Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Ealga Lodge Nursing Home
Name of provider:	Underhill Investments Limited
Address of centre:	Main Street, Shinrone, Birr, Offaly
Type of inspection:	Unannounced
Date of inspection:	12 December 2018
Centre ID:	OSV-0005665
Fieldwork ID:	MON-0022426

About the designated centre

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

Ealga Lodge Nursing home is located in Shinrone town centre. The centre is located in off the main road and is situated in a residential area. The centre is a purpose built 59 bed facility. The designated centre accommodates both female and male residents over the age of 18 years. Residents' accommodation is provided in 37 single and 11 twin bedrooms with en suite facilities over two floors. The first floor is accessible by means of a lift and a stairs located in the reception area of the centre. Communal sitting rooms are provided on both floors and a dining room is available on the ground floor. Two enclosed courtyard areas with outdoor seating are available to residents. The service employs nurses, carers, activity, catering, household, administration and maintenance staff and offers 24 hour nursing care to residents. Ealga Lodge Nursing Home caters for residents with long-term, convalescence, respite, palliative and dementia care needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	45

How we inspect

To prepare for this inspection the inspector or 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
12 December 2018	09:10hrs to 18:20hrs	Catherine Rose Connolly Gargan	Lead

Views of people who use the service

Residents who spoke with the inspector said they were happy living in the centre and were satisfied with the service provided and the care they received. Residents said they felt safe and staff were always kind and respectful towards them. Residents who spoke with the inspector said they were comfortable in the centre and enjoyed the food they received and the choice offered.

Residents confirmed that they knew they could make a complaint but had no reason to complain. They singled out various staff members they said they would be happy to talk to regarding any dissatisfaction they experienced with the service provided. Residents who spoke with the inspector said they liked bingo and watching television.

Capacity and capability

This was an unannounced inspection to monitor ongoing compliance with the Regulations. The inspector followed up on progress with completion of actions from the last inspection in April 2018. There were non compliances with four regulations found on the last inspection and improvements to bring medicine management into compliance were satisfactorily implemented. Refurbishment work was ongoing to upgrade the first floor of the premises. Non compliance found during the last inspection regarding provision of opportunities for residents to participate in meaningful activities to met their interests and capabilities was not satisfactorily addressed. These non-compliances were found again on this inspection and are restated in the compliance plan with this report. The inspector followed up on information in notifications and unsolicited information received by the Office of the Chief Inspector since the last inspection in April 2018.

Assurances were not provided that the governance and management of the centre was sufficiently robust. There was an arrangement in place where the person in charge had responsibility for two centres. There was not satisfactory assurances provided that this arrangement ensured the person in charge was engaged in the effective governance, operational management and administration of the centre. The inspector was also not assured that there were sufficient staff available to meet the activity needs of residents as described in the centre's statement of purpose. This was a finding from the last inspection in April 2018 that had not been addressed by the provider and person in charge. While all staff were facilitated to attend mandatory training, professional development training in meeting residents' activity needs and care planning to meet residents'

end-of-life care preferences and managing responsive behaviours.

Systems were in place to monitor the quality and safety of the service and quality of life for residents living in the centre. While key areas of the service were audited, this process was not informing continuous quality improvement in the centre. The process in place for reviewing the outcomes of audits was not comprehensive and required strengthening.

Staff were aware of their roles and responsibilities and knew the residents well. The provider ensured that all staff had completed Garda Vetting before commencing working in the centre as per the National Vetting bureau (Children and Vulnerable Persons) Act 2012.

Regulation 14: Persons in charge

The person in charge has responsibility as person in charge of Ealga Lodge Nursing Home and Eliza Lodge Nursing Home. The person in charge was not present in the centre on the day of inspection. Sufficient assurances were not provided to satisfy the Chief Inspector that the person in charge was engaged in the effective governance, operational management and administration of the centre.

Judgment: Not compliant

Regulation 15: Staffing

There was a minimum of one registered nurse on duty at all times. While sufficient numbers of suitably skilled staff were available to meet the physical care needs of residents, sufficient numbers of appropriately skilled staff were not available to meet the social needs of residents. The activity coordinator was on unplanned leave and arrangements for replacement for the period of their leave did not ensure residents' social needs were met.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were facilitated to attend mandatory and professional development training. A designated training officer was employed by the provider. All mandatory staff training was up-to-date. Staff were facilitated to attend training in dementia care which included supporting residents with responsive behaviours. Facilitating suitable activities for residents was the responsibility of the activity coordinator and

an integral part of the carers' role in the centre. Therefore, training in suitable and meaningful activity provision for residents with dementia or other conditions that negatively impacted on their ability to meaningfully participate in group activities was necessary to ensure residents' activity needs were met.

Staff were supervised according to their role and their performance was supported and monitored.

Judgment: Substantially compliant

Regulation 21: Records

A sample of staff files were examined and contained all items of information as required by the regulations in respect of persons employed in the centre including a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. The provider gave assurances that all staff working in the centre had completed Garda Siochana vetting disclosures available in their files.

Records of emergency evacuation drills and testing of fire equipment were available and examined by the inspector. The records of simulated fire evacuation drills did not reference the fire location or scenario simulated, the compartment evacuated and the length of time taken for evacuation of residents to an area of safety.

The policies as required by Schedule 5 were all available.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not ensured that there were appropriate systems and processes in place for effective oversight of this service. Sufficient assurances were not provided that the management structure as described in the centre's statement of purpose was in place. The person in charge was not present in the centre on the day of inspection and their attendance in the centre was not recorded on the duty roster for the centre.

Systems were in place to monitor the quality and safety of the service and quality of residents lives in the centre. Key clinical indicators (KPIs) were monitored and a schedule of regular audits were completed. However, action plans were not consistently developed to ensure areas identified as needing improvement were addressed effectively to completion and informed a process of continuous quality improvement of the service.

The provider was in the process of preparing an annual review of the quality and

safety of the service in consultation with residents for 2018.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of residents' contracts for residency in the centre were examined and contained all of the items set out in regulation 24 and statutory instrument 293 of 2016, including the details regarding the bedroom the resident will be provided with as required.

The contract included details of additional fees charged outside of that covered by the nursing home support scheme. Opt-out of all or part of payment of additional charges was facilitated.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider recently updated the centre's statement of purpose document. The revised document contained all of the items as set out in schedule 1 of the regulations. This document was forwarded to the Office of the Chief Inspector as required.

Judgment: Compliant

Regulation 34: Complaints procedure

The director of nursing is the designated complaints officer for the centre. Arrangements were in place to ensure the person in charge and the provider was aware of all complaints received. The director of nursing Arrangements were in place to record and investigate any complaints received. The complaints procedure was available to residents and residents confirmed that they knew they could make a complaint if dissatisfied with any aspect of the service. Complainants' satisfaction with the outcome of the investigation of their complaint was assessed and an appeal process was available.

Independent advocacy services were available to assist residents with making a complaint if they wished. Advocacy services were supporting a resident in the service.

Judgment: Compliant

Regulation 4: Written policies and procedures

A suite of policy documents including the policies required under schedule 5 of the regulations were prepared and available. The policy documents informed all practices and procedures in the centre. Review dates did not exceed three years and revision of the some policies was underway on the day of inspection in line with the centre's policy revision process.

Judgment: Compliant

Quality and safety

Overall, residents' nursing and healthcare needs were met. Residents had good access to medical services including acute hospital and psychiatry services and were provided with a good standard of nursing care. Risk in the centre was proactively managed, for example, measures to prevent unauthorised access to the first floor during refurbishment work were comprehensive.

The layout and design of the ground floor met residents' needs with the exception of twin bedrooms located at the end of the accommodation wings. The layout in a number of these bedrooms negatively impacted on residents' privacy and dignity and the space available did not optimise their comfort and quality of life.

A review of residents' care documentation demonstrated that while, their nursing care and healthcare needs were appropriately assessed and reviewed on a regular basis, improvements by the person in charge were necessary to ensure consistency in the high standard of person centred detail in most care plans. The provider had not ensured that all residents' activity needs were appropriately assessed and that they had sufficient opportunity to participate in meaningful activities that met the interests and capabilities.

Residents' medicines were safely managed, reviewed by their general practitioner (GP) and administered as prescribed.

The provider ensured residents were protected from risk of fire and that their evacuation needs were assessed. While simulated evacuation drills were completed, the records required improvement to provide sufficient assurances that residents could be evacuated safely in the event of a fire in the centre.

Residents had access to information including local newspapers and their civil and

religious rights were respected.

The provider ensured that resident were safeguarded from abuse and that any incidents, suspicions or disclosures of abuse were appropriately investigated and addressed.

Regulation 11: Visits

An open visiting policy is operated in the centre. There were several small seating areas at the end of the accommodation wings and in the reception area which were suitable areas for residents to meet their visitors in private outside their bedrooms if they wished.

Judgment: Compliant

Regulation 13: End of life

Staff provided end-of-life care for residents with the support of each resident's general practitioner (GP) and the community palliative care services. Each resident had an end-of-life care plan in place but information describing their wishes regarding their end-of-life care and the place in which they wished to receive care was not consistently documented in their care plan. While residents wishes regarding their end-of-life care was discussed as part of their admission assessments, this process was not completed until they became ill. This did not always give residents residents opportunity to express their wishes regarding their wishes and preferences regarding their physical, psychological and spiritual care while they are well. Where expressed, residents' wishes regarding the place they wished to receive end-of-life care was respected. Residents have access to a small small oratory. Residents were facilitated with access to clergy to meet their different faith denominations. Single room accommodation is available to meet residents' end-of-life care needs. Residents' relatives are facilitated to be with them overnight during end-of-life care. A small number of staff had attended end-of-life care training and the inspector was told that further training was planned in 2019. A remembrance service was recently organised in the centre to remember deceased residents during the year.

Judgment: Substantially compliant

Regulation 17: Premises

Residents accommodation is provided over two floors with life and stair access

provided between floors. The first floor consisting of seven single and three twin bedrooms is currently closed to residents during refurbishment work. Residents' accommodation on the ground floor consisted of 30 single bedrooms and eight twin bedrooms. All residents' bedrooms throughout were fitted with en-suite toilet, washbasin and shower facilities. The layout and design of the centre met residents' needs with the exception of some twin bedrooms located at the end of the accommodation wings on the ground floor. The floor space available did not provide sufficient space to meet residents privacy and dignity needs. Placement of a chair next to each residents' bed was not possible and the layout and design necessitated placement of one resident's bed against a wall. Single bedrooms were spacious and met residents' individual needs. Residents were supported and encouraged to personalise their bedrooms with their family photographs, favourite ornaments and soft furnishings. Some residents were also facilitated to have items of their furniture from home in their bedrooms. Residents' communal accommodation was bright and spacious with furnishings and fittings that were domestic in style and familiar to them.

Toilets and showers were fitted with grab rails and handrails were in place along all circulating corridors. Appropriate assistive equipment was available to meet residents' support needs such as hoists and wheelchairs. While residents' accommodation was in a good state of repair, review of toilets and hand basins in some en suites and communal facilities was necessary to ensure they were in a good state of repair.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire fighting equipment was observed to be in place throughout the building and emergency exits were clearly displayed and free of obstruction. The building was compartmented. Emergency exits were clearly indicated. Daily and weekly fire equipment checking procedures were completed. Arrangements were in place for quarterly and annual servicing of emergency fire equipment by a suitably qualified external contractor and were available up to quarter three 2018. The contractor provides an on-call repair service. Steps down to the footpath outside one fire exit required review to ensure residents safe evacuation in the event of an emergency was not compromised.

Each resident will have their individual evacuation needs assessed and this information was recorded. Staff training records confirmed that all staff employed in the centre had attended annual fire safety training. Staff who with the inspector were clear regarding the evacuation procedures in the centre. A member of staff was assigned fire marshal responsibilities each day and their name was displayed on an information notice board by the nurses' station. The records confirmed that simulated night and daytime evacuation drills were completed and facilitated all

staff to participate in a simulated evacuation drill.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Residents were protected by safe medicine management practices and procedures. There were written operational policies informing ordering, prescribing, storing and administration of medicines. Practices in relation to prescribing, administration and medication reviews met with regulatory requirements and reflected professional guidelines. Medicines were stored securely in a designated clinical room. The pharmacist who supplied residents' medicines was facilitated to meet their obligations to residents and was involved in reviewing residents' medicine prescriptions. Medicines administered in 'crushed' format and maximum dose of PRN medicines permitted in a 24hour period was clearly prescribed. They also audited residents prescriptions and communicated their findings to the person in charge and the residents' GPs.There were procedures in place for the return of out of date or unused medications. Systems were in place for recording and managing medication errors if necessary. Medicines controlled by misuse of drugs legislation were stored securely and balances were checked twice daily. Medicines requiring refrigerated storage were stored appropriately and the medicine refrigerator temperatures were checked daily.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Each resident's needs were comprehensively assessed on admission and regularly thereafter, using a variety of accredited assessment tools. This process included assessment of each resident's risk of falling, malnutrition, pressure related skin damage, depression and their mobility support needs. A physiotherapist attended the centre one day each week and was involved in assessing residents' mobility needs and fall prevention strategies. Residents were well supervised and there was a relatively low incident of residents falling and sustaining an injury.

Care plans were developed to inform the care supports and assistance each resident needed were person-centred and clearly described residents' individual preferences and wishes. However detail in care plans informing the care and support needs of residents with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and end-of-life preferences required improvement to ensure they clearly described effective person centred care. Residents social needs were not described in a care plan. The inspector was told that residents, or their

families on their behalf were involved in their care plan development and subsequent reviews but this consultation process was not evidenced in the records examined.

Residents were closely monitored for any deterioration in their health and wellbeing. For example, a small number of residents with unintentional weight loss had frequent weighing and intake monitoring procedures in place. Effective preventative care procedures were in place for residents with assessed risk of developing pressure related skin injuries. No residents in the centre had pressure related skin damage on the day of inspection.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Residents predisposed to episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were well supported to ensure any behaviour that caused them distress was minimised. There were four residents in the centre who were predisposed to episodes of responsive behaviours and needed support to manage their behaviours and their needs were seen to be met on the day of inspection. Procedures were in place to ensure responsive behaviours were tracked and recorded. Each resident had a behaviour support care plan developed to inform their care and support needs. The information in behaviour support care plans did not contain sufficient detail to inform the behaviour exhibited, triggers to the behaviours and the most effective person-centred de-escalation strategies and is addressed under regulation 5 in this report. Staff who spoke with the inspector were knowledgeable regarding care of residents with responsive behaviours. Use of PRN (a medicine taken as the need arises) psychotropic medicines were closely monitored and reviewed and were not in use for any residents. Several staff were facilitated to attend training in dementia care which included management of responsive behaviours.

Use of equipment that restricted residents in the centre reflected National Restraint policy guidelines. Use of full-length bed rails was low. Residents' need for and safety using full length restrictive bed rails was assessed and alternatives were tried before implementation.

Judgment: Compliant

Regulation 8: Protection

A policy informing the arrangements and procedures for safeguarding and protecting

residents from abuse was available. Staff training records confirmed that all staff employed by the provider had attended training on detection, prevention of and responses to abuse. Staff who spoke with the inspector confirmed attendance at this training and were clear on the reporting procedures and their responsibilities.
All incidents, allegations or disclosures of abuse were investigated in line with the centre's policy including appropriate referral to relevant external agencies. Residents who spoke with the inspector confirmed they felt safe in the centre. All interactions between staff with residents observed on the day of inspection were respectful, courteous and kind.

Staff control and monitor access to the centre. A record is maintained of all visitors to the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to participate in the running of the centre with residents' committee meetings. The meetings were attended by members of the management team and were chaired by a resident.

Local and national newspapers were made available for residents. Residents were facilitated to exercise their civil, political and religious rights. Residents had appropriate access to independent advocacy services.

Staff were respectful and discreet when attending to the personal needs of residents ensuring bed screens in twin bedrooms and bedroom and bathroom doors were closed when assisting residents with their personal care. However, residents' privacy and dignity was negatively impacted by the layout and design of some twin bedrooms especially twin bedrooms where residents needed assistive equipment for transferring into and out of bed. Residents' beds in these bedrooms were located close to the wall and within close proximity of each other. There was insufficient space for a chair by each resident's bedside. Screen curtains were fitted very close to residents' beds and the privacy of residents needing assistive equipment could not be assured during personal care or transfer procedures.

Residents were facilitated with sufficient access to activities that met their interests and capabilities. A record of each residents' life, significant events and past interests was maintained but this information was not used to inform activities that suited their interests and capabilities. This was especially evident for residents who were not interested in or unable to participate in the group activities provided. A member of staff had responsibility for coordinating residents' activities and the inspector was told that facilitating activities for residents was also an integral part of the role of care staff. The activity coordinator facilitates activities from 10:00hrs to 16:00hrs Monday to Friday each week and was on unplanned leave on the day of inspection. Care staff facilitated activities in the activity coordinator's absence when not

engaged in meeting residents' care needs. On the day of inspection, 24 residents were resting in the sitting room after lunch. The inspector observed that the activity scheduled did not take place and most of the residents were not engaged in the alternative activity which took place. This arrangement did not ensure that residents social needs were met, especially residents who required one-to-one or small group activities.The records of the activities residents participated in did not provide sufficient information to provide assurances regarding their suitability or residents level of interest in them. A small number of residents were supported to attend a day service five days each week.

Residents in twin bedrooms did not have choice of television viewing as they shared a television with a resident in the adjacent bed. Their choice of listening was also negatively impacted by this arrangement in the absence of appropriate discreet listening equipment.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ealga Lodge Nursing Home OSV-0005665

Inspection ID: MON-0022426

Date of inspection: 12/12/2018

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The current Director of Nursing will assume the role of Person In Charge. An NF30A form will be submitted on or before January 25th 2019 pending the receipt of renewed Garda Vetting for this role. The Director of Nursing/PIC is employed in a full time capacity in the Nursing Home and is knowledgeable about the requirements of the Health Act, Regulations and the National Standards. The Director of Nursing/PIC is supported in her role by a CNM amongst other supports within the organisation. The Director of Nursing/PIC, supported by the provider, is responsible for promoting a culture within the Nursing Home that advocates the individual and collective rights of the residents living in the Nursing Home and where residents are encouraged to participate in their care. The Director of Nursing/PIC will meet other supports within the organisation on a regular basis to review the Continuous Quality Improvement Cycle for the Nursing Home and is responsible for overseeing and monitoring the Quality and Safety of the service along with promoting professional development and learning.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In an effort to ensure that Activities occur on a daily basis and that planned and unplanned leave is covered; two further staff have been identified to attend training along with the Activities Coordinator. When all relevant staff have received training, there will be a robust system in place whereby these two staff will be allocated to cover in the event of the planned or unplanned absence of the Activities Co-Ordinator. This will ensure that the residents' social needs are met and that residents have the opportunity	

to engage in meaningful activity.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
At present, one care assistant has received training in Imagination Gym. Imagination Gym is a healthcare program based on music therapy, relaxation skills, imagination, nature awareness, communication skills and sensory stimulation and is suitable for residents of all abilities. The Activities Co-Ordinator and two other employees will be attending Imagination Gym training on 21st March. Further training will be arranged in the areas of art facilitation, reminiscence therapy and tabletop gardening for these staff members also in order to enhance their skills.

The Person in Charge will carry out regular performance appraisals with all staff, including a training needs analysis in order to ensure that staff possess the adequate skills and knowledge to fulfil their role. This will be monitored on a continuous basis.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The current documentation relating to Evacuation Drills will be updated to include the clear documentation of the following: The simulated fire location, the scenario, which compartment is being evacuated, length of time taken to evacuate the compartment. The quality of this documentation will be included in an audit as part of the ongoing Audit Cycle to ensure that it is up to date, of high quality and accurate at all times as specified in the regulations to ensure a safe and effective service.

Regulation 23: Governance and management	Not Compliant

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

The change in management structure and the appointment of the current Director of Nursing as the Person in Charge will be reflected in the Statement of Purpose on completion.

Action plans will be documented after an analysis of KPIs on a monthly basis as part of the ongoing improvement initiative. Structured meetings are in place for management to review, evaluate and discuss the quality and safety of the service with key stakeholders and supports. The Person in Charge will ensure that monitoring systems are in place in order to provide assurance on clinical performance indicators and other aspects of quality and safety within the Nursing Home. The Person in Charge, assisted by the Practice Development Co-Ordinator, will evaluate the service delivery, benchmark this against the standards and identify areas for improvement as part of the continuous improvement cycle. The PIC, with the support of the Provider and management team, will be responsible for ensuring that these areas of need are addressed effectively to completion in an informed and integrated process which seeks to involve all stakeholders including residents and their loved ones. This information will then be included in the Annual Review.

Regulation 13: End of life	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:
It is our aim in Ealga Lodge to provide End of Life Care for residents which is proactive, sensitive and which meets the resident's expressed wishes and assessed needs in a manner which is respectful, dignified and compassionate. There is a robust plan in place for residents to have an End of Life Assessment carried out by Nursing Staff on admission to the Nursing Home in order to meet the above aim. In order to ensure that this is completed effectively, we plan to identify staff members belonging to our End of Life Committee and allocate them to discuss end of life care with residents if they have declined to discuss this with their admitting nurse. This will ensure that important information such as the resident's preferred place to receive end of life care are documented in a timely manner which is also respectful of the residents' comfort with discussing sensitive issues. The area of communication regarding End of Life Care will also be included in the End of Life training program. This training program will be delivered by appropriately qualified staff in order to upskill the workforce.
End of life care plans will be evaluated and reviewed every three months or sooner if there is a change in the resident's condition ensuring that the plan of care is responsive to the resident's changing needs.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: We will be engaging the services of a design team to assist us in planning to redesign the twin bedrooms on the ground floor in Ealga Lodge. It is anticipated that a prospective start date for these works will be set down within the next three to six months. These works will be carried out in order to ensure that our residents will be provided with an environment which ensures their privacy and dignity and allows unimpeded movement and wellbeing. Any redecoration/refurbishment/extension will be carried out in consultation with residents. We have refurbished a number of bedrooms in the Nursing Home in consultation with residents and will continue to do so over the coming months. An environmental/facilities audit is being carried out to identify any areas which require improvement such as toilets and hand basins. A plan is in place to refurbish the communal toilet referred to in the report.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The steps outside the fire exit in question will be replaced with a ramp in order to ensure the safe evacuation of residents in the event of an emergency.	
Regulation 5: Individual assessment and care plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: A plan is in place to review all Care Plans relating to responsive behaviours to ensure that they contain individualised information which will assist staff to identify triggers for responsive behaviours and equip staff with the information to manage these respectfully and effectively. A more robust Activities Assessment is being developed and will be carried out by the Activities Co-Ordinator for residents on the day of admission. The information from this assessment will then be used to create the resident's Activities Care Plan. The Activities Care Plan will ensure that the residents' social care needs are identified and interventions are in place to meet them. A template is being developed to monitor and record resident and family input in to the	

residents' care plans.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Nursing Home endeavours to promote a culture which protects and promotes the residents' rights relating to fairness, respect, equality, dignity and autonomy.

The impact on residents' privacy and dignity in the twin rooms has been addressed above (Regulation 17-Premesis). At the present time, twin rooms are reserved for use by residents who do not require assistive equipment. A waiting list is maintained for residents who wish to request a single room and this is facilitated at all times where possible.

Activities Assessments will be carried out by the Activities Co-Ordinator as mentioned above (Regulation 5- Individual Assessment and Care Plan). The information from this assessment will then be used to create the resident's Activities Care Plan. The Activities Care Plan will ensure that the residents' social care needs are identified and interventions are in place to meet them.

The documentation relating to residents' participation in Activities has been updated to reflect the residents' engagement in the activity. The Occupational Therapist has agreed to review residents who demonstrate low engagement in activities to provide further support and advice regarding the provision of meaningful activities for these residents.

An Activity Profile will be in place for all Activities Provided in the Nursing Home. Activities are categorized under the following: Creative, Knowledge/Learning, Reminiscence, Practical, Social and Physical. The Activity Profile outlines the following information: The therapeutic benefits of the activity, what sensory input it provides to the resident, the appropriate group size, how many staff are required to facilitate the activity, the equipment required, the instructions for the activity and how the activity can be modified to suit residents who live with dementia.

A robust plan is now in place to cover the planned or unplanned absence of the Activities Co-Ordinator.

The residents will be provided with the opportunity to be involved in planning for activities in the residents' group meetings. We have also set up an Activities Committee which includes staff members and residents and the function of this committee is to plan for future activities, develop ideas to include the residents in the community and to plan for outings for our residents.

Residents who currently reside in twin bedrooms have been surveyed regarding the provision of a second television in the room or the provision of discrete listening devices.

The residents surveyed did not wish to avail of these options, we will continue to offer this and will provide same if residents wish.

Regulation 9: Residents' rights
Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The Nursing Home endeavours to promote a culture which protects and promotes the residents' rights relating to fairness, respect, equality, dignity and autonomy.

The impact on residents' privacy and dignity in the twin rooms has been addressed above (Regulation 17-Premesis). At the present time, twin rooms are reserved for use by residents who do not require assistive equipment. A waiting list is maintained for residents who wish to request a single room and this is facilitated at all times where possible.

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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 13(1)(d)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that where the resident indicates a preference as to his or her location (for example a preference to return home or for a private room), such preference shall be facilitated in so far as is reasonably practicable.	Substantially Compliant	Yellow	30/05/2019
Regulation 14(4)	The person in charge may be a person in charge of more than one designated centre if the Chief Inspector is satisfied that he or she is engaged in	Not Compliant	Orange	25/01/2019

	the effective governance, operational management and administration of the designated centres concerned.			
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	30/04/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/04/2019
Regulation 17(1)	The registered provider shall ensure that the premises of a 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.	Not Compliant	Orange	31/03/2020
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Substantially Compliant	Yellow	31/03/2020

	provide premises which conform to the matters set out in Schedule 6.			
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.	Not Compliant	Yellow	11/01/2019
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	Yellow	25/01/2019
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	25/01/2019
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/03/2019
Regulation 5(2)	The person in	Substantially	Yellow	28/02/2019

	charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Compliant		
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	28/02/2019
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	28/02/2019
Regulation 9(2)(b)	The registered provider shall	Not Compliant	Orange	30/04/2019

	provide for residents opportunities to participate in activities in accordance with their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Yellow	30/04/2019
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	30/03/2020