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:	09 December 2021
Centre ID:	OSV-0005665
Fieldwork ID:	MON-0034185

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:	42

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
Thursday 9 December 2021	09:00hrs to 17:00hrs	Sean Ryan	Lead
Thursday 9 December 2021	09:00hrs to 17:00hrs	Claire McGinley	Support

What residents told us and what inspectors observed

Residents in Ealga Lodge Nursing Home told inspectors that this was a nice and comfortable place to live, that staff were kind, caring and attentive to their needs and that there was a variety of choice in regard to daily activities.

This was an unannounced risk inspection carried out during the COVID-19 pandemic. On the day of inspection, there were no suspect or positive COVID-19 cases among residents or staff.

Inspectors arrived to the centre unannounced and were greeted by a member of the senior management team who guided the inspectors through the centres infection prevention and control procedure that included temperature checks and performing hand hygiene before progressing to an opening meeting with the person in charge and practice development manager. Following this meeting, inspectors walked through the centre with the person in charge and practice development manger.

Inspectors observed residents moving freely around the centre with some residents observed attending the dining room for breakfast while other enjoyed breakfast in their bedroom. Staff were visibly present to answer call bells and provided assistance to residents with their breakfast and morning care routine. Inspectors spoke with eight residents and a small number of visitors during the inspection. Residents were complimentary about staff and the quality of care they received and stated that they felt their choice and individual style was respected. For example, one resident said staff provided assistance with selecting outfits to wear, painting nails and applying make-up. Another residents commented that staff were always very busy but residents never felt like they were 'rushed' or 'taking up too much time' and felt comfortable and relaxed in the company of staff. In the morning, some residents were observed enjoying activities such as nail painting while other residents were chatting to staff at the nurses station.

The premises was observed to be bright, spacious and clean in all areas occupied by residents. The centre is a two-story purpose built facility registered to accommodate 48 residents in predominately single rooms with en-suite facilities. Since the previous inspection, significant refurbishment works had been completed on the first floor where rooms and corridors had been repainted and damaged floors replaced. The person in charge informed inspectors that repair works would commence on the ground floor in early 2022. Residents accommodated on the first floor were very content with their bedrooms and the space they had to display personal possessions such as ornaments and photographs. Each corridor in the centre was named after an American President and signage was in place to assisted residents in locating their bedroom, dining room , dayroom and enclosed garden easily. Corridors were spacious and facilitated the safe and free movement of residents around the centre through appropriately place hand rails. Inspectors observed some areas on the ground floor, namely resident en-suites, that required some maintenance and repair on floors and a plan was in place to progress with these works causing minimal

disruption to residents commencing in January. Inspectors observed the inappropriate storage of boxes in a number of areas including the oratory. This was brought to the attention of the person in charge who removed boxes from the oratory and this space was then observed to be enjoyed by a group of residents in the afternoon. The furnishings in resident's bedrooms and communal rooms was soft, comfortable and well maintained. Communal areas were bright and there was ample flow of natural light. Overall, inspectors found that the premises was clean and well laid out to meet the needs of the residents and had a homely atmosphere.

Residents had access to an internal courtyard with a large water feature and residents told inspectors that they played games in the water fountain such as 'fishing ducks'. There was also a large enclosed garden accessed through the main dayroom and this was accessible to residents upon request. Some residents told the inspector that they had a garden party in this area during the summer months and it was very enjoyable.

Residents were complimentary about the food they received and inspectors spent time observing the residents dining experience that had a calm and relaxed atmosphere. The dining room was bright and spacious and each resident had adequate space. Residents complimented the menu on offer and described their meal time experience as 'pleasant'. Staff were available to provide discrete assistance to residents and the engagement between residents and staff was person-centred. Residents who chose to have their meals in their bedrooms were supported to do this and staff were available to provided assistance. Residents confirmed the availability of snacks and juices throughout the day and confirmed they could request alternative meal choices if they wished.

In the afternoon, residents were observed engaging in a variety of activities that included singing, art, reading and music and receiving visitors. The activities coordinator was observed spending time with each individual residents throughout the day and chatting about local event and Christmas.

Inspectors spend time listening to residents, visitors and staff experience of living through the COVID-19 pandemic. Residents spoke of the challenges and difficulty they faced during this time and complimented the management team and staff with their efforts to keep them safe. Residents told inspectors how staff supported them to maintain contact with their relatives during this time. This included window visits, social media and regular telephone and video calls. Residents expressed their satisfaction that visiting had been resumed in the centre but requested a review of the system for booking visiting appointments.

Residents were consulted with on a daily basis and residents meetings were facilitated. Residents were supported to attend religious services in the centre and in the community. Resident confirmed that their call bells were answered promptly with the occasional wait for assistance if staff were busy elsewhere or there was a shortage of staff. Overall, inspectors were assured that residents received good quality care from a service that valued their feedback and was used to inform ongoing quality of improvements.

The following section of this report details the capacity and management of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

The findings from this inspection were that there was a responsive, consistent and established governance and management structure that was accountable and responsible for the quality and safety of the service provided.

Inspectors found that the provider had taken action to address some of the non-compliance's identified on the previous inspection in August 2020, such as the notification of incidents to the Chief Inspector, safeguarding of residents and complaints management. However, inspectors found that further oversight of regulations that support the quality and safety of the service was required as evidenced by repeated findings of substantial or non-compliance in:

- Regulation 15: Staffing
- Regulation 16: Staff training, development and supervision
- Regulation 23: Governance and Management.
- Regulation 5: Individual assessment and care plan.
- Regulation 7: Managing behaviour that is challenging.
- Regulation 17: Premises.
- Regulation 27: Infection control.

This was an unannounced risk based inspection carried out over one day by inspectors of social services to:

- Monitor compliance with the Health Act (2007), as amended and the Regulations and Standards made thereunder.
- Follow up on the actions taken to address non-compliance found on the previous inspection in August 2020.
- To review the centres infection prevention and control standards and the COVID-19 preparedness plan.

Underhill Investment Limited are the registered providers of Ealga Lodge Nursing Home. The governance structure of the centre included three company directors, one of whom was the provider representative. The senior management structure consisted of the provider representative, a general manager, a practice development manager and newly appointed person in charge who commenced in her role in November 2021. Arrangements were in place to support the person in charge during their period of transition into their new role by the practice development manager who was based full time in the centre during the induction process. The clinical management team consisted of the person in charge supported by a clinical nurse manager and their responsibilities included supervising staff, overseeing the care provided to residents, monitoring infection prevention and control and supporting

the person in charge to discharge her duties and regulatory responsibilities.

The person in charge had good clinical oversight of the service and information requested by inspectors on the day of inspection was made available for review. Systems were in place to monitor the quality of care provided to residents and collated information received from the clinical care team in regards to residents who were unwell, losing weight, wounds, residents requiring medical review and residents social care needs. This information was analysed and shared with the senior governance team on a weekly basis where further analyses of risk, health and safety, staffing and audit results were discussed and action plans developed with timeline for completion applied. Information pertinent to the day to day management of the service were discussed with the wider staff at daily handovers and on a formal monthly basis in staff meetings.

There were systems in place to monitor, evaluate and improve the quality of the service which included a schedule of audits. Information in regard to the quality of the service was also obtained through complaints and compliments, feedback from residents and relatives and continuous evaluation of the service. For example, the person in charge and practice development manager had completed a review of the premises, infection prevention and control and residents clinical care records and had identified areas for improvement. The action plans detailed that nursing staff were provided with additional supernumerary hours to complete reviews of clinical care documentation was this was scheduled on the rosters provided to inspectors.

While the systems of risk management had improved and risk related issues, such as the storage of oxygen, found on the last inspection had been addressed, the systems of risk identification was not sufficiently robust. This was evidenced by a number of risks identified by inspectors that had not been appropriately entered into the centres risk registered that included the risk associated with ongoing staff recruitment and retention challenges.

Arrangements were in place for the recording, investigation and learning from incidents and accidents involving residents in the centre. Incidents involving residents were appropriately screened, analysed and notifiable events were reported to the office of the Chief Inspector within the required timeframe. However, a review of the COVID-19 outbreak that occurred in the centre in April 2020 was not completed. This was brought to the attention of the provider during the previous inspection. Inspectors reviewed the centres updated COVID-19 preparedness plan that detailed the planned actions to taken should a resident or staff be suspected or confirmed with COVID-19.

On the day of inspection, there were 42 residents living in the centre. The centre was divided into two nurse led teams since the start of the pandemic. The team providing direct care to residents consisted of two nursing staff on duty during the day and they were supported by a team seven healthcare staff in the morning and five healthcare staff in the afternoon. The service was supported by housekeeping, laundry and catering staff daily. Night time staffing levels consisted of two registered nurse and two healthcare assistants. An additional staff member was rostered from 4pm to 10pm to support residents with their night routine. A review of the rosters

evidenced significant challenges in maintaining the planned rosters and inspectors found daily gaps in the roster where unplanned leave was not covered. Staff confirmed to inspectors that on days where they are short staffed. Inspectors observed that the daily staff and resident allocation plan was revised by the management team to ensure all residents had their needs met in line with their preferences and choice and the care provided to residents was observed to be unhurried and person-centred. Residents confirmed that their quality of care was not compromised as a result of staffing issues. Nonetheless, Inspectors were not assured that the service was sufficiently resourced in terms of nursing, healthcare and housekeeping staff. This was a finding in the previous inspection of the centre.

Record-keeping and file-management systems were in place to ensure records were well maintained, securely stored and accessible for review during inspection. Inspectors reviewed a sample of staff personnel files and were satisfied that each file contained the necessary documentation as required by the regulations.

Inspectors found that staff were knowledgeable in regards to fire safety precautions and the procedure for evacuation to be commenced in the event of fire alarm activation. Staff whom the inspectors spoke with detailed their role and responsibility in protecting residents from abuse and the policy available that was available to guide them. Staff were well informed in regard to the measures in place to protect residents from the risk of COVID-19 which included twice daily symptom monitoring of residents and staff. Nonetheless, there were gaps in the training records where staff had either not completed training or training had expired and inspectors observed some poor practices in regard to the use of personal protective equipment and hand hygiene. Inspectors were not assured that the oversight of staff training needs were effective as there continued to be issues in regard to the provision of training since the previous inspection. A number of staff had not completed fire safety training and only a small number of staff providing direct care to residents had received training relevant to support residents living with dementia and to support resident to manage responsive behaviour (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Inspectors were satisfied that all newly recruited staff, including the person in charge, underwent a period of induction with a senior member of staff and records reviewed evidenced the a number of professional core competencies staff were required to complete to successfully complete the induction period. Inspectors found that the supervision of staff required improvement in regard to the appropriate use of personal protective equipment.

All policies as required by Schedule 5 of the regulation were available for review and were in the process of being updated by the person in charge. Staff were familiar with the Schedule 5 policies and referenced these documents as additional supports and guidance in the provision of safe and effective care to residents.

The person in charge was responsive to the receipt and resolution of complaints. A complaints procedure was prominently displayed in the main reception area and detailed the personnel involved in complaints management. Residents and visitors whom the inspector spoke with were aware of the newly appointed person in charge

and identified them as the person to express concerns to. A complaints register was maintained and evidenced that all complaints were progressed through the complaints procedure and in line with regulatory requirements. There was evidence of ongoing communication with residents and relatives in regard to the quality of the service and expressions of dissatisfaction were progressed through the complaints procedure to resolution.

Regulation 14: Persons in charge

The centre was managed by a suitably qualified and experienced nurse who had been appointed in November 2021. The person in charge had a strong presence in the centre and was known to residents, relatives and staff. The person in charge held accountability and responsibility for the service provided to residents and had the required experience and management qualifications as required by the regulations.

Judgment: Compliant

Regulation 15: Staffing

Inspectors found that the health and social care needs of the 42 residents were met to a good standard on the day of inspection. Nonetheless, inspectors were not assured that there adequate staffing numbers to respond to planned and unplanned leave and ensure a consistent service was provided to residents. For example:

- A review the rosters from 29 November to 12 December 2021 and found that there were 12 days where planned healthcare assistant staffing levels were not maintained. There was a deficit of 12 hours on five of the 14 days reviewed.
- Inspectors observed ongoing challenges in maintaining the housekeeping and laundry rosters due to short notice unplanned leave which impacted on the daily cleaning schedule.

Inspectors were informed that staff scheduled to attend mandatory training were unable to do so as they were required to cover deficits in the healthcare assistant roster at short notice.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Inspectors observed good practice with regard to staff performing safe manual handling practices, supporting residents who live with dementia and responsive behaviours and in general good infection prevention and control practices.

As found on previous inspections, further oversight and analysis of staff training needs was required. The provision of training for staff had not been satisfactorily actioned since the previous inspection. Inspectors found that:

- Manual handling training had not been completed by 11 staff.
- Two staff had not completed infection prevention and control training and 11 staff required refresher training.
- Six staff had completed end-of-life care training.
- Only 11 staff had completed training relevant to supporting residents living with dementia and responsive behaviour.

Further improvement was required to ensure staff were supervised to carry out their duties to protect and promote the care and welfare of all residents. Inspectors found that further supervision of staff in regard to the appropriate wearing of personal protective equipment and hand hygiene, in line with current guidelines, was required.

Judgment: Not compliant

Regulation 21: Records

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

Nursing records were maintained on an electronic system that was made accessible to the inspector for review. Daily health and social care needs were documented in the electronic system for each resident.

Staff personnel 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.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors were not assured that there were sufficient staffing resources in the centre to ensure that care could be consistently delivered in line with the centres statement of purpose and function.

While it was evident that direct care was delivered to a high standard, inspectors found that further development of management systems in place to monitor, evaluate and improve the overall quality and safety of the service require further strengthening and improvement. For example:

- An review of the outbreak of COVID-19 in the centre in 2020 had not been completed. This was identified to the provider on the previous inspection.
- The training needs of staff had not been satisfactorily addressed since the previous inspection of the centre.
- The oversight of restrictive practices, the assessment of residents needs and corresponding care plan development required improvement.
- The oversight of infection prevention and control practices required further oversight and monitoring.
- The oversight of medication management practices was not sufficiently robust.

The systems of risk identification required improvement. Although a risk register was maintained in the centre, it did not include all risks as observed by inspectors on the day, to ensure appropriate controls were put in place. For example the provider had not identified:

- The risks associated with the system of medication management.
- The risk associated with insufficient staffing resources and potential impact of service provision.
- The risk of cleaning chemicals left on top of cleaning trolleys that were left unattended.
- The storage of chemicals in an unlocked cupboard accessible to residents.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The Statement of Purpose required review and updating to ensure it accurately reflected the service provided. For example:

- The available staffing whole time equivalents (WTE) were not aligned with the WTE described in the statement of purpose submitted to the Chief Inspector for the purpose of registration.
- The statement of purpose and floor plans required updating to reflect the current layout and design of the centre.
- The governance and management structure required updating to reflect the current governance structure.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in Schedule 4 of the regulations were notified to the Chief Inspector within the required timeframe. The inspectors followed up on incidents that were notified and found that they had been managed in line with the centres policy and procedures.

Judgment: Compliant

Regulation 34: Complaints procedure

Complaints were maintained on an electronic system and there were no complaints open on the day of inspection. There was an effective complaints procedure in the centre which was displayed at the reception. There was a nominated person to oversee the management of complaints and inspectors found that each complaint detailed:

- if the complainant had received acknowledgement of the complaint made.
- the actions taken on foot of the complaint such as an investigation.
- the complainants satisfaction with the outcome of the complaint.

Judgment: Compliant

Regulation 4: Written policies and procedures

The required policies and procedures were in place in line with the requirements of Schedule five of this regulation. Policies were up-to-date and were being reviewed by the person in charge.

Policies and procedures were accessible to all staff and provided appropriate guidance and support on the provision of safe and effective care to the residents.

Judgment: Compliant

Quality and safety

Overall, inspectors found that residents living in the centre received a good standard of health and social care support that took account of their individual needs and

preferences and promoted their independence. While inspectors identified a number or areas requiring improvement in infection control, the premises and residents clinical care documentation, the person in charge provided an action plan that would address some of these deficits. However, inspectors found that improvement was also required in the management and oversight of restrictive practices and medication management in the centre.

Residents were assessed on admission to the centre and validated nursing assessments were used to assess residents mobility and falls risk, risk of impaired skin integrity, risk of malnutrition, dependency level and social care needs. Assessments formed the basis for which person-centred care plans were developed. Inspectors identified that further improvement was required in regard to developing care plans bsed on assessment of needs, reviewing and updating of care plans in line with the requirements of the regulatiion and to ensure that care plans were available to guide staff in supporting the resident’s with their identified care needs. Arrangements were in place for residents to access allied health and social care professionals for additional expertise such as dietetic services, physiotherapy and speech and language therapy. Where residents required further treatment or review in acute hospital services, systems were in place to ensure that the receiving setting were provided a transfer letter that detailed the residents care needs, personal preferences and medical history of the resident to ensure a smooth transition to the acute services for the resident.

The centre was home to a small number of residents who, because of their diagnosis, were predisposed to episodes of responsive behaviour (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Inspectors observed the staff and resident interactions during episodes of responsive behaviour and the engagement was polite, kind and non-restrictive. Distraction techniques were used by staff such as engaging activities, walks and music and this resulted in no resident requiring the use of ‘as required’ PRN psychotropic medication. While staff were knowledgeable in regard to residents individual needs, precipitating factors of responsive behaviour and de-escalation strategies, guiding documents such as positive behavioural support plans did not capture this person-centred information in detail. Additionally, some staff required further training and supervision in regard to the appropriate and safe use of bedrails.

Through conversations with residents and staff and a review of the records maintained in the centre, inspectors were assured that residents were protected from the risk of abuse. Staff maintained safety checks on all residents and ensured residents were appropriately supervised in communal areas. Inspectors identified that some improvement was required in the supervision and education of staff in the appropriate use of bedrails and the person in charge confirmed that further training for staff was scheduled for 29 December 2021.

The premises, both internally and externally, was maintained to a good standard in areas occupied by residents. Inspectors observed that significant refurbishment works had been completed on the first floor of the premises. Flooring had been replaced in bedrooms and en-suite facilities and bedrooms were repainted and

redundant screening curtains were removed from bedrooms. The large spacious hairdressing rooms had been refurbished with new floors and worktops and was well maintained with the exception of inappropriate storage of personal protective equipment that impacted on effective cleaning of the area. Inspectors observed that some aspects of the premises required further attention as it impacted on effective infection prevention and control measures in the centre.

Housekeeping staff provided a demonstration of the cleaning procedure and system that was observed by inspectors to conform to best practice guidelines. The provider had a number of assurance processes in place in relation to the standard of hygiene which included specifications and checklists, colour coding to reduce cross infection and guidance documents. Inspectors observed many good examples of infection prevention and control practices on the day of inspection that included completion of some of the actions arising from the previous inspection of the centre. This included:

- Alcohol hand sanitisers placed through the centre.
- Twice daily symptom and temperature checks of residents and staff.
- Assistive equipment used by residents, such as commodes and hoists, were cleaned after each use and lables attached to confirm cleaning.
- Damaged and unsuitable taps had been replaced on some sinks.
- Hand hygiene sinks and additional shelving were installed into the housekeeping room and cleaning trollies were visibly clean and a daily cleaning schedule for their cleaning in place.
- The laundry room was relocated to the ground floor to allow for appropriate segregation of clean and dirty linen.
- Cleaning chemicals were labelled and a safety data sheet was available to guide appropriate use and disposal of chemicals.
- Sluicing facilities had adequate storage for continence aids and had wash sinks were clearly identified.

Nonetheless, inspectors identified that further oversight was required in areas such as store rooms, laundry storage area and treatment rooms which were not clean on inspection. Additionally, there were some actions outstanding from the previous inspection that included the appropriated storage of chemical off the floor. Further findings are discussed under Regulation 27: Infection Control.

The centre had an up-to-date risk management policy that contained the risks and controls in place to mitigate specific risks as required by the regulations. The system of recording incidents was not aligned with the risk management policy and although inspectors were assured that all incidents were recorded, the policy required review to reflect the system of incident recording.

Inspectors reviewed aspect of the medication management processes in the centre and found that they were not sufficiently robust. While an online medication administration record of medication was maintained for all residents, inspectors were not assured that all medication management practices complied with professional regulatory requirements or guidelines.

Residents personal clothing was laundered on-site and the laundry room had been relocated to the ground floor. Residents reported being satisfied with the service provided.

Inspectors were assured that residents enjoyed a good quality of life in the centre and were supported to maintain connections with their community. Inspectors observed a range of activities occurring throughout the day that were developed in line with each residents interests and capabilities. Residents had access to local and national newspapers and were supported to go to the local shop by staff. Residents confirmed they were kept informed about changes in the centre such as visiting guidelines. Residents were observed to have their individual style and appearance respected and were supported by staff to maintain this.

Regulation 11: Visits

Residents were supported to maintain personal relationships with families and friends. The centre was facilitating visits in line with the current Health Protection Surveillance Centre (HPSC) COVID-19 visiting guidelines.

However, inspectors were informed of the requirement to make an appointment to visit 48 hours in advance. Both residents and visitors were not satisfied with this arrangement as, on occasions, some visitors reported not being facilitated to visit on their requested day.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Residents bedrooms were bright and spacious and there was adequate storage facilities for personal belongings. Bedrooms were decorated with items of significance to each individual resident.

Residents clothing was laundered on-site and the laundry system in place minimised the risk of items of clothing becoming damaged or misplaced. Residents were satisfied with the service provided.

Judgment: Compliant

Regulation 17: Premises

Significant refurbishment works had been completed in the first floor in regard to

resident's accommodation, storage and clinical rooms and corridors. New flooring had been installed and the area had been redecorated. The centre was bright, spacious and decorated to a good standard with a homely appearance. Works were ongoing to replace worn and stained flooring in the centre and a phased plan that focused on priority areas was in place.

However, inspectors found that further improvement was required in regard to the premises. For example:

- There was inappropriate storage of personal protective equipment in the hairdressers room.
- Access to an enclosed courtyard was through a smoking room.
- Worktop surfaces and floor coverings in the ground floor clinic room were in a poor state of repair. Adhesive tape was used to prevent the floor lifting.
- Linen rooms and store rooms were over stocked with some linen stored on the ground.
- Despite additional shelving being installed into the housekeeping room, chemicals and cleaning consumables were stored on the ground.
- The floor around drainage holes in some residents showers were damaged, lifting and had a build-up of organic material underneath as a result.
- Limescale build-up on floors, tiles and taps continued to present an issue.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were offered a choice at mealtime and a menu was displayed in the dinging room area for residents to view. Meals were wholesome and nutritious and residents with specific dietary requirements had a nutritional plan in place to support their needs.

Residents confirmed to inspectors that they had access to snacks and drinks throughout the day and residents who chose to remain in their bedroom were also provided with refreshments throughout the day.

Catering staff were knowledgeable in regard to each residents likes and preferences at mealtimes and confirmed that residents could chose something different from the menu if they wished.

There was sufficient staff were available to provide assistance to residents in the dining room and in bedrooms and staff ensured that a calm and enjoyable dining experience was provided to residents.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Arrangements were in place to ensure information pertinent to resident's physical, psychological and social care needs were included in a transfer letter to the receiving setting such as acute hospitals. Transfer letters were generated from the online record system and included a copy of residents care plan and prescription.

Judgment: Compliant

Regulation 26: Risk management

The centre maintained a risk management policy that contained the risks as required by the regulation and the control in place to mitigate risk.

A register of risks was maintained in the centre which included additional risks due to COVID-19. These were regularly reviewed with appropriate actions in place to mitigate risk.

However, Inspectors found that further improvement was required in regard to risk identification and the systems of recording risk into the risk register and this is actioned under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 27: Infection control

Inspectors observed the following risks that had the potential to impact on infection prevention and control measures in the centre. These risks included:

- Inspectors observed a number of incidents of poor hand hygiene and the inappropriate use of personal protective equipment both of which posed an infection control risk to the residents.
- Face masks was inappropriately stored on a shelf above a waste bin in the laundry.
- Clinical care equipment such as blood specimen bottles were stored on the floor and clinical equipment was stored in cupboards alongside domestic use equipment which increased the risk of cross contamination.
- The housekeeping room and laundry room were not clean on inspection and the inappropriate storage of items on the floor in both these areas meant that there were not amenable to effective cleaning.
- Effective cleaning of residents en-suites was hindered due to the material used around waste pipes and the integrity of some en-suite floors.

- Toilets were positioned on raised wood plinth with some being discoloured and damaged by water and could not be decontaminated effectively.
- Hand hygiene sinks did not conform to the required specifications.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors reviewed storage and administration of medications and found that medication management practices did not comply with the centres own policy, professional regulatory requirements or guidelines. For example

- Emergency stock held on site was not appropriately monitored as many items of stock were expired.
- Delays in administering medications meant that some residents did not receive their medication at the prescribed time.
- Medication awaiting disposal was not securely stored in the ground floor clinic room where the door was left open.
- Controlled drugs were not secured in accordance with relevant legislative requirements. For example, the keys to the cupboard which contained controlled drugs were left unattended in the cupboard.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of residents assessments and care plans and observed that improvements were required to ensure that each residents' care plan accurately reflected the assessment of their needs and was person centred in its detail. For example:

- Residents required to restrict their movements and required further COVID-19 testing, as a precautionary measure, upon admission to the centre did not have a care plan in place to reflect this requirement.
- Some care plans had not been updated to reflect the easing of restrictions in response to the pandemic. For example, one residents care plan detailed the suspension of their family outings and local church services as a result of the pandemic.
- Some residents with a history of chronic pain and receiving analgesia to manage pain did not have their pain assessment or care plan updated since April 2021.
- A residents identified as a high risk of developing pressure sores did not have a corresponding care plan in place to guide preventative care measures.

- Inspectors found that changes in residents assessed needs were not always updated into the residents care plan. For example, a resident identified as a high risk of falls did not have their care plan updated for five months.

Through discussions with residents and their relatives, inspectors were not assured that care plan reviews occurred in consolation with the residents and, where appropriate, their relative. There was no record of such consultation occurring.

Judgment: Not compliant

Regulation 6: Health care

Arrangements were in place for residents to retain their general practitioner (GP) on admission to the centre and residents could access their GP on-site at their request or when required.

Resident had access to a range of health and social care professionals that included dietician services, speech and language, tissue viability nursing expertise, physiotherapy and psychiatry of later life. When further professional expertise was required, a referral system was in place and this was followed up by the nursing staff.

Inspectors were assured that residents were supported and facilities to attend appointments in regard to specific medical conditions such as cardiac care clinics.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Inspectors reviewed observed that residents that exhibited responsive behaviours received care that supported their physical, psychological and social care needs. Inspectors observed person-centred interactions between staff and residents who have responsive behaviour but this person-centred information and interventions were not described in the residents behavioural support plan.

Some resident that required the use of bedrails had consented to their application and the appropriate risk assessment and supporting documentation was in place. However, while residents were provided with alternative equipment to bedrails, inspectors observed some residents in the centre using bedrails in the absence of detailed safety risk assessment or care plan.

Judgment: Substantially compliant

Regulation 8: Protection

Arrangements were in place to ensure that residents were protected from the risk of abuse. Staff were appropriately trained in recognising and responding to allegation of abuse.

Systems were in place to ensure incidents involving residents were recorded by the clinical team and reviewed by the person in charge. Inspectors were informed that where suspected abuse may have occurred, the person in charge investigated each matter and a safeguarding plan was developed with the residents and, where appropriate, their relative. The safeguarding team were notified of allegations of abuse and the office of the Chief Inspector.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors found that residents rights and choice were respected in the centre and the service placed an emphasis on ensuring residents had consistent access to a variety of activities seven days a week. Residents detailed the past activity events that had occurred in the centre and were looking forward to the upcoming Christmas party. Residents who did not participate in group activities were provided with one to one time

Residents said that they were kept informed about changes in the centre though monthly resident forum meetings and daily discussions with staff and felt that their feedback was valued and used to improve the quality of the service.

Residents could enjoy access to ample communal and private space in the centre where they could receive visitors in private, watch television or listen to the radio without impacting on others around them. Residents were supported to attend the local churches services with their relatives or support from staff and visits from some religious clergy had resumed.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ealga Lodge Nursing Home OSV-0005665

Inspection ID: MON-0034185

Date of inspection: 09/12/2021

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
Regulation 15 requires there are sufficient staff with an appropriate skill-mix on duty day and night and at weekends to meet the assessed needs of residents.

• Nursing staff, HCA, House keeping staff have been recruited

• Agency staff have been secured where required to fill roster.

• Our worked rosters are above national care hour average

The Recruitment process was commenced prior to inspection and is ongoing.
There is a robust induction and competency assessment framework in place support new staff</td></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Regulation 16 requires – Staff have the required competencies to manage and deliver person-centred, effective and safe services to all residents. Staff are supported and supervised to carry out their duties to protect and promote the care and welfare of all residents. Training is provided to staff to improve outcomes for all residents.

Mandatory Compliance is currently 86% - efforts to increase this has been frustrated due to C19 outbreak. Mandatory training will be 100% compliant by 31/3/22</td></tr>
</table>

Deficits in practice and training have been acknowledged and competency assessments were carried on staff in the areas of Restrictive Practice and Manual Handing to ensure staff are competent in carrying out their duties to protect and promote the welfare of residents in their care.

There is an inhouse training schedule in place to capture training needs of all staff in the areas of Safeguarding, Infection Prevention and control, supporting Residents living with Dementia and Responsive Behaviours and documentation and care planning (with emphasis on assessments and care plans associated with restrictive practice). This will be completed by end of April 2022

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. A Full Governance Review based on HIQA regulations is provided by the DON on a monthly basis to Senior Management Team – this has been strengthened to incorporate the following;
• Risk Management – all high risk is reported and controls monitored this will continue going forward
• Staffing levels on worked rosters continue to be monitored on a weekly basis to ensure that they remain in line with National Standards
• Staff recruitment is a standing agenda item with ongoing recruitment in place
• IPC is audited monthly and compliance percentage is reported with an action plan – this includes environment and Housekeeping
• All chemicals are stored in closed containers on trolleys
• Medication Management – logistics and supplies are being closely monitored to ensure that residents medications are available within agreed timeframes.
• The look back review for 2020 has been completed as of 14/01/2022.

Medication Safety has been reinforced with all nursing staff regarding key safety. All cupboards are secure

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

With the Commencement of newly recruited staff we should be compliant with our WTE as outlined in out Statement of purpose.

The statement of Purpose has been updated to reflect the current layout and design of the centre and current management structure.

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
The requirement of 48 hours' notice in advance of for booking was identified are unsatisfactory. This was changed immediately.

Visiting is in line with Public Health Guidance and we will continue to review in line with same.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
There is a full Maintenance Schedule in place which includes the areas identified during the inspection.
• Ground floor clinic room worktops and flooring are integrated into Maintenance schedule
• The floor around residents showers are also being addressed as part of the maintenance schedule – Once we can be reassured that sub-contractor entering the building are not at risk these repairs will be commenced and completed by end of April 2022
• Limescale build-up on floors, tiles and taps are also integrated into the schedule
• Appropriate storage of PPE and Linen has been addressed
• Cleaning and Cleaning consumables are off the ground and audited as part of IPC monthly Audit
• The access to the internal courtyard via smoking room is under review and an alternative smoking area will be identified and in use by end of March 2022.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control: The incidents of poor hand hygiene and inappropriate use PPE as identified on day of inspection were addressed through training and audit We are confident in our use of PPE and IPC as evident by containment of recent outbreak. Facemasks were removed from shelf above bin in Laundry immediately, this is no longer used for storage of masks. All equipment in housekeeping and laundry room has been assigned storage space. This is now compliant with infection control requirements and facilitates ease of cleaning. We have updated our house keeping checklist to incorporate this area. Work has commenced in residents ensuites to include removal of plinths under toilets, boxing in flexi pipe (tile finish) and flooring repairs have commenced. Thermostatic valves to be replaced where necessary in hand hygiene sinks.	

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: Stock control is maintained by CNM on a monthly monitoring – emergency stock is checked bi-weekly As stated about our Medications logistics and supply are integral to a Medication QIP The ground floor clinic room was cleared of excess stock and equipment. We have updated our systems to ensure medications are returned on a timely basis. Staff nurses have been reminded of their responsibility relating to securing controlled medications and ensuring controlled access is maintained at all times to restricted areas/rooms. Controlled Medication Security has been reinforced, with the breach identified on the day of inspection brought to the attention of the nurse in question and addressed accordingly. We have reviewed medication management system, provided training and we are assured that residents are receiving their medications as prescribed within the acceptable timeframe. Administration times are monitored on a daily basis.	

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
In house care plan training is arranged for all staff to be completed by end of March 2022.
We have reviewed current care plan system and have decided to streamline to holistic care plans with a goal of having a more efficient, effective and personalised care plan approach. We currently have 25 percent completed and expect 100 percent completion by 31/03/22.

The DON has reinforced admission checklist to ensure that all assessments are completed within the required timeframe.

Going forward with immediate effect an audit will be undertaken on a monthly basis by DON or CNM to triangulate that assessments and care plans are reflective of actual practice.
This audit will include ensuring that care plans are updated in line with regulatory requirements and reported as part of monthly Clinical Governance

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Restraint and Restrictive Practice competency assessments are in place to ensure all staff are aware of policy and guidelines. All staff have been reminded of appropriate risk assessments and requirement of consent and absolute necessity to comply with procedure in the application of any form of restraint (e.g., Bedrails)

Nursing Staff are reminded of the importance of capturing all person-centered information necessary to support the de-escalation of responsive behaviors.

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	09/12/2021
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.	Substantially Compliant	Yellow	09/12/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff	Not Compliant	Orange	31/03/2022

	have access to appropriate training.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	09/12/2021
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	30/04/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	09/12/2021
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	14/01/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the	Not Compliant	Orange	09/12/2021

	prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	09/12/2021
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	17/01/2021
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from	Substantially Compliant	Yellow	09/12/2021

	other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	07/01/2022
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	09/12/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise	Not Compliant	Orange	31/03/2022

	it, after consultation with the resident concerned and where appropriate that resident's family.			
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	31/03/2022
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	09/12/2021