Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Ealga Lodge Nursing Home
Name of provider:	Underhill Investments Limited
Address of centre:	Shinrone, Birr, Offaly
Type of inspection:	Unannounced
Date of inspection:	06 July 2022
Centre ID:	OSV-0005665
Fieldwork ID:	MON-0037367

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 49 bed facility. The designated centre accommodates both female and male residents over the age of 18 years. Residents' accommodation is provided in 47 single and one 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:	34

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 6 July 2022	08:15hrs to 18:15hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

On the day of inspection, the inspector observed that residents received respectful and attentive care from staff who were kind and caring. The feedback from residents was positive with regard to their experience of the care and support they received, and their quality of life.

The inspector was met by the person in charge on arrival to the centre. Following an introductory meeting, the inspector walked through the centre with the person in charge and person participating in management. On the day of inspection, the centre was experiencing an outbreak of COVID-19, and while all staff and residents had completed their isolation period, the outbreak was not yet officially declared over. However, normal day-to-day activities had returned to normal and residents were observed freely moving around the centre and receiving visitors.

Ealga Lodge Nursing Home provides long term care for both female and male residents with a range of dependencies and needs. The centre is situated in the village of Shinrone, Co. Offaly. The church, shops and local amenities are within walking distance for residents to access. The centre is a two-storey building, accessible by passenger lift, that accommodates 48 residents, in predominately single room accommodation. There is one twin room on the second floor of the premises. All bedrooms have full en-suite facilities.

Throughout the day, residents were observed in a variety of communal settings that included the oratory, communal dayroom, enclosed courtyard and smoking area. Staff were observed engaging with residents and attending to their needs without delay. The interactions between residents and staff were observed to be polite, caring and unhurried. Activities were ongoing throughout the day, in the main communal room, with a blend of group and one-to-one activities taking place. Visitors were observed coming and going during the day.

The inspector observed that the premises was generally clean with the exception of some storage rooms. Improvements were observed in the provision of a smoking room for residents that was nearing completion and overlooked the enclosed courtyard and water feature. The provider intended to formally submit an application to vary a condition of their registration once the smoking room was completed. The dayrooms were decorated to an appropriate standard and had soft and comfortable furnishing for residents. The external garden area was not well maintained. The inspector observed moss and weeds penetrated the paths. There were areas of the premises, internally, that were in a poor state of repair. Floors in some areas were observed to be torn and damaged. The inspector found that the mechanism to open the door from the dayroom to the garden area was difficult to operate and had the potential to restrict residents from independently accessing the garden area.

Residents complimented their bedroom accommodation, Bedrooms were observed

to be personalised with items of significance to each resident, such as family photographs and artwork from grandchildren. Residents' bedrooms were clean and bright and most had adequate space for residents' personal belongings and to have a comfortable chair at the bedside. The inspector observed residents' toiletries stored in baskets on the floor of en-suites, indicating that there was inappropriate storage in en-suite facilities.

The inspector spoke with several of the residents and the general feedback was that Ealga Lodge Nursing Home was a pleasant and safe place to life. Residents stated that staff and management were responsive to their needs and they did not have to wait long for their call bells to be answered. Residents were complimentary of all the staff in the centre. The inspector had the opportunity to speak with some visitors who expressed their satisfaction with the quality of care provided to their relatives.

Residents were provided with a choice for their meals and could attend the dining room or remain in their bedroom to have their meals. Staff were available to provide support and assistance to residents with their meals. The dining experience was observed to be a pleasant and enjoyable experience for residents.

Residents stated that they were satisfied with the activities schedule that was displayed on each corridor and in the dayroom. Activities staff consulted with residents on what activities and events they would like to celebrate.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection conducted by an inspector of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspector also reviewed information submitted by the provider and person in charge and the action taken by the provider to address the non-compliant issues found on inspection in December 2021. The inspector found that the provider had taken action following the previous inspection to comply with the regulation that included;

- Regulation 15, Staffing,
- Regulation 16, Training and staff development,
- Regulation 7, Managing behaviour that is challenging,
- Regulation 5, individual assessment and care plan, and,
- Regulation 29, Medicines and pharmaceutical services.

While progress had been made to address issues with regard to the premises and infection control following the previous inspection, progress was not sufficient to

bring the centre into full compliance with those regulations. Additionally, the provider was required to take action to ensure full compliance with Regulation 23, Governance and management, Regulation 21, Records, Regulation 11, Visits, and Regulation 28, Fire precautions.

Underhill Investments limited is the registered provider of this centre. The company is comprised of three directors, one of whom represents the company and attends the centre on a weekly basis, with the general manager to provide senior management support and governance oversight. There was evidence of senior management support provided to the person in charge through records of formal quality and governance meetings that discussed aspects of the quality and safety of the service provided to residents in Ealga Lodge. The clinical management team consisted of the person in charge supported by a recently appointed clinical nurse manager who oversaw the quality and safety of care provided by a team of nursing, healthcare and activities staff. The general manager informed the inspector that a second clinical nurse manager had been appointed to further strengthen the governance structure and oversight of the service. The service was also supported by team of housekeeping, laundry, catering administrative and maintenance staff.

The quality of care was monitored through a variety of clinical and environmental audits, complaints, incidents, resident and relative feedback. Where deficits in the service were identified, a corresponding quality improvement plan was developed and kept under review. There was evidence of effective communication with staff to ensure staff had the appropriate knowledge with regard to potential risks to resident's health and welfare and the actions to be implemented to mitigate risk and bring about the required quality improvements in the service. The direct provision of care was audited and the management team had implemented standard operating procedures specific to conditions associated with the care of the older person to provide guidance for staff on meeting those care needs.

The risk management systems were outlined in the risk management policy and the person in charge was responsible for the oversight of those systems. Incidents involving residents, visitors and staff were appropriately recorded within the online risk management system. A review of incidents evidenced that incidents were appropriately recorded, investigated, and there was evidence of learning to inform quality improvement. However, the system to analyse falls was not robust to identify trends and potential risks to residents. Furthermore, a number of risks identified during the inspection had not been identified by the management team or through the auditing system. This is discussed further under Regulation 23, Governance and management. The annual review of the quality and safety of care for 2021 had been completed.

Record keeping and file management systems consisted of both electronic and paper based systems. Staff personnel files contained a vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021. However, not all files contained the information specified in Schedule 2 of the regulations. The provider was in the process of changing to a new system to monitor staff training needs. However, this system was in the early stages of being

implemented and as a result some staff training records were not accurate.

Training records were made available for review and the number of staff that did not have mandatory training had reduced since the previous inspection. Action had been taken since the previous inspection to facilitate staff to attend training relevant to supporting residents living with dementia. Training with regard to end of life care had been suspended as a result of the current outbreak of COVID-19 and was rescheduled for the weeks following this inspection. The inspector found that there were systems in place to ensure staff were appropriately supervised through induction and appraisal records and through senior nursing management support.

On the day of inspection, there were 34 residents living in the centre. Staffing levels had been adjusted to reflect reduced occupancy and there were sufficient staff on duty to ensure residents received appropriate and timely nursing and social care. The provider confirmed that staffing levels would be increased if occupancy or dependency levels of the residents increased.

The person in charge was responsive to the receipt and resolution of complaints in the centre. Records were maintained on an electronic systems and the recording, investigation and learning from complaints met the requirements of the regulations.

Regulation 15: Staffing

There was a sufficient number of staff, with the appropriate skill-mix, to meet the assessed needs of the residents. There was two registered nurses on duty during the day and one nurse at night time. Nursing staff were supported by an adequate number of healthcare staff to meet the health and social care needs of the current residents. The provider confirmed that an additional nurse would be reinstated on night duty when occupancy increased.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were facilitated to attend training relevant to their role and staff demonstrated an appropriate awareness of their training such safeguarding of vulnerable people and infection prevention and control.

Staff were appropriately supervised through annual appraisals, induction for newly recruited staff and through senior management presence in the centre.

Judgment: Compliant

Regulation 21: Records

Action was required to comply with the requirements of Regulation 21. This was evidenced by;

- Two staff files did not contain two written references as required by Schedule 2 of the regulations.
- Records of staff training, as required by Schedule 4, were not maintained in a manner that was easily retrieved or accessible. For example, training records were provided to the inspector in two different formats and both records gave incomplete and inaccurate information. This meant that it was difficult to review both the training that had been completed, and the training requirements of staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

Action was required with regard to the management systems and oversight of aspects of the quality and safety of the service. This was evidenced by;

- Record keeping and file management systems were not effectively monitored. For example;
    - Employment references for newly appointed staff were not in place. They had been sought in April 2022 but there had been no follow-up by the management team to ensure that records would be compliant with the regulatory requirements.
    - There system to manage staff training records was poor. This meant that both completed and required training could not be analysed by the provider, and therefore, no action plan was developed to ensure staff had access to appropriate training.
- The system to monitor, evaluate and improve the quality and safety of the service was not effective to identify risks. For example;
    - A fire safety audit completed in June 2022 indicated compliance with fire containment and fire doors. As a result, there was no action plan developed or assessment of risk, despite a number of fire doors being compromised due to missing seals and door closers.
- The systems to manage and review risks were not robust. For example;
    - Identification of risk was poor and not in line with the centre's own risk management policy. For example, damaged fire doors had not been identified as a risk and therefore no action had been taken to mitigate the risk.
    - Poor analysis of falls resulted in no risk assessment or quality

improvement plan being developed.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The inspector reviewed the complaints logged for 2022. Records available contained details on the nature of the complaint, investigation carried out and follow up communication with the resident and family as required. There was evidence that the outcome of a complaint was documented and this included the complainant's level of satisfaction with the result.

Judgment: Compliant

Quality and safety

The inspector found that residents were receiving an appropriate standard of care that was monitored by the clinical management team. While the provider had taken action to address the majority of issues identified during the previous inspection, further action was required to comply with Regulation 17, Premises, Regulation 27, Infection control, Regulation 28, Fire precautions and Regulation 11, Visits.

A review of fire precautions in the centre found that records, with regard to the maintenance and testing of the fire alarm system, emergency lighting and fire fighting equipment were available for review. Systems were in place to conduct daily checks to ensure means of escape were unobstructed and weekly checks were completed on the integrity of fire doors. However, action was required to ensure full compliance and ensure resident safety in the event of a fire. For example, some fire doors were missing smoke seals and intumescent strips. This compromised the function of the fire doors in containing the spread of smoke and fire in the event of a fire emergency.

The provider had taken action to improve the quality and safety of the premises since the previous inspection. This included additional shelving for storage, replacement of damaged and worn equipment used by residents and most notably, a new smoking area was nearing completion which meant that residents no longer had to pass through the smoking area to gain access to the enclosed courtyard. As found on the previous inspection, communal rooms, corridors and residents accommodation were sufficiently spacious and brightly decorated. Repairs had been mostly completed to the floor lining in residents en-suites and around toilets. Nonetheless, some areas of the centre appeared to be poorly maintained and in a poor state of repair. These issues are addressed under Regulation 17, Premises.

On the day of inspection, the centre was experiencing an outbreak of COVID-19 that had affected eight residents and 15 staff. The inspector acknowledged that the management team had moved swiftly to implement the COVID-19 contingency plan to contain the spread of infection. The person in charge updated the contingency plan following ongoing review of the outbreak control measures. Staffing had been identified by the person in charge as an area that required immediate action and agency staff were secured to support the management of the outbreak. The person in charge reported that recruitment of staff was ongoing to ensure adequate staff levels could be maintained in the event of future outbreaks. Housekeeping staff demonstrated an appropriate knowledge of the cleaning procedure and the single use, colour-coded, mop and cloth system in place to minimise the risk of cross contamination. Nonetheless, a number of risks with regard to effective infection prevention and control and the risks are described under Regulation 27, Infection control.

The inspector reviewed a sample of assessments and care plans and found evidence that the residents' needs were being assessed using validated tools. The care plans reviewed were person-centred and provided evidence-based guidance to support the current care needs of the residents.

A review of residents' records found that there was regular communication with residents' general practitioners (GP) regarding their healthcare needs and residents had access to their GP as requested or required. Arrangements were in place for residents to access the expertise of allied health and social care professionals for further assessment. The recommendations of health and social care professionals was observed to be implemented and reviewed frequently to ensure the care plan was effective.

The person in charge was actively promoting a restraint-free environment and the use of bedrails in the centre had reduced since the previous inspection. The person in charge monitored the use of restrictive practices to ensure they were only initiated after an appropriate risk assessment and in consultation with the multidisciplinary team and the residents concerned.

The inspector found improved compliance in the medication management systems that supported the safe storage and disposal of medications. Controlled drugs were secured in accordance with relevant legislative requirements.

Residents had opportunities to participate in scheduled activities over the seven days of the week. An activities co-ordinator was seen engaging with residents and encouraging participation in a group activity. Residents told inspectors they enjoyed activities in the centre. Resident meetings took place frequently and records indicated a high level of attendance by residents. These meetings provided residents' with opportunities to be consulted about and participate in the organisation of the centre. Residents had access to independent advocacy services.

Residents could receive visitors in both communal and private areas. However, visiting restrictions in place were not in line with the regulations.

Regulation 11: Visits

Inspectors found that the visiting restrictions in place, on the day of inspection, were not compliant with the regulations. This is evidenced by;

- Restrictions, such as scheduled appointments and shortened visiting times placed on visiting, had not been appropriately risk assessed.

Judgment: Substantially compliant

Regulation 13: End of life

Resident's end of life care needs and wishes were assessed on admission to the centre and reviewed as part of the overall care plan review process, at intervals not exceeding four months.

End of life care plans were developed following a holistic assessment of the resident's physical, emotional, social, psychological and spiritual care needs.

There was documentary evidence of a multidisciplinary approach to the decision making process regarding residents resuscitation status and evidence that the resident's wishes in this regard were respected.

Judgment: Compliant

Regulation 17: Premises

There were areas of the premises that were not maintained in a satisfactory state of repair as required by Schedule 6 of the regulations. For example;

- The external general and clinical waste storage area was not secured and was untidy with construction material and equipment laying about.
- The paths in the secure garden was not well maintained with moss and weeds growing up through them.
- Floor coverings in communal toilets and the laundry were visibly torn and lifting.
- The woodwork around door frames, skirting boards and some bedrooms doors were damaged and in a poor state of repair and decoration.
- There was inadequate storage for resident's toiletries in en-suite bathrooms, as evidenced by toiletries stored in baskets on the floor.

Judgment: Substantially compliant

Regulation 26: Risk management

There was an up-to-date risk management policy and associated risk register that identified risks and control measures in place to manage those risks. The risk management policy contained all of the requirements set out under regulation 26(1).

Judgment: Compliant

Regulation 27: Infection control

The infection prevention and control management in the centre did not fully comply with the requirements under Regulation 27. For example;

- Bedpans and urinals were stored on the draining board and floor which presented a risk of cross contamination.
- Floor coverings in communal toilets and the laundry were torn, damaged and lifting in areas. This compromised the ability to effectively clean and decontaminate those areas.
- The floor in housekeeping store room was visibly unclean on inspection. Sinks in this area had layers of dirt around the drain.
- Carpets in a store room and the passenger lift were visibly unclean with evidence of dried spillages.
- The role of staff with regard to laundry and cleaning duties were not segregated which posed a risk of cross contamination.
- Hand hygiene sinks in the sluice room and nurse's treatment room did not comply with recommended specifications.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required by the registered provider to comply with fire precautions in the centre. This was evidenced by;

- Some fire doors contained gaps and were missing essential smoke seals. For example, fire doors to the kitchen and dining room area were missing seals and had visibly gaps between doors when released. This compromised the function of the fire doors to contain smoke in the event of a fire emergency.

- One cross corridor fire door did not close when released because the automatic door closure device had been removed.
- A staff smoking area contained two bins used to dispose of cigarette butts and rubbish. This presented a fire risk. This area was located adjacent to an unlocked storage area that contained combustible material, underneath the escape stairs.
- Fire evacuation drill records evidenced a simulated evacuation from one bedroom but records did not evidence if the evacuation drill progressed to a full compartment evacuation. Furthermore, the drill records did not include the time taken for staff to attend the location of the fire and return to the fire panel with their report. This meant that the provider could not provide assurance that a compartment could be safely evacuated, in a timely manner, in the event of a fire.
- There was a significant distance to travel from the fire panel to the furthest point in the centre. This had the potential to delay the timely evacuation of residents and contacting the emergency services. This risk had not been incorporated into the simulated fire drills or training, so that staff would be aware of the risk in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed a sample of five resident care plans and found that they accurately described the interventions necessary to support residents with their assessed needs. Residents' care plans were developed following assessment of need using validated assessment tools. Care plans were seen to be person-centred and updated at regular intervals.

Judgment: Compliant

Regulation 6: Health care

Residents had access to general practitioners (GP), geriatrician and psychiatry of later life specialists. Services such as speech and language therapy and dietetics were available when required. Physiotherapy services were provided on a weekly basis. The inspector found that recommendations were acted upon which resulted in good outcomes for residents.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

A restraint free environment was supported in the centre. Each residents had a full risk assessment completed prior to any use of restrictive practices. Assessments were completed in consultation with the residents and multidisciplinary team.

Residents who experienced responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were observed to receive care and support from staff that was person-centred, respectful and non-restrictive.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that residents right's were upheld in the centre and their privacy and dignity was respected.

- Residents were consulted for their feedback on the quality and safety of the service. There was evidence that issues arising in, for example, residents forum meetings were appropriately actioned. This included requested changes to the activity schedule, menu, visiting and the overall quality of the service they received.
- Residents were provided with meaningful activities seven days per week. Records captured each residents involvement and level of participation in scheduled activities.
- Residents were supported to exercise their religious beliefs and were facilitated to attend religious services in both the centre and in their community.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ealga Lodge Nursing Home OSV-0005665

Inspection ID: MON-0037367

Date of inspection: 06/07/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All staff will have 2 written references as per schedule 2 of the regulations. Staff files will be audited regularly to ensure that they contain all required documentation. Completed 29/07/22. A new training record system has been updated and is now in place. The new training platform clearly shows training completed, allocates training as required and allows for improved oversight of training. Completed 03/08/22	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: All staff will have 2 written references as per schedule 2 of the regulations. Staff files will be audited regularly to ensure that they contain all required documentation. Completed 29/07/22. A new training record system has been updated and is now in place. The new training platform clearly shows training completed, allocates training as required and allows for improved oversight of training. Completed 03/08/22 Seals and door closures were rectified 07/07/22. New intumescent strips replaced on fire doors where required, 07/07/22.	

A competent person will undertake a fire audit of the premises, and if required an action plan will be developed from the report. To be completed 15/09/22.

A fire drill was complete on the 21/07/22, which included a review of all potential risks identified and submitted to the inspector.
To reduce the potential risks associated with time to travel to the fire panel and any potential delays in safe resident evacuation a a portable two-way radio system has been introduced. To further enhance the fire safety system night staff will keep a radio on their person. Complete 26/07/22
A second simulated fire evacuation drill will be completed using the two-way radio system by 08/08/22.

A full review of risk management system will take place in nursing home by 15/09/22. The outcomes/ findings will be communicated to staff by 30/09/22. Included in the risk management system will be a monthly building Health & Safety / IPC walkthrough/ audit, which will capture any identifiable risks, these will be added to the risk register with details of the measures required to mitigate/ remove risks.

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
All visiting within the center is in line with HPSC guidance from 07/07/22. Moving forward, where there may be a need (based on guidance/ advice from the HSE/ Department of Public Health) to impose restrictions on visiting a risk assessment will be completed.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The external storage area was tidied and is now free of construction materials, completed 07/07/22.
Clinical waste storage is secured, general waste will be secured by 30/09/22.
All required garden works have been completed 22/07/22.
Floor coverings in communal toilets and housekeeping room will be completed by 02/09/22
A scheduled plan of internal works has been developed and repairs have commenced. The work will be completed by 30/09/22 in addition there is an ongoing maintenance schedule in place (which will include preventative and upkeep maintenance).

Residents will have adequate storage in en-suite bathrooms. This will be completed by 30/09/22

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Correct storage for bed pans and urinals in place from 25/07/22.

Floor coverings in communal toilets and housekeeping room will be completed by 02/09/22.

Deep clean of house keeping store room completed 08/07/22.

Cleaning audit schedule in place to ensure high standard of IPC maintained. Completed 08/07/22.

When there is a need for laundry staff work in housekeeping, they change uniform prior to commencing duties, housekeeping & laundry staff have had appropriate training for both work areas. Completed 07/07/22.

Hand hygiene sinks in sluice room and nurses' station to be completed by 30/08/22.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Seals and door closures were rectified 07/07/22.

The unlocked storage area adjacent to smoking area has been cleared and is no longer used for storage, safer cigarette disposal bin in place in staff smoking area. Completed 07/07/22.

Appropriate waste management system is in place from 29/07/22.

Fire extinguisher placed in external smoking area.

A competent person will undertake a fire audit of the premises, and if required an action plan will be developed from the report. To be completed by the 16/09/22.

A fire drill was complete on the 21/07/22, which included a review of all potential risks identified.
To reduce the potential risks associated with time to travel to the fire panel and any potential delays in safe resident evacuation a a portable two-way radio system has been introduced. To further enhance the fire safety system night staff will keep a radio on their person. Complete 26/07/22
A second simulated fire evacuation drill will be completed using the two-way radio completed 08/08/22.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Substantially Compliant	Yellow	07/07/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a	Substantially Compliant	Yellow	03/08/2022

	designated centre and are available for inspection by the Chief Inspector.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	03/08/2022
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.	Substantially Compliant	Yellow	29/07/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/08/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	27/07/2022
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the	Substantially Compliant	Yellow	08/08/2022

	designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	16/09/2022