports planned with the introduction of an external company to review the homes cleaning.
• As the home is out of COVID outbreak the allocated 60 hours per week for the homes activity coordinators is again in place.
• A detailed activity timetable is in place and the staff will have completed a resident specific person centered social and activity care plan for each resident.
• A senior project manager has been identified through our external provided whi is assigned exclusively to Silver Stream Homes and will have responsibility for the provision of effective and compliant maintenance and cleaning services and associated audit.
Estimated start date November 1st 2021

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
To ensure compliance the PIC will have the following in place and implemented and actioned as required.
• The PIC has an agreed timetable of training for staff.
• The PIC will complete monthly audits in infection control to ensure the staff implement the center's policies and procedures. The above PM will have responsibility for training and audit associated with maintenance (Including fire and Health and Safety) and cleaning. A further level of governance and audit will be provided by the Corporate governance and compliance team will verify these audits and any non-conformances identified will have an action plan with follow up in place.
• Premises: All staff have been educated in the safe and appropriate storage of items in the home.
• Staff have been training to report any premises issues immediately to the homes dedicated maintenance personnel and PIC so issues will be resolved in a timely and safe manner storage. New Project manager (which will be in place for as long as the Group Facilities Manager is on extended medical leave) will have responsibility for ensuring proper procedures for maintenance issues including Storage.
• New Storage area has been identified and will be included in the scope of work to be carried out over the next several months by contractor. The work will commence by end of October and will be completed project by project until complete. Timing is subject to availability of contractor services
• The PIC completes a weekly home review with the home maintenance person and actions will be addressed as found. This weekly home review will be sent to the RPT team weekly and actioned by Project manager
• All Silver Stream Homes will be supported by a 24 hour help desk to report and facilitate repairs
• An online portal will be available to key staff to ensure all required and preventative maintenance issues are tracked and actioned.

Fire Regulations:
• An independent Fire Inspection/Assessment has been carried out by a competent provider and report received (Attached to this submission for your review.
• The report will be actioned by the Project manage in order of urgency and within the timelines indicated in the fire assessors report.
• All staff will complete fire training on an annual basis.
• On a bimonthly basis scenario fire drills based on day and night time's levels are completed and reviewed with staff.

Governance and Management:
• The policies as set out in schedule 5 will be reviewed with all staff to ensure they are familiar with and follow as guided.

Individual assessments and care planning:

• All staff nurses and HCAs will have training completed to ensure they are supported in commencing, updating and reflecting all residents care needs.
• A new PIC is in place and has ensured that the care plans will be reviewed at least 4 monthly and after any significant event, example, resident incident, GP review, Allied Healthcare review.

Household Staff
• All household staff have received training from an external trainer re cleaning and maintenance of the home.
• The newly appointed PM with responsibility will assume responsibility and oversight of cleaning staff and will provide the correct equipment, training and audit
• Staff supervision will be by the homes Staff nurses, ADON and PIC with overall governance and oversight by the PM. The PM will be a member of the Leadership team and report issues and seek approvals for essential identified issues on a weekly basis

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
To ensure compliance the registered provider will have the following in place:
• To ensure all Residents that require a record of repositioning as per their care plans.
• The Nurse on duty at the middle and end of each shift will meet with their team members and review the electronic care plan to ensure the records are updated.
• The PIC and ADON can verify this has been maintained by completing a report audit review together with random skin integrity review to ensure compliance.
• The Clinical Governance and Compliance RPR team will verify this on a monthly basis.
• If any non-conformances found an agreed action plan and verification plan will be put in place.
• To ensure all records are safely filed and stored the policy has been updated and staff trained in ensuring all records are appropriately stored and filed.
• A feature of the new governance structure will see announced and unannounced audits of each home carried out at least bimonthly (To be agreed) by the Clinical Governance and Compliance team at each home review.
• Any non-conformances will be actioned and verified as completed.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

To improve the current systems to ensure all clinical and non-clinical practices are monitored and reviewed by the provider the following is in place ;
• An experience Project manager has been identified and will work with the group until the return of our Group Facilities Manager. The has significant experience in fire prevention, training and audit
• Risks identified: Fire precautions: A full fire risk assessment has been completed by an appropriate expert and an action plan has been agreed that will ensure the home is fully compliant. The fire risk assessment is attached to this report. The report includes a timeline for completion of works required.
• The management system to monitor care, such as audits now includes a quality improvement plan. This will be reviewed on a monthly basis to ensure all actions identified are completed and verified as such. These will be reviewed with the PIC and Clinical Governance and Compliance Team.
• The provider is in the process of recruiting a Director of Operations and the establishment of a dedicated audit team to ensure compliance is maintained. This team will support the center's audit and compliance reviews along with the Project Manager who is a full time member of the Leadership Team, supported by externally contracted services.
• The roster will have an identified Staff member in charge at the weekend. The Provider has an on-call support team made up of a PIC and RPT team member available every weekend. This team do and will continue to provide any support the home and staff require. The team allocation is displayed in each nurse's station and at reception.
• The PIC will complete monthly audits in infection control to ensure the staff implement the center's policies and procedures. The PM and governance and compliance team will verify these audits and any non-conformances identified will have an action plan with follow up in place.

Premises:
• All staff have been educated in the safe and appropriate storage of items in the home.
• Staff have been training to report any premises issues immediately to the homes dedicated maintenance personnel and PIC so issues will be resolved in a timely and safe manner storage. The PIC completes a weekly home review with the home maintenance person and actions will be addressed as found. This weekly home review will be sent to the RPT team weekly by the PM
• The infection control audit review will be further enhanced by the appointment of the Project Manager and if needed the use of contracted provider
• The PIC will submit the weekly care quality indicator reports on a Tuesday and these reports will be verified monthly by the Clinical Governance and Compliance team.
• A clear role and responsibility review is under way with the Group HR Manager and the Clinical Governance Manager this will ensure that each staff member is fully aware and trained to meet the requirements of their role and ensure residents care and safety is maintained.
• A process has been agreed with the PIC and ADON to ensure the review and management of resident's individual care plans are reviewed, implemented and followed up on. This process is a weekly PIC/ADON review of:
o Incidents reports reviewed,
o GP visits reviewed,
o Allied Healthcare profession visits reviewed,
o Complaints/concerns reviewed, resident change in condition.

o The residents electronic care plan will be reviewed and signed off by the PIC/ADON following this review.

Regulation 10: Communication difficulties	Not Compliant
Outline how you are going to come into compliance with Regulation 10: Communication difficulties: The registered provider and PIC to ensure compliance have implemented the following: • The PIC has completed a full review of all residents with a communication difficulty. • Each care plan is being reviewed and discussed with resident and/NOK and will be reviewed if any change in condition or 3 monthly. • The care plans now effectively guide and support staff to meet the needs of residents with a communication difficulty. This includes residents with cognitive impairment and those whose first language is not English. • Each resident PEEPS now includes if they have a communication deficient and how to impart instructions.	
Regulation 13: End of life	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: End of life: • The PIC is reviewing all residents care plans to ensure they reflect the wishes of the resident and/or the nominated NOK. • The care plan will be reviewed on a 3 monthly basis to confirm their wishes again. • The religious and cultural needs of the resident will now be included in the care plan as per resident's wishes. • The clinical governance and compliance team will complete a random audit on a monthly basis to ensure compliance and any non-conformances will have an action plan and follow up verification process.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	

The registered provider to ensure compliance has completed the following:
The grab rails in the communal bathroom are in place.

• An experienced PM will assume responsibility for existing maintenance team and oversee maintenance and cleaning issues
• The emergency call bell in the resident's toilet is now accessible.
• A full review is currently underway and schedule of works is being prepared to provide additional suitable storage for the Centre, this schedule is attached to this report for review.
• The bed pan washer was serviced annually, records available in the home and fault was repaired following inspection. (see feedback)
• The full review has been carried out on the issues identified in the Draft report and a plan to complete repairs and upgrades as identified.
• The radiator cover in the communal bathroom is now securely fixed to the wall.
• While all available resources are fully utilized by all staff in the prevention of nosocomial and other infections within the home, and in line with the relevant standard of the time (HBn 00-10 not applicable),
• Best endeavours will be made to implement recommendations but can only be actioned if feasible to do so.
• The five year rolling capital plan makes provision for the upgrading of at least 20% of the existing rooms and every effort will be made to include recommendations where possible.
• A with any older building, modifications are not always possible – for example, handwashing sinks will need proximity to existing pipework etc.
• PM will bring recommendations to Leadership Team
• Schedule of work for works identified in inspection is attached
• Equipment identified by inspectors, although functional and serviced at the time of inspection but had blemishes were replaced with new ones within day and all older equipment removed from facility. (See attached verification from HC21)

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The registered provider to ensure compliance will have the following in place:

• The homes COVID contingency plan will be reviewed on a monthly basis by the PIC to ensure it reflects the needs and requirements as set out by public health guidance and support documents. This plan will be submitted to the Clinical governance and compliance team to be verified and any actions required or gaps found can be addressed.
• A full deep cleaning x 2 of the home was completed following the inspection and is ongoing as per reports submitted to inspector on the 1st of each month.
• A full terminal cleaning schedule was completed as per HSE terminal cleaning guidance

document.
• A PM from Specialist company will join SS team with responsibility fof maintenance and cleaning and will implement best practice procedures on housekeeping procedures, deep cleaning schedules and enhanced terminal cleaning processes.
• Full and ongoing training was provided to all household staff again re the correct use of cleaning equipment such as mops and cloths. All mops and cloths correct and in use. The PIC/ADOMN will supervise re the use of same. This will be ongoing and governed by PM
• The Laundry facilities have been reviewed to ensure the correct flow of dirty to clean linen. – Plan in place to move the steam press from dirty to clean side of laundry as an interim measure. A more significant remodeling is catered for in capital plan.
• New linen skips have been ordered and we are awaiting delivery.
• Dedicated storage areas for cleaning equipment has been identified and will no longer be stored in the sluice room.
• A full home review of all storage areas is taking place and each area will be clearly
• identified as what can be stored and how the item is to be stored safely.
• The extractor fans in bathroom have all been cleaned and have been added to the cleaning schedule.
• Any item of equipment which showed signs of rust at time of inspection have been replaced (H21 attached)rust on it has been removed from use. Additional equipment (specialist scales etc) has been ordered and we are awaiting delivery.
• Clear concise equipment cleaning schedule in place and this is reviewed and signed off by the staff nurse on duty and verified by the PIC.
• A Furniture review is underway and furniture will be replace as per agreed capital plan for the home.
• External painting of building completed to residents specifications with internal painting (Phase 1) in progress with Phase 2 commencing once structural work complete (estimated Q1 2022)
• Kitchen in Olivers ward to be replaced and is currently ordered with installation in November
• Leak identified by inspector was resolved within one hour of occurrence from drain blocked by leaves during August 7th heave rains. Repair is part of scheduled works (see attached)
• Worn toilets on order and part of scheduled works during November
• Alcohol hand gel dispensers are checked on a regular basis through each day to ensure they are clean and to standard.
• New resuscitation bags have been ordered and we are awaiting delivery.
• Waste bins – storage for bins is part of the attached schedule of works
• To date improvements in Infrastructure and Equipment in excess of €60,000 has been invested with an additional €28,000 of building improvements, and €12,000 of painting scheduled over coming months.
• The sticky floors identified in the inspection (and we noted hand rails in hall ways) was identified as improper use of new cleaning agents and was not dirt related. A deep clean by specialist contract services removed the residue and training of staff by product vendors.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The registered provider to ensure compliance has the following in place:

• An expert PM has been appointed vis external and will work full time with Silverstream. He is competent in Maintenance, Fire and Cleaning audits
• A full fire risk assessment has been completed by a competent expert with specialism in Long Term Care Facilities. Report Attached
• An action plan has been agreed that will ensure the home is fully compliant within the time frames recommended in the report
• The Electrical wires that were found to be exposed in the report presented no electrical risk to staff or resident as the wires were not exposed, rather the cable itself which provided insulation to the wires. However, the wires did appear untidy and unpleasing to the eye and have subsequently been concealed
• A call bell is now in place for residents use in the outside smoking area.
• All PEEP plans were reviewed as part of the immediate action plan.
• The PEEPS will be reviewed by the PIC. The clinical governance and compliance team will on a monthly basis complete a random audit and verification of Peeps. Any non-conformances found will be actioned and followed up with the PIC.
• Signage is in place for any resident requiring and using oxygen. The oxygen cylinders that had been provided to the home for use during the recent COVID outbreak have been returned.
• All emergency escape routes, fire evacuation equipment and fire extinguisher are now free and not blocked by resident's equipment, cleaning trolleys or furniture. This is checked daily by staff on duty and reviewed and verified by the PIC and by the Clinical Governance and Compliance team when in the home.
• Emergency Lighting signs in place as required.
• The fire evacuation chairs are stored appropriately and accessible to all staff as required.
• Fire drills of a full compartment evacuation has been completed for all staff and will continue bi-monthl

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:
The registered provider and the PIC to ensure compliance have put the following in place:

• The clinical governance and compliance team will complete a detailed wound audit on a monthly basis which will include a review of the wound body, skin integrity, care plan

and allied healthcare professional review. This is to ensure that the wound specific care plan are detailed, show wound progress and measures to promote wound healing. The PIC will also review each care plan weekly to ensure action followed in place.
• The activity coordinators have reviewed all residents social and activity care plans to ensure that they reflect the resident's preferences and abilities to meet their activity needs and wants. That they are meaningful and person centered.
• A random audit of these plans will be completed by the clinical governance and compliance team and any non-conformances identified will have an action plan and learning and outcomes followed up on with the PIC.
• The PIC will review all care plans with the resident and/or their nominated next of kin to ensure they are reflective of the current needs of the residents.
• A review of all manual handling charts and PEEPs has been completed to ensure they reflect the same identified care need.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The registered provider and the PIC to ensure compliance with this regulation have completed the following:

• During the Covid outbreak (as per feedback document) the home had both in-person and virtual assessments of residents in line with the guidance from our GPs and HPSE recommendations
• The residents GP has since reviewed all residents post COVID infection and any residents that required further supports as identified following GP review will be referred for a geriatrician assessment as required.
• Staff nurses are to receive further training in the correct use MUST nutrition assessment to ensure appropriate and timely care interventions with a dedicated care plan to support weight gain is in place.
• This process will be reviewed by the clinical governance and compliance team to ensure compliance.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The independent resident advocate supports all residents within the home and is trying to source specific advocacy services if the residents under 50 wish him to. Once sourced they will be offered to the residents, and they will choose to engage as per their own wishes.

• As the home is out of COVID outbreak the allocated 60 hours per week for the homes activity coordinators is again in place.
• Staff are in the process of writing up care plans for each resident to clearly outline how the resident wishes to express their beliefs or their future care planning in line with their faith. This will also be included in the resident's end of life care plans.

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 10(1)	The registered provider shall ensure that a resident, who has communication difficulties may, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre concerned, communicate freely.	Not Compliant	Yellow	19/10/2021
Regulation 10(2)	The person in charge shall ensure that where a resident has specialist communication requirements, such requirements are recorded in the resident's care plan prepared under Regulation 5.	Not Compliant	Yellow	19/10/2021
Regulation 13(1)(a)	Where a resident is approaching the end of his or her	Substantially Compliant	Yellow	19/01/2022

	life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.			
Regulation 13(1)(b)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that the religious and cultural needs of the resident concerned are, in so far as is reasonably practicable, met.	Substantially Compliant	Yellow	19/01/2022
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	19/10/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	19/10/2021
Regulation 17(1)	The registered provider shall ensure that the premises of a	Substantially Compliant	Yellow	30/06/2022

	designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Yellow	30/06/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	19/10/2021
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	31/12/2021
Regulation 23(c)	The registered provider shall ensure that management	Not Compliant	Orange	28/02/2022

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
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.	Not Compliant	Orange	28/02/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Yellow	19/10/2021
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Yellow	30/06/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Yellow	19/10/2021
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for	Substantially Compliant	Yellow	19/10/2021

	evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	19/10/2021
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	31/12/2021
Regulation 5(5)	A care plan, or a revised care plan, prepared under this Regulation shall be available to the resident concerned and may, with the consent of that resident or where the person-in-charge considers it appropriate, be	Not Compliant	Orange	31/12/2021

	made available to his or her family.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	31/12/2021
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	31/12/2021
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	19/10/2021
Regulation 9(3)(e)	A registered provider shall, in	Substantially Compliant	Yellow	31/12/2021

	so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.			