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:	Eliza Lodge Nursing Home
Name of provider:	Eliza Care Limited
Address of centre:	Boherdurrow, 5 Roads, Banagher, Offaly
Type of inspection:	Unannounced
Date of inspection:	13 April 2022
Centre ID:	OSV-0000663
Fieldwork ID:	MON-0036641

About the designated centre

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

Eliza Lodge Nursing Home is a purpose built 50 bed nursing home in a rural setting within driving distance of the town of Banagher in Co Offaly. The designated centre is a single storey premises and accommodates both female and male residents over the age of 18 years. Residents' accommodation is provided in 34 single and eight twin bedrooms, all with full en suite facilities. A variety of communal areas are available to residents including a dining room, sitting rooms and an enclosed garden area. The service employs nurses, carers, activity, catering, household, administration and maintenance staff and offers 24 hour nursing care to residents. Eliza 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:	48

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 13 April 2022	09:00hrs to 19:00hrs	Sean Ryan	Lead
Wednesday 13 April 2022	09:00hrs to 19:00hrs	Oliver O'Halloran	Support

What residents told us and what inspectors observed

On the day of inspection, the inspectors observed that residents received a satisfactory standard of care from a team of staff who residents described as polite, caring and respectful. Residents spoke positively about the staff who made them feel safe and comfortable in the centre. However, some residents described their daily routine as being inconsistent which they attributed to daily staffing shortages and voiced that they often experienced delays in receiving assistance and support from staff.

On arrival at the centre, inspectors were met by the person in charge who guided them through the infection prevention and control measures in place. Following an introductory meeting, inspectors walked around the centre with the person in charge.

Inspectors observed residents enjoying their breakfast in their bedrooms while some residents were observed receiving assistance from staff with their morning care needs. Inspectors observed a familiar rapport between residents and staff who greeted one another and engaged in polite conversation about activities for the day and local news. Inspectors observed a busy but plesant atmosphere during the morning of the inspection. Inspectors spoke with a number of residents in the communal dayroom and residents in their bedrooms. Residents told inspectors that while staff 'would do their best for you', but 'there was not enough of them' most days. One resident told inspectors that they got up from bed earlier than expected but were still delayed going to the dayroom as staff were interrupted during morning care to answer the call bells of other residents. Some residents told inspectors that they often experienced long delays waiting for their call bell to be answered while other residents told inspectors that they would not be certain if their planned showers would go ahead on a particular day because the availability of staff was 'unpredictable'. One resident told inspectors that they had to forgo a planned shower on three occasions because staff were either too busy or were not available.

The lunchtime experience was observed by inspectors. Residents were complimentary of the choice of meals and the quality of the food. There were two sittings for meal times to accommodate all residents who wished to attend the dining room. Staff were observed to provide discrete assistance and support to residents in the dining room and to those residents who chose to remain in their bedrooms. Residents told inspectors that they were provided with a choice for their meals daily and confirmed the availability of snacks and drinks throughout the day.

Residents personal clothing was laundered on-site and the laundry staff detailed the procedure to minimise the risk of residents clothing becoming damaged or misplaced. This included applying discreet identity lables on clothing. The laundry area was observed to be small in size which resulted in clean linen and clothing being stored on trollies in the corridors until returned to residents. This was observed to obstruct residents mobilising freely and safely. Inspectors observed that

the laundry area was not maintained in a satisfactory state of repair and it was visibly unclean. Residents were mainly complementary of the laundry service with some residents reporting that items of clothing had went missing or become damaged in the past but those issues had been resolved.

The design and layout of the premises was generally suitable to meet the residents' individual and collective needs. There was a variety of communal areas including a large dayroom and quiet room with a smaller seating area near the reception and an oratory. There was also a secure enclosed garden area that residents could access at will. However, inspectors observed that this was not maintained to a satisfactory standard for residents to enjoy. Inspectors observed changes to the function of the smoking room which was now an office space. When brought to the attention of the management team, inspectors were told that residents could smoke in the wooden garden gazebo in the centre of the enclosed garden. Inspectors found that this was not a suitable or safe place for residents to smoke as there was no appropriate place to extinguish cigarettes and no fire-fighting equipment.

The centre was found to be well-lit and warm on the day of inspection. Residents described the centre as comfortable but some residents voiced that their bedrooms and the dayroom were cold on occasions. Inspectors observed thermometers in some rooms around the centre to monitor the temperature. Records of environmental temperature checks were not maintained.

Inspectors observed that there were many areas of the premises in both residents private accommodation and communal areas that were visibly unclean and in a poor state of repair. Some corridors and bedroom walls were stained from spillages. Paint was chipped on walls and door and the was skirting visibly scuffed and damaged. Inspectors observed inappropriate storage of hoists, trollies, and mobility aids on corridors posing a mobility hazard to residents.

Residents bedrooms were bright, spacious and personalised with ornaments, pictures and personal furnishings. Residents in single room accommodation expressed their satisfaction with their bedrooms while some residents in shared accommodation told inspectors they would like their own television to watch their preferred programmes.

Inspectors observed residents to be engaged in activities throughout the inspection. Residents told inspectors that they were satisfied that consistent activities had resumed in the centre but would like a more varied activities schedule to suit all residents' interests. Residents told inspectors there were no activities occuring at the weekends. Residents were kept informed about changes in the service through conversations with the staff and at residents' forum meetings. Some residents had recently completed a survey on the quality of the service and had taken this opportunity to highlight issues to the management team.

The following sections of this report detail the findings with regards to the capacity and management of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

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

- monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended)
- follow up on actions taken by the provider to address issues of non-compliance found on the last inspection in May 2021.
- follow up on notifications and information submitted by the provider and person in charge
- follow up on unsolicited information received by the office of the Chief Inspector.

Unsolicited information received by the Chief Inspector was reviewed and found to partially substantiated with regard to insufficient levels of staff, infection prevention and control, and the quality of environmental hygiene.

The findings of this inspection were that the management systems in place required improved oversight and monitoring to ensure the a safe, consistent and quality service was provided to residents living in the centre. The provider had not ensured that the service consistently met the needs of the residents in the centre. Non compliances were identified with Regulation 23, Governance and management, Regulation 34, Complaints procedure and Regulation 27, Infection control. Action was also required to ensure compliance under the following regulations:

- Regulation 15, Staffing
- Regulation 16, Training and staff development
- Regulation 21, Records
- Regulation 17, Premises
- Regulation 5, Individual assessment and care plan
- Regulation 9, Residents' rights.

Eliza Care Limited is the registered provider of this centre. The provider is involved in the operation of two other designated centres. The senior management team consisted of a representative of the company directors, a general manager and a practice development manager. A member of the senior management team attended the centre on a weekly basis.

Since the previous inspection, there had been changes to the clinical management team including a change in person in charge. The person in charge was supported in their role by one newly appointed clinical nurse manager. However, inspectors found that the management support for the person in charge and the staffing numbers available for the direct provision of care were not in line with those committed to in the statement of purpose. For example, the statement of purpose outlined a requirement for two clinical nurse managers to support the person in charge and

only one was available. Inspectors found that the current management structure impacted on the clinical oversight, supervision of staff and the governance. This was further compounded by the requirement for the clinical nurse manager to fill vacant nursing shifts on a weekly basis.

There were management systems in place to monitor the quality of the service. Information was collated from clinical and environmental audits, residents feedback and complaints. However, this information was not analysed to develop improvement action plans. Monthly governance meetings were taking place with senior levels of management where issues such as staffing, infection control and fire safety were discussed. Inspectors reviewed the records of staff meetings and found that information regarding audits, resident feedback and complaints was not disseminated to the staff for learning and quality improvement.

Risk management systems were underpinned and guided by the risk management policy. This included maintaining a risk register to record all potential risks to residents safety and welfare. The person in charge was identified as the person responsible for implementing the policy. However, the electronic risk management system was not known to the clinical management team on duty.

A review of the staffing rosters evidenced significant daily challenges in maintaining planned nursing and healthcare staffing levels. Additionally, inspectors found that the staffing levels present in the centre on the day of inspection were not reflective of the staffing levels in the rosters or aligned with the staffing levels described to inspectors on arrival to the centre. Inspectors found that the levels of staff allocated to housekeeping on a daily basis was not adequate considering the size and layout of the building.

A comprehensive training and development programme was in place for all grades of staff. However, there were gaps in the training records where a number of staff had not completed training pertinent to supporting the provision of safe care to residents. This included safeguarding of vulnerable adults, resident manual handling techniques and dementia care training. Inspectors acknowledged that fire safety training was scheduled for staff in the week following the inspection. Inspectors found that while many staff had completed infection prevention and control training, the training records had not been updated to reflect this. Inspectors found that the arrangements for staff supervision were inconsistent as the clinical management team were required to carry out nursing duties and support the provision of care which left limited time to supervise and support the staff.

A sample of staff personnel files were reviewed by inspectors. There was evidence that each staff member had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 on file prior to commencing employment. However, record-keeping and file management systems were not effectively monitored. Inspectors found that records were not managed in line with the regulatory requirements.

A centre specific complaints policy detailed the procedure in relation to making a complaint and set out the time-line for complaints to be responded to. Inspectors

found that the complaints procedure was not in line with regulatory requirements and therefore complaints were not managed in line with the requirements of the regulation.

Regulation 14: Persons in charge

The person in charge is a registered nurse and works full time in the designated centre. The person in charge was suitably qualified and experienced and met the requirements of Regulation 14.

Judgment: Compliant

Regulation 15: Staffing

The centre did not have adequate levels of cleaning staff available for the size and layout of the building to ensure the environment and residents equipment was appropriately cleaned. As a result the centre had not maintained the standard of cleanliness required to provide a safe environment for residents.

While there was adequate staff available to meet the social and care needs of residents on the day of inspection, staffing levels did not reflect the actual staff rosters. A review of the rosters for the two weeks prior to the inspection evidenced that staff availability was not adequate to ensure the centre was consistently staffed. The impact of this staff shortage was reflected in the resident feedback in relation to staffing and reporting long wait times for care. This staffing resource issue is addressed under Regulation 23, Governance and Management.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Inspectors observed gaps in the training records for staff with regard to:

- Fire safety
- Safeguarding of vulnerable adults
- Manual handling
- Dementia awareness & supporting residents with responsive behaviours (how people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

- Infection prevention and control.

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of all residents. This was evidenced by:

- A number of staff demonstrated poor practice in relation to wearing of personal protective equipment (PPE).
- there was poor supervision of the housekeeping staff and the cleaning procedure.

Judgment: Substantially compliant

Regulation 21: Records

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

- Staff rosters did not accurately reflect the staffing levels on the day of inspection and rosters for the weeks prior to the inspection were not reflective of the roster that was actually worked by staff.
- The training records reviewed by the inspector did not accurately reflect the training attended and completed by staff.
- Staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations. For example, two files did not contain a satisfactory employment history and one file did not contain two written references.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider did not ensure that the service had sufficient staffing resources to:

- maintain consistent nursing and healthcare staffing levels on a daily basis to meet the assessed needs of all residents.
- ensure effective cleaning of the premises in line with the centres own cleaning procedure and policy.
- ensure the management structure, and support for the person in charge, was maintained in line with the statement of purpose.

Governance and management systems were not effectively monitored. For example:

- While audits were completed, they did not provide a quality improvement plan to address risks identified. For example, risks identified with

environmental hygiene in January 2022 did not have an appropriate action plan and had not been addressed.
- Information from resident forum meetings, feedback surveys and complaints, the information was not analysed to inform improvement action plans. For example, staffing issues, residents experiencing long wait times for assistance and the temperature of the environment were recurring issues raised by residents but their concerns had not been satisfactorily addressed.
- Record-keeping and file management systems were not effectively monitored.
- The oversight of risk management systems was not robust. This was evidenced by:
    - Risks, and the effectiveness of controls in place to mitigate risk, were not reviewed by the management team.
    - Identification of risk was not adequate. For example, the designated smoking area had not been environmentally risk assessed with regard to its safety and suitability for residents.
    - The electronic risk management system was not known to the management team on duty who were responsible for the management of risk in the centre as detailed in the risk management policy.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifiable events as set out in Schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. Inspectors followed up on events that were notified, and found these were managed appropriately.

Judgment: Compliant

Regulation 34: Complaints procedure

Inspectors reviewed a sample of complaints that had been received in 2021. Complaints management was not in line with regulatory requirements. This was evidenced by:

- A number of verbal complaints were not recorded in line with the requirements of the regulations.
- Complaints documented as closed and resolved did not consistently record if the complainant was satisfied with the actions taken to resolve the complaint.
- Some complaints did not evidence any action taken or if improvements were required in response to the complaint.

Judgment: Not compliant

Quality and safety

On the day of inspection, residents health and social care needs were maintained by a satisfactory standard of evidenced-based care and support from a team of staff who knew their individual needs and preferences. Residents reported feeling content and stated that they felt safe living in the centre. However, inspectors found that the instability in the daily staffing levels impacted on the consistent provision of person-centre care to residents. Inspectors found that non-compliances in relation to infection control impacted on residents' safety and well-being. Further action was also required to ensure compliance with the premises, assessments and care plans and residents rights.

At the time of inspection, the centre was nearing the end of an outbreak of COVID-19. Inspectors acknowledged that the residents and staff had been through a difficult and challenging time during the outbreak. Measures to support the management of the outbreak included an outbreak management plan detailing procedure to cohort residents and staff replacement plans. Staff and residents were monitored for signs and symptoms of COVID-19 and there were adequate supplied of personal protective equipment (PPE). Staff demonstrated an awareness of the centres cleaning procedure and a colour coded cloth and mop system was in place. However, inspectors observed that the centre had not maintained a satisfactory level of environmental hygiene. Furthermore, some staff demonstrated poor knowledge in the use of PPE. This meant that inspectors were not adequately assured that infection prevention and control standards were robust to ensure the safety of residents in the centre. Further findings are discussed under Regulation 27, Infection control.

The design and layout of the premises was appropriate to support the needs of residents. It provided adequate indoor private and communal space and secure enclosed gardens that residents could access independently. Inspectors found the centre to be well-lit and warm on the day of inspection. Residents described the centre and comfortable and homely. Inspectors found that there were some areas of the premises where furniture and floors were worn and torn. Inspectors observed that walls and doors were chipped and found to be in a poor state of repair.

Residents' records and daily notes were maintained on a computerised system. Care plans were developed following completion of validated nursing assessment tools to establish individual residents needs and aspects of their daily life that required support from staff. Inspectors acknowledged that the needs of residents were known to the staff. However, a review of a sample of care plans found that some improvement was required in relation to maintaining and updating the care plans to reflect residents assessed needs.

Residents had access to their general practitioner (GP) and were supported in the

centre by appropriate referral to health and social care professionals such as physiotherapy, psychiatry of later life, speech and language therapy and dietitian services. Residents assessed as being at high risk of malnutrition had their nutritional intake and weights monitored frequently.

Inspectors observed that staff supported residents who displayed responsive behaviours in a manner that was respectful, person-centred and non-restrictive. There was an ongoing initiative to reduce the incidence of restrictive practice in the centre such as physical, chemical and environmental restraints of which staff were well informed.

The centre's risk management policy set out the information that is required under Regulation 26. As described under the capacity and capability section of this report, inspectors found that the oversight of risk required improvement. Environmental risks were not identified and addressed in a timely manner.

Action had been taken by the provider to correct issues identified on the previous inspection with regard to issues of fire containment relating to the fire doors. Up-to-date service records were in place for the maintenance of the fire equipment, fire detection and alarm system and emergency lighting. Fire drills were carried out to ensure staff had the required skills to safely evacuate the residents in the event of fire. The provider had proactively engaged the service of a competent person to carry out a fire safety risk assessment of the centre and the report was pending.

Residents were provided with daily newspapers and had access to radio, telephone and Wifi if they wished. Resident were kept informed and consulted about changes in the operation of the centre through residents forum meetings and feedback surveys. However, as described under Regulation 23, Governance and Management, issues raised by residents were not appropriately responded to or appropriate action taken to address issues raised by residents. While activities were provided on the day of inspection, further development of the activities programme was necessary to ensure all residents had equal access to activities and social engagement in line with their interests and capabilities.

Regulation 11: Visits

The registered provider had ensured that visiting arrangements were in place in line with the current Health Protection Surveillance Centre (HPSC) guidance and public health advice. Visits were encouraged and residents could meet their relatives or friends in a designated visitor area or in their bedroom if they wished.

Judgment: Compliant

Regulation 17: Premises

Action was required to ensure compliance with Regulation 17. This was evidenced by;

- The inappropriate storage of equipment in frequently used areas of the centre. For example, hoists and linen trollies were stored on corridors which obstructed residents mobilising with mobility aids.
- Floor coverings in some residents' bedrooms were lifting at the joint between the bedroom and the en-suite bathroom.
- Doors, skirting and frames were visibly chipped and damaged.
- Some beds were visibly damaged with large areas of paint work missing.
- Garden furniture was not maintained in a satisfactory state of repair and the internal garden was not appropriately landscaped.
- Inspectors found that the temperature of the centre was not monitored to ensure residents were comfortable.
- The smoking room had been converted into an office changing the function of the room from what is described in the centre's statement of purpose.

Judgment: Substantially compliant

Regulation 26: Risk management

The centre has a risk management policy in place which includes the requirements as set out in regulation 26 (1).

Further oversight was required in the systems of risk management and identification and this is addressed under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 27: Infection control

The provider did not ensure that infection prevention and control procedures were consistent with the national standards for infection prevention and control in community services as published by the Authority. This was evidenced by:

- There was poor oversight of the cleaning procedure and the quality of environmental hygiene. For example, some bedrooms documented as being cleaned were found to be visibly unclean on inspection.
- Sluice rooms, storage rooms, communal toilets and shower rooms were not cleaned to an acceptable standard.
- The spouts on wall mounted hand sanatisers were visibly stained and dirty
- Toilet aids were heavily soiled, not cleaned after use and placed along side

clean equipment.
- The cleaning of residents equipment was not supervised and equipment was not consistently cleaned after each use.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had taken action since the previous inspection to ensure residents were protected from the risk of fire. Issues of fire containment relating to fire doors had been resolved.

Records showed that fire-fighting equipment had been serviced within the required time-frame. The fire alarm and emergency lighting were serviced on a quarterly and annual basis by an external company.

Fire drills were held regularly and a variety of scenarios were simulated. Fire drill records indicated that staff had a clear knowledge of how to evacuate residents in the event of a fire.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A number of care plans had not been reviewed following a change in a resident's health status or assessed need as required under Regulation 5. This was evidenced by;

- the recommendations of allied health care professionals were observed to be implemented in the care provided to residents. However, the recommendations were not integrated into residents care plan record and therefore the care plan was not based on the up-to-date assessment of the residents specific nutritional requirements.
- care plans were not person-centred and did not contain interventions specific to each resident to support them with their responsive behaviours.
- While care plan reviews occurred within the time-frame specified in the regulations, they were not reviewed in consultation with the residents.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector found that residents had access to appropriate medical and allied health and social care professional support to meet their needs. Residents had a choice of GP. Services such as physiotherapy, tissue viability nurse specialists, speech and language therapy and dietetics were available when required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a low incidence of bedrails used in the centre. Residents that required the use of bedrails had an appropriate risk assessment and supporting documentation in place with evidence of multi-disciplinary team decision making.

Staff delivered care appropriately to residents who had responsive behaviours. The least restrictive practice was seen to be used, in accordance with national policy.

Judgment: Compliant

Regulation 9: Residents' rights

Residents did not have equal access to activities. Inspectors observed residents spending long periods of time without social engagement in their bedrooms. Some residents in the dayroom did not participate in activities and told inspector the would like a review of activities because the activities did not suit their interests. Residents told inspectors that there was limited opportunities for social engagement at weekends when activities staff were not on duty.

Residents in shared bedrooms told inspectors that they did not have a choice of television viewing as they had to share a television with another residents. Privacy screens also obstructed the view of the television when closed.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Eliza Lodge Nursing Home OSV-0000663

Inspection ID: MON-0036641

Date of inspection: 13/04/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • We will continue to monitor rosters on a daily basis to ensure team allocation is aligned to residents' care needs • Continue to recruit HCA and Nursing staff to increase capacity on Roster to address shortfalls owing to unforeseen absences/sick leave. • Staff recruitment since inspection includes; CNM2, Care supervisor, 7 HCAs, Housekeeping supervisor and 1 nurse • Additional CNM2 and a second Health Care Assistant Supervisor recruited and in post to enhance oversight of clinical, physical and social care for all residents. • Staffing roster in line with statement of purpose with addition of CNM2 to support PIC • An additional Housekeeping deep clean day have been added to the roster to ensure that twice a week there is a full deep clean of the nursing home • Care hours monitored daily and reported as part of the Monthly Governance Review • Care audits and call bell audits in place – compliance and action plans reported to Monthly governance Review.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 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 training is compliant on 30/5/22	

• On line Training Platform in place - The Platform will track all training requirements and maintain accurate compliance • Training ongoing compliance monitored as part of Monthly Governance Review. • House Keeping supervisor, Care Supervisor and CNM2 hired to provide enhanced oversight and supervision of all care needs and environmental hygiene. • PPE monitored by CNM daily

Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 1. All staff personnel files have a compliance index on the front cover: Action complete (Administration) 2. Staff files will be audited for all new staff on 5th of each month and non-compliance addressed and reported as part of monthly Governance Review: Action Complete (PIC) 3. Roster changes will be reflected on the worked roster as well as in timepoint – checked daily by CNM: Action complete and ongoing (CNM/PIC) 4. Training certificates are filed in staff records'	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Monthly Governance Review will continue to be submitted on 5th of each month. • Insufficient staff resources as identified on the day of inspection has been addressed and ongoing recruitment in place. Additional staff recruited to date include; CNM2/HK supervisor/Care Supervisor/7 HCA/1 Nurse • PIC supported in line with Statement of Purpose with addition of Supervisory staff as above; CNM2/HK supervisor/Care supervisor • Resident feedback and recommendations identified at time of Inspection have been actioned and will inform practice going forward. • Robust check list in place for daily cleaning schedule – monitored by CNM • Quality/Improvement Action Plans strengthened to capture progress and identify emerging gaps. New template in place and senior management training completed • The PIC will oversee audit results and development of action plans • Quality improvement is a standing agenda at all staff meetings • Emerging themes from complaints and resident survey shared with staff • Weekly management meeting in place. • Risk Register continues to remain responsibility of PIC.	

• All Nursing staff supported with Risk Management practice and documentation. • Risk management systems strengthened and available in Risk Management Log at nurses' station and on the online risk management system. • All risks will be logged by category – RED risks will be reviewed weekly by Nursing Home senior management and reported monthly to Governance Team • Schedule 5 Audits compliance reported to Governance Team – including action plans. • PIC will have oversight of all record keeping and file management systems; rosters, staff management file and training matrix • Smoking area in garden risk assessed and PICs office being repurposed to resident use.

Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • Complaints procedure updated to include verbal complaints • The Policy includes a template letter of satisfaction to complainants. • Complainants level of satisfaction will be solicited in writing following investigation and resolution of all complaints. • Learning from complaints shared with staff and will inform Annual Quality Review going forward - Jan 23 • All verbal complaints actioned and completed to date.	
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 for completion 30/6/22 • Maintenance schedule has been updated and on track; includes repainting of chipped or dented door frames, bed frames, floor covering between bedrooms and bathrooms and laundry floor • Storage of equipment has been reviewed and a hoist/equipment room identified each side of the building to ensure mobility of residents is not impeded. • All linen and laundry removed off corridors post morning assistance to ensure residents mobility not obstructed • PICs office being repurposed following environmental risk assessment on smoking area in garden. Work in progress to be completed by 30/6/22 • Daily checklists in place for housekeeping staff schedules – checked by CNM • Additional deep cleaning day rostered. • Garden maintenance and landscaping has been completed	

• Garden furniture has been upgraded and garden chairs have been re painted (colors chosen by residents)
• Residents have filled flowering pots and hanging baskets with colorful foliage and plants to enhance enjoyment of the internal garden space.
• Ambient temperature checked by maintenance and recorded in daily temperature log.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Housekeeping Supervisor and CNM oversee environmental cleaning daily including sluice rooms/communal spaces/bathroom chairs and equipment.
• Decontamination of equipment strengthened and staff reminded to use tags to identify decontamination/cleaning
• All sanitizing sprouts monitored and cleaned daily.
• Full environmental Infection Control Audit in place monthly. Compliance reported to Governance Team Monthly.
• All Infection Control Actions completed to 95% compliance.
• Environmental cleaning monitored daily by CNM on duty.
• Wearing of PPE reinforced in line with current National Guidelines monitored by CNM

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• Care Plans have been reviewed to ensure they reflect all allied professional recommendations and assessments
• Residents with diagnosis of Dementia will have a Mood and Behavior care plan integrated into Holistic Care Plan
• All families and NOKs have had an opportunity to discuss their loved one's care plans. Going forward residents will be involved in developing their Care Plan
• Monthly Admission and Care Plan audit in place to ensure that all assessments and allied professional recommendations are reflected in the resident's care plan

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Schedule of available activities has been expanded to meet expressed wishes of residents. YouTube travel to places of interest and more exercise related activities are in place.
• Feed back from Focus groups and resident surveys shared with staff during staff meetings
• Daily staff allocation is in place ensuring that there are sufficient skills on the floor to meet residents care needs.
• Weekend activities are rostered
• Available activities are extending daily to meet interests of residents, including residents who prefer to remain their rooms
• Tablets are made available for residents in shared rooms should they wish to watch a different program on TV.

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 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	30/05/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/05/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/05/2022
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Substantially Compliant	Yellow	30/05/2022

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
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	30/06/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/05/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/05/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service	Not Compliant	Orange	30/05/2022

	provided is safe, appropriate, consistent and effectively monitored.			
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.	Not Compliant	Orange	30/05/2022
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	30/05/2022
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation	Substantially Compliant	Yellow	30/05/2022

	into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	30/05/2022
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	30/05/2022
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after	Substantially Compliant	Yellow	30/05/2022

	consultation with the resident concerned and where appropriate that resident's family.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/05/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	30/05/2022