



**Health
Information
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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:	Ealga Lodge Nursing Home
Name of provider:	Underhill Investments Limited
Address of centre:	Main Street, Shinrone, Birr, Offaly
Type of inspection:	Announced
Date of inspection:	26 January 2020
Centre ID:	OSV-0005665
Fieldwork ID:	MON-0023180

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:	42
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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
Sunday 26 January 2020	18:30hrs to 20:45hrs	Mary O'Donnell	Lead
Monday 27 January 2020	09:50hrs to 17:30hrs	Mary O'Donnell	Lead

What residents told us and what inspectors observed

Two relatives completed satisfaction questionnaires in advance of the inspection and the inspector met with a number of residents and their relatives during the inspection. Their feedback was generally positive about their experiences living in Ealga Lodge.

Residents particularly praised the home cooked food and were pleased that there was always a choice of meals offered. One resident said he was tempted to lick the plate, because the food was so good. Some residents said they enjoyed the group activities such as chair exercises and music and others stated that the range of activities on offer did not reflect their interests and they would participate in more activities if they were offered. One resident was pleased that staff took her into town to do her Christmas shopping. Some residents attended day care services in the community during the week. The last day trip was to the Zoo in June 2019 and residents said they should have day trips more often. The inspector saw residents saying the rosary in the day room and Mass being celebrated on the second day of inspection. Many residents were very grateful that Mass and Church of Ireland Service was celebrated in the centre. People from the community also attended religious services in the centre and this supported residents to maintain contact with friends and family.

Bedrooms were personalised and some residents was pleased that they choose the paint for their bedrooms. One resident wished they had more storage space for personal possessions. The inspector noted that storage space was inadequate in another resident's room and many of her possessions were stored in bags and boxes on the floor. Residents were satisfied with open visiting arrangements. They were observed meeting visitors in the sitting rooms, their bedrooms and in the foyer. One relative would prefer if there was more private space for visitors to meet with residents. The inspector observed that apart from bedrooms there was no private room to meet with visitors and residents in shared bedrooms could be impacted especially. The dining room had a code lock and residents didn't use this room outside of mealtimes.

Staff were observed to engage with the residents using a personal centred approach, it was clear that nurses and care staff were aware of each resident's needs. All residents were observed to be well groomed, wearing suitable clothing and footwear. Residents were observed being supported by staff to attend to their personal care routines. Residents were pleased that they can take a shower any time they wanted one. Residents commented that staff were very caring but also very busy. Residents said there were times when there were not enough staff on duty. Cover when staff went on breaks was deemed to be particularly problematic. Some residents commented that they were not impacted by staff shortages but they identified other residents whose care and safety was compromised because staff could not get to them on time or there was no staff member to supervise residents

in the day room.

The inspector observed that a household staff member was supervising residents in the sitting room in the evening. She did not have the skills to defuse a peer to peer incident or to mitigate a trip hazard when it was brought to her attention. Staff were busy taking residents to the bathroom and serving tea and biscuits to residents. A resident who was prescribed a high calorie diet because of weight loss was not offered food or drink in the evening. According to the residents intake charts for the previous three days, no food or fluid was recorded at supper time. The inspector observed that three residents walked around constantly, one resident stood for a prolonged period looking in the mirror. The inspector did not see these residents being supported to engage in occupational or social activities to distract the resident or to meet the unmet need which caused the behaviour. Activity charts and other records did not indicate that a social programme was implemented to support these residents.

Relatives commented that clothing sent for laundering sometimes went missing. The labels on clothing was marked with a black pen and this didn't work if the label on a garment was also black. Relatives remarked that they sometimes found other residents' garments in their resident's wardrobe and socks went missing because there was no system to mark socks. Laundry staff told the inspector of plans to use white labels which could be ironed on to garments. However this system was not in place at the time of inspection.

Capacity and capability

This was an announced inspection to monitor on-going compliance with the regulations and standards. The provider and person in charge progressed and completed six of the seven action plans developed to achieve compliance following the previous inspection on 31 October 2019. The installation of a second grab rail beside the toilet in the en suite bathrooms had not progressed, as the plan evolved into a larger project, to upgrade the en suites and remove a wooden plinth beneath the toilets. Refurbishment works were in progress, including the renovation of the 9 unoccupied bedrooms on the first floor. The completion date for the refurbishment project is September 2020. The provider acknowledged that eight twin rooms on the ground floor were too small and the occupants were offered single rooms. Three of the eight rooms still operated as twin rooms and residents in room number 9 and 27 expressed a wish to continue to live in shared bedroom accommodation. Appropriate action was taken to ensure compliance with other regulations including Regulation 28 Fire Safety. However staffing levels required review to ensure that sufficient staff with the appropriate skills were available to meet the assessed needs of the residents.

There was a clear governance and management structure that ensured oversight of

the service. There were management systems in place to monitor the quality and safety of the service and to ensure on-going quality improvement in the service. The inspector found that several key areas of the service were audited and action plans were developed for these audits. The practice development co-ordinator visited the centre on a monthly basis to conduct audits and she supported the person in charge and communicated audit findings with the provider. The provider representative visited the centre on a weekly basis. Formal management meetings were held two monthly and the standing agenda included staffing, quality, risk, safety complaints and audit reports.

The person in charge worked full time in the centre. The person in charge and clinical nurse manager, provided weekend on-call cover to ensure the management team was available to respond to issues seven days a week. This arrangement gave assurances of timely access to key personnel for staff for any issues arising. The clinical nurse manager deputised for the the person in charge.

Staffing levels were in line with the statement of purpose. However the staffing resource was insufficient and there were not sufficient staff with the necessary competencies and skills to meet the assessed needs of the residents and this impacted on the care and well being of residents. Arrangements to cover staff absence also required review to ensure that staff were appropriately supervised and the care delivered to residents was in line with their care plans. Staff were facilitated to attend mandatory and professional development training but oversight to ensure that all staff had refresher training need to be strengthened, to ensure that all staff had the necessary skills to meet residents diverse needs.

The provider ensured that all staff had completed Gardá Vetting before commencing working in the centre in line with the National Vetting bureau (Children and Vulnerable Persons) Act 2012. The provider had appropriate arrangements in place to discharge their duties as a pension agent.

Registration Regulation 4: Application for registration or renewal of registration

The provider representative was aware of the provider's responsibility to submit an application to renew the centres registration six months before the current registration was due to expire. The Statement of Purpose had been updated and occupancy levels in twin rooms had been reduced in preparation for the application to renew registration.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge (PIC) worked full time in the centre and was in post since May 2017. She was a registered nurse and was currently completing a MSc in Management. She also held a Diploma in Palliative care.

Judgment: Compliant

Regulation 15: Staffing

There were insufficient numbers of staff with the necessary skills to consistently meet the needs of residents. Staff were caring and knowledgeable regarding the individual and collective needs of residents. However there were not enough staff to provide the quality of care which staff and residents felt residents deserved. There were no spare staff to replace staff who were absent due to planned or unplanned leave. It was evident that it was an ongoing issue and the service depended on the goodwill of current staff to work extra hours to replace staff who were absent due to planned or unplanned leave. This impacted on the safety and quality of care as follows:

- Supervision to ensure that residents had adequate food and fluid intake was ineffective. Records for a resident at risk of dehydration showed that she had 450 mls in the previous 24 hours.
- Residents, who were at risk of absconding, required regular location and safety checks. The records of safety checks for the days preceding the inspection had no entries between 14:30 hours and 20:30 hours, when night staff came on duty.
- The clinical nurse manager provided direct care when two nurses went on extended leave. The outcome was that she could not carry out the quality checks to ensure that care was delivered in line with residents' care plans. Records showed that the last quality checks were carried out on 1 November 2019.
- The activity co-ordinator was responsible for facilitating activities and engaging with residents socially. She also served teas and supervised residents in the sitting room in the mornings. She provided a daily group activity, which was sometimes interrupted when she had to provide personal care or accompany someone to the bathroom.
- Care staff engaged socially with residents while providing care but they did not have sufficient time to spend with residents who required one-to-one engagement or residents with responsive behaviours.
- Vulnerable residents were not consistently supervised in the day room. Residents told the inspector that supervision during staff breaks was not always adequate. It was sometimes too late when staff arrived to assist residents who needed to use the bathroom.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to appropriate training, which included fire safety, safeguarding, manual handling, food hygiene, infection control and managing responsive behaviours. Oversight to ensure that all staff attended refresher training required strengthening. Over 50% of staff were overdue infection control training. Staff were supervised but the supervision of staff was compromised when supervisors provided direct care to cover staff absences.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was maintained in the centre. This directory contained all of the information specified in paragraph (3) of schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

Records set out in Schedules 2, 3 and 4 were kept in the centre, stored safely and available for inspection.

The inspector reviewed a sample of staff files. The files contained the necessary information as required by Schedule 2 of the regulations including evidence of a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Records of each fire practice, drill and test of fire equipment were maintained. The fire drill records contained all the required information including the learning identified and actions followed up to ensure on-going improvement.

Judgment: Compliant

Regulation 22: Insurance

There was a valid contract of insurance against injury to residents and additional risks, including loss or damage to a resident's property.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear governance and management structure in the centre. The provider representative was present in the centre on one or two days each week and met with the person in charge both formally and informally. The management team met on a two monthly basis to review the service. Minutes from these meetings evidenced that a comprehensive standing agenda to ensure that to all aspects of the service were reviewed and addressed as necessary. Systems were in place to monitor the quality and safety of the service. Data on key quality indicators was routinely gathered and analysed to monitor trends. A schedule of audits was carried out and used to inform continuous quality improvements. The audit programme had been strengthened since the previous inspection to include action plans developed and responsible persons assigned for completion of the actions recorded. Improvements had been made to reduce the use of bedside rails and a significant reduction in resident falls was evident from audit reports.

The provider made resources available for equipment such as low-low beds, a new bed pan washer and hoists and there was on-going investment to maintain and improve the premises. Refurbishment of the first floor was in progress and replacement of floor covering in parts of the ground floor was underway. The provider was proactively reducing occupancy in twin rooms as the space in these rooms was confined and compromised the privacy and dignity of residents. Further improvements were required to ensure that the external areas were accessible and suitable for the residents.

Staffing levels required review especially, arrangements for covering shifts when staff were absent. The current arrangements did not provide assurances in relation to the safety of residents or the quality of care provided. This impacted on the provision of activities and the care and welfare of residents with complex needs, including residents with responsive behaviours. It also impacted on the quality of staff supervision. The clinical nurse manager who was responsible for overseeing the quality of care and documentation of care delivered was part of a team delivering direct care and she had not carried out routine quality checks for 12 weeks.

There were regular residents' meetings and a residents survey was being carried out to elicit residents' views on the running of the centre and to inform service improvements. Audit reports and feedback from residents and relatives will be reflected in the annual review of the quality and safety of the service 2019.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

The contract for the provision of services contained all of the items as set out in regulation 24.

Judgment: Compliant

Regulation 3: Statement of purpose

The document was recently amended. It described the service and contained the correct information as required in schedule 1.

Judgment: Compliant

Quality and safety

There was a good standard of evidence based health care provided to all residents. Residents had good access to GP, specialist medical and allied health services. The provider employed a physiotherapist who did assessments, facilitated chair exercise classes and offered individual physiotherapy treatments as required. Nursing care was evidence based. The incidents of falls, repeat falls and pressure ulcers was low.

Care plans were improved and contained sufficient detail to support person-centred care. However, the inspector was not assured that the care plans were implemented. Lack of staff was identified as an issue and this presented challenges in relation to staff supervision to ensure that appropriate care was provided and record keeping. It also impacted particularly in areas such as activity provision and supporting residents with responsive behaviours.

Risks were assessed and controls put in place to manage identified risks. However a more proactive approach to risk taking was required to ensure that residents could freely access a safe external environment. The use of bed rails was low and less restrictive options were trialled before a restriction was applied. The use of environmental restraints such as locked external doors required review to ensure that freedom of movement was not limited and not impacting negatively on

residents.

Residents felt safe in the centre and all staff had received training in the prevention detection and response to abuse. All staff in the centre had a valid Garda Vetting disclosure in place. The centre managed pensions for some residents and this was done in line with the department of social protection guidelines and subject to a monthly audit.

Refurbishment works in the centre were on-going. Bedrooms were personalised and homely, with sufficient storage space for most of the residents and secure storage space. The provider was gradually converting the twin rooms into single rooms and respected residents' right to remain in a twin room if they wished to do so. The enclosed outside space was not secure and it was poorly maintained. None of the residents were observed going in and out throughout the day. Corridors were all painted in different colours to help way finding and orientation for residents.

The centre was clean and waste and laundry were managed well. However improvements in staff practices to minimise the risk of cross infection and labelling of clothing were required review to ensure that laundered clothing were returned to the owner.

Residents' rights and choice were respected. Residents were encouraged to contribute in the organisation of the service. Improvements in the provision of activities were required to enhance the residents' daily experience. Further improvements were required to ensure that residents with higher dependencies or more complex needs had opportunities for social engagement or to participate in meaningful activities.

Regulation 11: Visits

There was an open visiting policy in place in the centre. Visitors were welcomed and residents met their visitors in in the day room or the foyer. There was no private room available to meet with visitors apart from the residents' bedrooms.

Staff controlled access to the centre and a record of all visitors to the centre was maintained to ensure residents were appropriately safeguarded.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Storage facilities were adequate for most of the residents, however some residents

required additional storage space in their bedrooms. Residents were encouraged to personalise their rooms and to bring personal items and soft furnishing from their homes into their bedrooms if they wished. A lockable space was available in all residents' bedrooms.

The provider acted in the role of pension agent for collection of social welfare pensions for some residents. The system in place was secure and transparent. Some monies were held in safekeeping on behalf of some residents for their day-to-day expenses. This money was held securely and records of transactions were maintained and the balances checked were correct. Pension accounts and comfort fund transactions were audited on a monthly basis. Residents had access to their monies as they required.

Labelling of clothing required improvement to ensure that residents' clothing was safely returned to the owner when laundered.

Judgment: Substantially compliant

Regulation 13: End of life

Staff were trained to support them to have conversations with residents and relatives and plan their end of life care. Residents are also represented on the End of Life Committee. Each resident was consulted with and given opportunity to express their wishes and preferences regarding their end of life care. The detail of the information was documented in residents' care plans and reviewed on an ongoing basis.

The provider made efforts to provide a single room for overnight accommodation, so that relatives could be with a resident in the event of them becoming very ill. Residents and relatives who spoke with the inspector were satisfied that residents' religious and cultural practices and faiths were facilitated. Members of the local clergy from the various religious faiths were available to and provided pastoral and spiritual support for residents.

Judgment: Compliant

Regulation 17: Premises

The premises internally were maintained to a good standard and were visibly clean throughout. Residents were currently accommodated on the ground floor, as the first floor was being refurbished. Bedroom wings were painted in different colours to help residents to find their way in the centre. All bedrooms had full en suite

facilities and there were sufficient toilet and bathroom facilities in the centre. Single bedrooms were spacious, but twin rooms were small and residents were offered single rooms instead. Four residents expressed a preference to share a room with a partner or another resident and only three of the eight twin rooms were now operating as twin rooms. The vacant second beds were still in the bedrooms and plans were in place to move these beds upstairs as the bedrooms on the first floor became available.

Flooring on the first floor had been removed and the provider had plans to replace stained and worn flooring in communal toilets on the ground floor. There was a leak in one communal toilet and the lock on the door was faulty. The dark tiles on floors of the en suites were stained with a white film. The provider representative said this was due to lime in the water and he had sourced a product which would remove lime-scale from the floors.

Most of the residents spent their day in the sitting room. They also had access to an activity room, an oratory and a dining room, which was used by staff as well as residents. The conservatory was used as a smoking room. It was very cold and overlooked an enclosed patio with a water feature. The sitting room opened onto an enclosed garden which was not secure because the perimeter fence was low. Residents did not have free access to the garden as there was a risk that some residents might abscond and when the door was opened it created a breeze in the sitting room. This required review to ensure that residents could freely access and enjoy a suitable external area.

This external area was not inviting or well maintained. The flower bed had weeds, the cobble lock was covered with moss and the garden furniture was in need of maintenance work and fresh paint.

Judgment: Not compliant

Regulation 20: Information for residents

The 'Guide for Residents' booklet was reviewed in December 2019 and it held all the required information. The document and was made available to residents in the centre.

Judgment: Compliant

Regulation 26: Risk management

The centre had an up to date safety statement in place and the centre's risk

management policy met the requirements of the regulations. Measures to control identified environmental and clinical hazards were specified, implemented and monitored. Risk management in the centre was reviewed at management meetings which were attended by the provider representative.

A designated smoking room for residents was provided and controls were in place to mitigate the risk to residents. Risk assessments were completed and a smoking apron, a fire blanket and extinguisher were located in the smoking room.

All accidents and incidents that occurred in the centre were reviewed by the person in charge and discussed at the management meetings. Areas for learning were identified and communicated to staff. Many of the residents were at risk of falling. The falling leaf system was introduced and training provided to all staff. This had impacted positively on residents with a significant decrease in the incidence of falls. There were a number of residents at risk of leaving the centre unaccompanied. The person in charge had appropriate measures in place including a record of what each resident was wearing each day and missing persons drills were carried out to ensure that staff responded appropriately if a resident went missing.

Judgment: Compliant

Regulation 27: Infection control

The centre had policies and procedures in place for the prevention and control of healthcare associated infections. At the time of inspection these procedures were being updated to reflect the new National Infection Prevention and Control Standards. There were good practices in place for the management of laundry and waste.

Hand hygiene dispensers were located at convenient locations throughout the centre. Thirty five staff had not had training or were overdue refresher training on infection control and some poor practices were observed which presented a potential risk to residents. More robust systems were required to ensure that all staff had appropriate training and implemented best practice in infection prevention and control.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There was improved oversight of fire safety in the centre since the previous inspection. The compliance plans had been completed to erect ramps at two fire

exits to accommodate wheelchairs. The floor plan for the first floor was displayed at the fire alarm panel and compartment boundaries clearly displayed. All residents had a personal emergency evacuation plan (PEEPs) in place that contained appropriate details to inform staff of each residents specific requirements should an emergency evacuation be required. Summarised PEEPs were located in residents' bedrooms for immediate access for staff in the event of a fire.

Annual fire training was provided for staff and all staff were up to date. Staff who met the inspector were knowledgeable about fire safety and evacuation routines. There was an L1 fire alarm in the centre. All doors had automatic closure devices to delay the spread of smoke and fire in the centre. Daily and weekly fire safety checks were carried out and documented. Quarterly servicing of the fire detection and alarm system and the emergency lighting were completed. Fire drills had been completed and good evacuation times were recorded for the larger compartments with night time evacuation scenarios.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The inspector found that residents' clinical care needs were assessed and met to a good standard for most of the residents. Improvements were made to ensure that residents' care plan information reflected residents' individual preferences and wishes regarding their care. However in relation to residents who had complex needs it was not clear if their care plans were fully implemented.

When the inspector followed up on residents at risk a malnutrition there were gaps in the intake records. Current information was not shared with the catering staff. The information which chef was working from was dated November 2019.

From the sample of four residents' files reviewed, one care plan had not been updated to reflect the changing needs of the resident. In another case additional measures had been taken to mitigate risk following a fall but the resident's care plan had not been updated to reflect this. A care plan had not been closed out when the problem had been resolved.

There were records of daily checks carried out by night duty staff to ensure that pressure relieving mattresses were operating at the appropriate setting for the resident's weight.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of health care provided to residents. There was reasonable access to local GP services including out of hours medical care. Residents also had access to consultant led psychiatry of old age and palliative care services.

Residents were supported to access allied health care services such as, dietician, occupational therapy, chiropody and optician services. The provider employed a physiotherapist who assessed residents and facilitated group exercise classes in the centre.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Some residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The staffing levels were inadequate to meet the needs of some of these residents. Residents freedom was restricted, as all the external doors had key coded locks and there was no secure, suitable, external area for these residents.

Residents with responsive behaviours had behavioural assessments completed and person centred care plans were developed with details to support a consistent approach to care. However the staff levels and documentation did not provide evidence that the care plans were implemented. For example the inspector observed that residents, who were at risk of absconding, required regular location and safety checks. The records of safety checks for the days preceding the inspection had no entries between 14:30 hours and 20:30 hours, when night staff came on duty. Staff said this was due to inadequate staff on duty.

Staff expressed concern for four residents at risk of leaving the centre unaccompanied but the impact on residents being confined to an indoor area had not been fully considered or risk assessed. The provider said residents could go outside when accompanied by staff but it was not possible from speaking with staff or from the records to clarify when any of these residents had been outdoors. Residents had ample space to walk around inside, and the corridors were wide and grab rails were installed in all circulating areas. If there were more seating areas it might prompt the residents to sit and rest. The inspector observed the residents constantly walking around the centre. Apart from a friendly comment from passing staff, the inspector did not witness any therapeutic social interaction with these residents. The inspector observed that other residents who were relaxing in the sitting room in the evening became irritated by a resident who constantly walked about. The inspector witnessed a physical altercation between two residents,

which was not witnessed by any staff member.

The physical environment and staffing arrangements required review to ensure that the physical, social and emotional needs of residents with responsive behaviours were met.

Judgment: Not compliant

Regulation 8: Protection

The provider had a policy and systems in place to ensure residents were safeguarded and protected from abuse. Staff were facilitated to attend training so that they could recognise and respond to a suspicion, incident or disclosure of abuse. Staff who spoke with the inspector discussed the different kinds of abuse and were clear about their duty to report any concerns or disclosures. The inspector was assured that safeguarding concerns reported to the person in charge were appropriately managed in line with the centre's policy.

The inspector observed that interactions between staff with residents were respectful, courteous and kind. Residents who spoke with inspectors said that they felt safe in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Resident's rights were generally respected in the centre and the ethos of care was person-centred. The restrictions imposed by locked external doors is discussed under Regulation 7.

There were facilities for residents to participate in activities and in November '19 all residents were assessed to ensure that suitable activities were provided to meet their individual needs. Two additional staff were trained to facilitate activities, including imagination gym, art and tabletop gardening. However given the age profile of the residents and the range of dependencies it was not possible to meet the activity and social needs of residents with the current staffing resource.

The activity co-ordinator worked until 15:00 Monday to Friday. Health care staff were rostered to do activities at the weekend but staff told the inspector that they were sometimes called upon to undertake health care duties. Some residents who participated in group activities told the inspector they enjoyed the activities and others said they participated because it was something to do but the range of activities on offer did not suit them.

The activity said coordinator facilitated a group activity each day and also tried to have a chat with residents who had higher support needs. Overall opportunities, for one to one engagement were limited and the inspector was not assured that the social needs of residents, especially those who could not participate in group activities were met.

Residents attended regular meetings and contributed to the organisation of the service. A residents' choir was set up following a suggestion at the residents meeting. This impacted positively on residents. Staff reported that a resident who had communication difficulties had begun to communicate verbally as a result of being involved in the choir.

Residents also had access to independent advocacy through the national advocacy service.

A variety of daily papers were available to residents as well as local newspapers. Religious services were facilitated regularly by the local clergy. Residents met with friends from the community who came to the centre to attend religious services. Two residents attended day services in the community during the week. Residents were supported to exercise their civil, political and religious rights. A polling station operated in the centre during the inspection to facilitate residents to vote in the general election.

Residents' choice was respected and facilitated in the centre. Residents could retire to bed and get up when they choose. Residents in shared accommodation had their privacy and dignity protected by the use of screens. The dignity of residents was respected when a resident required a hoist to transfer into and out of bed. These residents used the standing hoist which was small and could operate within the allocated bed space.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ealga Lodge Nursing Home OSV-0005665

Inspection ID: MON-0023180

Date of inspection: 27/01/2020

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
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: A review of staffing levels over the last three months took place with particular attention paid to the number of hours of sick leave which were not covered. It was found that a total of 0.63% of care assistant hours were not successfully covered. On further analysis, these hours were day time hours only and staff workloads were re-allocated to ensure that the residents' needs were met including care staff receiving assistance from staff nurses. This did not impact on the safety of the residents as there were sufficient staff on duty to evacuate safely in the event of a fire. Staff attendance is monitored and discussed at appraisals and any ongoing issues are discussed with staff. Measures can be put in place if there are any difficulties in an effort to maintain good attendance records for all staff.</p> <p>Recruitment of staff is ongoing. I have successfully added to both our nurse and care assistant roster since our inspection.</p> <p>The management checks which were to be carried out once per month by the CNM have now been updated and the frequency has been changed to once per week to ensure that any time management issues can be rectified quickly. This documented is forwarded to the PIC on a weekly basis and signed off. The CNM was able to carry out these checks over a one day period in February 2020 (this took a maximum of 8 hours). The CNM was rostered for 100% of their hours supernumerary in January and 55% of their hours supernumerary in December.</p> <p>Supervision of the sitting room is allocated to care staff on an allocation sheet on a daily basis. Their name is also written on a board in the sitting room. Adherence to this is monitored by the staff nurse on duty and any non-compliance with this is managed by the staff nurse on duty/PIC/CNM. Staff are also allocated on their breaks to ensure that there are sufficient staffing levels available to assist residents with their needs. There is a residents' meeting scheduled for 25/2/2020 and concerns raised by residents during the inspection will be explored further with residents in an effort to continue improving the service provided.</p>	

Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development: 100% of staff are now trained in infection control.</p> <p>Training completed as of 20/2/2020</p>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management: External areas being accessible for residents: see Regulation 17 (Premises) below.</p> <p>Staffing issues identified: On review of the KPIs being monitored on a monthly basis, the quality of the care being provided is evidenced in the low occurrence of incidents, falls, pressure areas and infection. Please also see Regulation 15: Staffing above.</p> <p>Activities: The CNM will now be analysing activities provision on a monthly basis to ensure that the activities being provided meet the needs and preferences of our residents. Due date for completion: 31/4/2020.</p>	
Regulation 11: Visits	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 11: Visits: There is a private room available upstairs for visiting purposes which will be more accessible when upstairs renovations are complete. Visitors are also welcome to use the activities room adjoining the sitting room for visits also. We have an upstairs living room which is used by families wishing to hold parties or celebrations with residents.</p> <p>Due date for completion: 30/3/2020</p>	

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Regulation 12: Personal possessions	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 12: Personal possessions:

A review of all bedrooms and storage facilities in residents' bedrooms has taken place. There were four rooms identified which had large volumes of personal belongings in them which were placed on the floor beside the wardrobe. One of these residents is awaiting placement within the community and has large amounts of boardgames and art supplies in her room. She has been facilitated to store these in a different area and has been assured that they will be kept safe until she moves. The remaining three residents collect large volumes of papers and other items which they like to keep in their room. Staff regularly assist these residents to clear out and organise their space for health and safety reasons. The condition of their private space is monitored by staff and they are assisted to clear out items in a respectful way with them being fully consulted and involved. These residents have been offered alternative storage but have declined. We will continue to monitor this and will continue to offer alternative storage solutions.

We have purchased white labels which can be written on with a laundry marker and ironed on to clothing to improve the laundry labelling practice. All clothes should be re-labelled by 30/3/2020.

Regulation 17: Premises	Not Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:

The second beds vacant in twin rooms will be moved upstairs when refurbishment is completed. Date:30/9/2020

External areas are scheduled to be maintained (weather permitting). This will include removal of moss from cobbles, replanting of plant pots and window boxes, maintenance and painting of outdoor furniture. This is due to be completed by 30/5/2020.

The flooring in the communal toilets on the ground floor is scheduled to be replaced by 31/3/2020.

The leak in the communal toilet was noted on day of inspection and was repaired on the same day.

The lock on the door of the communal toilet was noted on the day of inspection and was repaired on the same day.

The floors of the ensuites will be cleaned using a specialist limescale removal product and is to be completed by 31/3/2020.

The conservatory is designated as a smoking area for residents. This area requires appropriate ventilation due to the purpose of the room and the opened windows do contribute to a cold environment depending on the weather. The residents who use the smoking area have the ability to independently regulate their temperature and will put on a coat when going out if needed. All residents who smoke are risk assessed and any new admissions who smoke and who are unable to independently regulate their own body temperature will be assisted to do so by staff.

The enclosed garden at the front of the building has a surrounding wall and fence. The fence in one area is 94cm in height. This will be reviewed to ensure that the external garden is secure. Due date for completion: 30/5/2020.

Regulation 27: Infection control

Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

There was an excellent uptake of the flu vaccination program amongst staff. There is evidence available to support the quality of the infection control practices within the home overall such as the extremely low occurrence of infection within the Nursing Home. There have been no outbreaks of flu over the winter months and no notifiable outbreaks of any illness within the past three years.

Infection control training has now been provided to 100% of our staff.

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:

We had control mechanisms in place to monitor the documentation of residents' fluid and diet intake. To improve staff compliance with documenting diet/fluid intake, staff are now allocated with the responsibility to check that this documentation is fully completed and

any failures are notified to the nurse on duty.

We are currently using huddle groups to improve awareness around the importance of maintaining adequate hydration and documentation of same.

Our computer system is being upgraded and we are aiming to document all care provided electronically which will allow for the efficient and effective documentation and audit of same.

Date for completion: 30/5/2020

A meeting took place between the PIC and the chef after the inspection and it was ensured that the kitchen had all of the most up to date data available.

Care plan audits are currently underway to ensure that all care plans are user friendly and up to date. Staff nurses are allocated residents whose care plans they are responsible for and this is audited monthly. Our computer system is also being updated to streamline the monitoring

Date for completion: 31/3/2020

Regulation 7: Managing behaviour that is challenging

Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

The front door to the Nursing Home is accessible only by the use of a keypad. The rationale behind this is to maintain controlled access and exit from the building in order to protect residents at risk of absconsion. Although 5 residents are at risk of absconsion, there have been no absconsions from the building over the last 18 months. The other external doors of the Nursing Home are fire doors and can be opened, they are connected to the alarm system. Residents who have the ability to open the door and exit can do so but staff are alerted to the door that has opened and can ensure that the resident is then safe. A risk assessment has been carried out regarding this and also considering the potential restrictive practice which this poses.

It was found that records of safety checks had not been carried out for a period of time during the inspection. Staff interviewed had reported that this was due to inadequate staff on duty. This has been fully investigated. There was no care assistant on duty for the 16.00-22.00 shift due to sick leave and inability to cover this with a care assistant. As per staff allocations, this staff member is not responsible for carrying out these safety checks and therefore this would not have contributed to this failure in documentation. We have placed additional controls to ensure that any failure in documentation is identified and dealt with immediately.

The impact on the possibility of residents being confined to an indoor area is currently being risk assessed and care plans are being reviewed. This is due to be completed by 30/3/2020.

The altercation between two residents which was witnessed by the inspector did not result in any injuries. There have been no peer to peer safeguarding incidents or injuries recorded in our time in Ealga Lodge (September 2017). This incident has been investigated fully and there is an action plan and care plan in place to prevent the re-occurrence of same. There is a very low occurrence of responsive behaviour within the nursing home and we audit the use of psychotropic medications in the management of responsive behavior very carefully. Care plans are in place for all residents with responsive behavior and we have implemented a tool to ensure that residents are not administered psychotropic medications unnecessarily.

Regulation 9: Residents' rights

Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: At present structured activities are provided for residents by the Activities Co-Ordinator acting Activities Co-Ordinator for 6 hours five days per week and 4 hours 2 days per week. The staff make a conscious effort to ensure that the residents' social and activities needs are met and we will continue to work to improve in this area. A staff meeting due to be held in February 2020 will aim to address the issue of the acting activities coordinator being asked to carry out other tasks by care staff.

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 11(2)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	30/03/2020
Regulation 12(b)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in	Substantially Compliant	Yellow	30/03/2020

	particular, that his or her linen and clothes are laundered regularly and returned to that resident.			
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	26/02/2020
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	30/03/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant		20/02/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	20/02/2020

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.	Substantially Compliant	Yellow	30/09/2020
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	Orange	30/09/2020
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	30/04/2020
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections	Substantially Compliant	Yellow	26/02/2020

	published by the Authority are implemented by staff.			
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).	Substantially Compliant	Yellow	30/03/2020
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		30/03/2020
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	26/02/2020
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other	Not Compliant	Orange	30/03/2020

	persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/03/2020
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/03/2020