Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Aras Chois Fharraige
Name of provider:	Aras Care Ltd
Address of centre:	Pairc, An Spidéal, Galway
Type of inspection:	Unannounced
Date of inspection:	06 April 2022
Centre ID:	OSV-0000382
Fieldwork ID:	MON-0034385

About the designated centre

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

Aras Chois Fharraige Nursing Home is a purpose built unit with views of the sea. The Centre is located in the Irish speaking Cois Fharraige area of the Connemara Gaeltacht. Accommodation is provided on two levels in 34 single rooms and four sharing rooms. Aras Chois Fharraige provides health and social care to 42 male or female residents aged 18 years and over. The staff team includes nurses, healthcare assistants and offers 24 hour nursing care. There is also access to allied health care professionals.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	40

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 6 April 2022	10:05hrs to 18:50hrs	Fiona Cawley	Lead
Wednesday 6 April 2022	10:05hrs to 18:50hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Overall, inspectors found that the residents living in this centre were supported by caring staff who knew them well. Residents reported that they enjoyed their life in the centre and that the staff were kind to them. Inspectors found that the atmosphere in the centre was quiet, calm and orderly.

This unannounced risk inspection was carried out over one day. There were 40 residents accommodated in the centre on the day of the inspection and two vacancies.

Following an opening meeting with the person in charge, the inspectors completed a walk around of the centre. The premises was laid out to meet the needs of the residents and to encourage and aid independence. The communal areas were styled with comfortable furnishings. Bedrooms were appropriately decorated with many residents personalising their rooms. The corridors were wide and well lit with grab rails in place to assist the residents to mobilise independently. Residents had safe unrestricted access to outdoor areas.

The centre was clean and tidy. Housekeeping staff who spoke with the inspector were knowledgeable about the cleaning process required in the centre.

During the course of the inspection, inspectors observed a number of residents who required immediate clinical review and support. This was identified to the nursing staff and swift action was taken. However, inspectors were not assured that there was adequate levels of resident monitoring and supervision to ensure that appropriate and timely nursing intervention could be delivered.

A number of residents were observed to use the selection of communal day rooms available. Other residents chose to spend the day in their bedrooms. Inspectors spoke with a total of 16 residents on the day of the inspection. The feedback from the residents was generally positive. However, some residents reported that they felt that staff were 'rushed off their feet at times' while others said that they sometimes had to wait for their needs to be attended to. A number of residents reported finding the days long. Residents agreed that the meals were of a good quality and that there was always a choice offered at mealtimes.

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

This was an unannounced risk inspection conducted by inspectors of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors also reviewed the action taken by the provider to address the non-compliant issues found on inspection in June 2020. The provider had submitted an application to renew the registration of the centre. Inspectors reviewed the detail of this application on this inspection.

The findings of this inspection were that the registered provider had failed to take action to address the issues of non-compliance in relation to the governance and management of the centre since the last inspection. This had resulted in a chaotic and poorly defined organisational structure and ineffective monitoring systems. The registered provider had also not ensured that the service met the needs of the residents living there, particularly in terms of staff training, individual assessment and care planning and health care.

The provider of this designated centre was Aras Care Ltd. A director of this company represented the provider and attended the centre daily. The director attended the feedback meeting following this inspection.

On the day of the inspection, the organisational structure of the centre was not clearly defined. There was a person in charge who attended the centre up to seven days a week. The person in charge was supported in this role by two clinical nurse managers and a team of nursing, care and support staff. The roles and responsibilities of the person in charge and the clinical nurse managers were unclear. Both roles included the provision of direct nursing care to the residents. While inspectors acknowledged the benefits associated with a nursing management contributing to residents care, the findings of this inspection was that nursing hours allocated to the provision of resident care were being supplemented by the nurse management team. This meant that there was less time available for nursing oversight and governance. This organisational structure was found to have a negative impact on the service provided to the residents.

The person in charge was rostered as a staff nurse on the day of the inspection and therefore not available to facilitate this inspection. A clinical nurse manager arrived at the centre at midday to facilitate the inspection.

Following the previous inspection, the provider had committed to an additional staff member being added to the staff roster for the early evening. The person in charge informed the inspectors that this arrangement was not in place and that one of the staff nurses on duty every day worked an extra two hours instead. This meant that the staff nurses rostered to work the day shift worked for 14 hours. A review of the staff roster for the centre found that the staffing level present in the centre on the day of the inspection did not reflect the staffing levels rostered or the levels described to the inspectors on arrival to the centre.

Inspectors were unable to establish the resources available to safely staff the centre. Inspectors reviewed the current and previous staff rosters and spoke with

the management team, but were unable to establish the availability of staff. A review of the roster found that clinical management time was allocated mostly to the provision of direct nursing care. The staff roster for the two weeks prior to the inspection included the person in charge and the clinical nurse manager working excessive hours to supplement the staff nursing hours.

Furthermore, inspectors observed that the care staff had to use their allocated care hours to supplement kitchen and laundry duties. This meant that there was less hours available for the direct care of residents.

There were management systems in place such as a risk management and clinical and environmental audit, however, these systems were not used to identify appropriate risks or to develop quality improvement action plans.

There was no annual review of the quality and safety of care for 2021. Inspectors were informed that this review was in progress.

While staff had access to training, the inspectors found that there were gaps in staff attendance in mandatory training sessions. In addition, there was no system in place to evaluate the quality of the training provided and to ensure that up-to-date training was implemented. This is discussed further under Regulation 16: Training and staff development.

While the management team confirmed the use of antigen test for residents with suspected COVID-19, the Chief Inspector was not notified of the suspected cases of COVID-19 as required under Regulation 31: Notification of incidents.

The inspectors found that records were not managed in line with the regulatory requirements.

Regulation 15: Staffing

While there was adequate staff available to meet the needs of the residents on the day of the inspection, staffing levels did not reflect the staff roster and staff availability was not adequate to ensure the centre was consistently staffed. This staffing resource issue is addressed under Regulation 23:Governance and management.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors found significant gaps in the staff fire safety training record.

The inspectors found that staff supervision arrangements were not appropriate. Staff observed and spoken with did not demonstrate the required competencies and knowledge to deliver effective and safe services to the residents. This was evidenced by:

- staff failed to respond to the care needs of residents in a timely manner
- staff demonstrated poor practice in relation to the use of personal protective equipment (PPE).
- staff were not clear about the procedure to be followed in the event of a fire.

Staff did not have access to relevant guidance in relation to the management of COVID-19 in the centre.

- The current Public Health & Infection Prevention & Control Guidelines on the Prevention and Management of Cases and Outbreaks of COVID-19, Influenza & other Respiratory Infections in Residential Care Facilities were not readily available in the centre on the day of the inspection.

Judgment: Not compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements . For example;

- The nursing records for residents' health and condition and treatment given were not completed in accordance with the requirements of Schedule 3. For example, one resident receiving antibiotic treatment did not have the rationale for such treatment recorded in their daily progress report.
- Historical nursing records for a resident who no longer resided in the centre were not available for review as required under Regulation 21.
- Staff rosters did not accurately reflect the staffing in the centre on the day of the inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had failed to ensure compliance with Regulation 23. This was evidenced by;

- insufficient level of nursing staff to ensure the that residents care needs were

met,
- ineffective and disjointed organisation structure where the roles and responsibilities of person in charge were not clear,
- laundry and catering duties were supplemented by care staff. This meant that care staff had to leave their care duties to complete housekeeping tasks.
- poor systems of oversight of care and care documentation. For example, a review of residents records found that resident assessment and care planning did not contain the detail required to guide care. This had not been identified in a recent care plan audit.
- inadequate monitoring of clinical and environmental risk. Audits completed did not provide a quality improvement plan to address issues identified.

There was no annual review of the quality and safety of care in the centre carried out for 2021 or a quality improvement plan for 2022 available.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not submitted the required monitoring notifications for notifiable events in the centre in line with Regulation 31. For example, the Chief Inspector was not notified of the following;

- suspected cases of a notifiable infectious disease within three days of its occurrence.
- two allegations of suspected abuse of a resident.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints policy and procedure in place. A complaint register was reviewed. Inspectors found that improvement had been made in the overall management of complaints since the last inspection. Complaints were managed in line with the centre's policy and in line with regulatory requirements.

Judgment: Compliant

Quality and safety

Inspectors found that the day to day interaction between residents and staff was kind and respectful throughout the inspection. Residents were generally satisfied with the quality of the service they received. Nonetheless, significant improvements were required in relation to care delivery, with particular regard to residents' assessments and care plans and health care. Inspectors reviewed the files of three residents with significant care needs and found that the care received was impacted by inadequate nursing supervision, inadequate care intervention, and nursing documentation that was not in line with professional guidelines.

Inspectors reviewed a sample of assessments and care plans and while there was evidence that the residents' needs were being assessed using validated tools, the care plans reviewed did not reflect person-centred, evidence-based guidance on the current care needs of the residents. This is discussed further under Regulation 5: Individual assessment and care plans.

Review of residents' records found that there was regular communication with residents' general practitioners (GP) regarding their health care needs. However, a number of residents had not been reviewed in person by their GP for over six months despite showing signs and symptoms of physical deterioration.

While residents were provided with access to other health care professionals, referrals for specialist advice was not always timely and recommendations made by the allied health care professionals was not incorporated into the residents' care plans. In addition, there was no documented referral pathway in place to provide assurance that residents could avail of the services of the identified in the centre's statement of purpose.

There were opportunities for residents to consult with management and staff on how the centre was run. However, minutes of residents meetings were not available to review on the day of the inspection. A resident satisfaction survey was carried out in 2021.

There was an activity schedule in place and residents were observed to be facilitated with social engagement and appropriate activity throughout the day.

Residents had access to television, radio, newspapers and books. Internet and telephones for private usage were also readily available. Visiting was facilitated in line with current Health Protection Surveillance Centre (HPSC) COVID-19 Guidance on visits to Long Term Residential Care Facilities.

There was a COVID-19 Contingency in place however, the detail of this plan did not reflect the current COVID-19 guidelines and reflected out-of-date advice issued to centre at the start of the pandemic.

Regulation 27: Infection control

Inspectors found that the centre was clean and well maintained. A cleaning schedule

was in place and reviewed regularly.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A review of the resident's assessments and care plans found that they were not compliant with the regulatory requirements. For example;

- care plans were not developed in a timely manner, in line with the assessed needs of a resident. For example, a resident with a 12 month history of significant weight loss did not have a care plan developed until six months after the onset of weight loss
- one resident did not have their current medical care needs integrated into their care plan. For example, a resident who was described as mobile and active in current care plan was no longer mobile.

Judgment: Not compliant

Regulation 6: Health care

The registered provider failed to provide appropriate medical and health care including a high standard of evidence-based nursing care in accordance with professional guidance issued by the Nursing and Midwifery Board of Ireland (NMBI). This is evidenced by;

- failure to identify and develop an appropriate care plan from a resident with significant weight loss
- failure to recognise and appropriately document possible typical and atypical symptoms of COVID-19
- failure to document an accurate assessment of a residents physical, psychological and social well being, including intervention or treatment received.
- failure to provider timely access to medical review.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors found that the staff made satisfactory efforts to ensure the residents'

rights were upheld in the designated centre. Staff were observed to engage in positive, person-centred interactions with residents.

There was an activity schedule in place. Residents were observed to be socially engaged throughout the day of the inspection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Aras Chois Fharraige OSV-0000382

Inspection ID: MON-0034385

Date of inspection: 06/04/2022

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The three staff members with out-of-date fire training have received up to date fire training 11/05/22

The training matrix has been audited to ensure that all staff have mandatory training completed and will continue to updated as required 11/05/22

All staff are renewing their training in Hand Hygiene, PPE and Infection control 05/06/22

Mandatory training is being monitored each week in the management meeting 26/04/22

The current Public Health & Infection Prevention & Control Guidelines on the Prevention and Management of Cases and Outbreaks of COVID-19, Influenza & other Respiratory Infections in Residential Care Facilities is available in the centre for staff 6/04/22

A call bell audit was conducted to ensure that residents call bells are responded to in a timely manner. Average response time was 1.02 seconds 11/05/22</td></tr>
<tr><td>Regulation 21: Records</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 21: Records:
Nurses are now documenting all correspondence with G.Ps and other allied health care professionals in their progress notes and adding to residents care plans as necessary. This is being overseen by PIC and ADON 07/04/22</td></tr>
</table>

A records/nursing documentation audit will be conducted to ensure that all relevant information is included in the progress notes and care plans. This has been added to the audit schedule. 30/06/22

The provider of the electronic care plan system has fixed the temporary glitch in their system which caused a delay in accessing the records for this former resident. The records have been supplied to the inspector. 7/4/22

The nurse in charge is now checking the roster every morning and every evening to ensure accuracy 7/04/22

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Protected governance hours are being provided 40 hours per week 23/05/22

The job description for the PIC has been reviewed and updated to ensure it clearly outlines the roles and responsibilities of the person in charge. 29/05/22

A review of scheduled audits will be conducted to ensure that all quality improvements are captured, and completed 30/06/22

The annual review for 2021 is being finalized 20/06/22

Ongoing recruitment of staff is being conducted - 2 HCAs have been recruited and 1 HCA has returned from maternity leave. We are in the process of recruiting 2 new nurses to commence employment in June 30/06/22

There has been an increase of 42 extra healthcare hours per week 07/04/22

A clinical governance meeting will take place with the nurse in charge and the nurses from both floors daily 29/05/22

All care plans are currently being reviewed and updated as necessary 11/06/22

An audit of care plans is being conducted by an external auditor to identify improvements 30/06/22

Audits are to be discussed at management meetings to ensure improvement plans are fully implemented 23/05/22

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
A notification for a suspected case of Covid19 is now being submitted where an antigen test is carried out, even if the result is negative 07/04/22

Where there is more than one related incident requiring an NF06, separate Notifications will be submitted for each one 7/04/22

All potential Notification will be reviewed at the weekly management meeting 23/05/22

The PIC is responsible for ensuring all notifications are submitted within the required timeframe and in the absence of the PIC the ADON is responsible 7/04/22

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:
A new Care plan tool is being used to assist Nurses to complete care plans 15/4/22

All Care plans are currently being reviewed and updated by nurses and once completed are to be audited and then 4 monthly after that 30/05/22

Training in care plan completion has been booked for June 30/6/22

A specific care plan audit with the focus on residents' nutrition has been completed and all nutrition care plans are now in place and the dietary folder in the kitchen has been updated 10/05/22

Any resident reviewed by allied health care professionals will have the information recorded in their daily progress notes and relevant information will be added to their care plans 07/04/22

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
All residents now have nutritional care plans in place and nutritional care plans are being completed for all admissions 10/05/22
All dietician recommendations will be incorporated into the residents care plans as well as being noted in residents progress notes 07/04/22
All reviews by GPs and allied health professionals are being documented in the progress notes and added to Care plan as required. 7/04/22
Residents are being referred for medical review in a timely manner when necessary by nurses overseeing resident care 7/04/22

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	05/06/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	07/04/2022
Regulation 16(2)(c)	The person in charge shall ensure that copies of relevant guidance published from time to time by Government or statutory agencies in relation to designated centres for older people are available to staff.	Substantially Compliant	Yellow	06/04/2022
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	Not Compliant	Orange	07/04/2022

	for inspection by the Chief Inspector.			
Regulation 21(3)	Records kept in accordance with this section and set out in Schedule 3 shall be retained for a period of not less than 7 years after the resident has ceased to reside in the designated centre concerned.	Substantially Compliant	Yellow	07/04/2022
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	30/06/2022
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	29/05/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe,	Not Compliant	Orange	23/05/2022

	appropriate, consistent and effectively monitored.			
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Yellow	20/06/2022
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	07/04/2022
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	Not Compliant	Orange	30/05/2022

	concerned and where appropriate that resident’s family.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	30/05/2022
Regulation 6(2)(a)	The person in charge shall, in so far as is reasonably practical, make available to a resident a medical practitioner chosen by or acceptable to that resident.	Substantially Compliant	Yellow	07/04/2022
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	07/04/2022