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:	Esker Lodge Nursing Home
Name of provider:	Esker Lodge Limited
Address of centre:	Esker Place, Cathedral Road, Cavan
Type of inspection:	Unannounced
Date of inspection:	28 May 2024
Centre ID:	OSV-0000135
Fieldwork ID:	MON-0042771

About the designated centre

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

The designated centre provides care and support to meet the needs of both male and female older persons. It provides twenty-four hour nursing care to 70 residents both long-term (continuing and dementia care) and short-term (convalescence and respite care). The philosophy of care is to provide excellence in the delivery of compassionate care to residents. The centre is a three storey building located in an urban area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	65

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
Tuesday 28 May 2024	19:00hrs to 21:45hrs	Michael Dunne	Lead
Wednesday 29 May 2024	10:00hrs to 17:50hrs	Michael Dunne	Lead
Tuesday 28 May 2024	19:00hrs to 21:45hrs	Nikhil Sureshkumar	Support
Wednesday 29 May 2024	10:00hrs to 17:50hrs	Nikhil Sureshkumar	Support

What residents told us and what inspectors observed

Overall, the inspectors found that residents living in this designated centre were adequately supported and facilitated to enjoy a good quality of life.

Feedback from residents was positive, those who expressed an opinion told inspectors that they liked living in the centre and felt that their assessed needs were being met by the provider. One resident said " I get my clothes back from the laundry with no problems", another resident was complimentary about the support they receive maintaining their bedroom and said " they keep my room spic and span".

Inspectors carried out the first day of this inspection over an evening and completed the inspection the following day. Upon arrival the inspectors were met by the nurse in charge. The inspectors held an introductory meeting where they discussed the purpose of the inspection which included a review of the provider's compliance plan arising from the last inspection held in November 2023. Shortly after this meeting the person in charge arrived at the centre and facilitated the inspection.The provider also contacted the inspectors and agreed to meet them the next morning on the second day of the inspection.

After the introductory meeting both inspectors commenced a tour of the designated centre where they had the opportunity to meet with residents and staff. On the evening of the first day, inspectors observed that staff were busy providing care and support to residents who wished to retire to their bedrooms or to other areas of the designated centre. Several residents were observed spending time in communal areas of the centre and were found interacting and discussing topics with staff assigned to supervise those areas. The inspectors observed these interactions to be based on respect for the individual. It was clear that staff were aware of residents communication needs and observations confirmed that residents were given time and space to make their views known.

On the second day of the inspection,observations confirmed that residents were supported to attend to their personal care requirements in a discreet and dignified manner. Staff were observed knocking on bedroom doors, announcing their arrival to residents when entering residents bedrooms and were found to explain the purpose of their visit. Residents were encouraged and supported to attend the activities provided which included a review of new stories from the local paper. Other residents were supported to follow their own routines and personal hobbies.

Esker Lodge Nursing Home is based on the outskirts of Cavan Town and is in close proximity to local services, shops and amenities. The centre is registered to accommodate 70 residents and at the time of the inspection there were 65 residents living in the centre. The centre has a mix of accommodation with both single and twin occupancy rooms available for residents. Residents rooms viewed on this inspection were well set out to promote residents independence, there was

unhindered access to both ensuite and storage facilities. Residents also had access to secure storage in the form of a lockable unit. Resident bedrooms were personalised and contained many items familiar to residents such as photo's of their relatives and personal items such as ornaments,books and magazines.

There was a programme of decoration underway at the time of this inspection and inspectors noted the overall improvement to the ambiance on the ground floor from the previous inspection. This work had significantly enhanced the lived environment for residents accommodated on this unit. The redecoration programme was due to be extended to the entire centre with an expected completion date of December 2024.

There was a calm relaxed atmosphere found throughout the centre. Communal areas were well maintained and clean. Overall the centre was well maintained, suitably furnished and suitable for the needs of the residents. There were however some outstanding premises issues which are discussed under the relevant regulations.

There was a well-maintained activity programme in place to cater for the social care needs of the residents.

A variety of activities were provided seven days a week and shared across all units of the designated centre. Residents who spoke with the inspectors said they enjoyed the activities and it helped maintain contact with their friends and other residents in the home. One resident told the inspectors about the fun had during card games which were organised on a regular basis. Inspectors observed a range of activities provided on the day which included an Arts and Crafts session, a reminiscence discussion where staff engaged with residents concerning items they used to use when they were younger. Inspectors also observed a chair exercise programme in the afternoon. Some residents preferred to follow their own activities and hobbies and inspectors observed staff providing support to those residents where required.

Residents were aware of the upcoming elections and confirmed that the centre ensured that they were enrolled on the electoral register.

A meal service was observed on the second floor which consisted of a lamb or beef dish. Residents spoken with said they were happy with the quantity and quality of the food provided. Resident's also said that they were offered a choice of food according to their preference should they not like what was on the menu. The service was well organised and there was ongoing engagement between staff and residents to ensure that residents were happy with their meal.

Residents were observed to receive visitors throughout both days of the inspection, there were no restrictions on visits to the centre, and it was obvious that visitors were well known by the staff team. Visitors who spoke with the inspectors confirmed that they were happy with the care and support provided to their relatives in this centre.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the designated centre

and how these arrangements impacted on the quality and safety of the services being delivered.

Capacity and capability

Overall, this inspection found that the designated centre was managed for the benefit of the residents who lived there, however some improvements were required to the oversight and management processes to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

This was an unannounced inspection carried out by inspectors of social services over an evening and a following day to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 (as amended). Inspectors also followed up on the compliance plan received from the provider following the previous inspection held in November 2023.

The inspectors found that the compliance plan submitted by the provider had not been fully implemented at the time of this inspection. Although the provider had carried out a number of actions and was clearly working towards full compliance there remained some outstanding actions to achieve compliance with Regulation 23: Governance and Management.

The inspectors followed up on unsolicited information that had been received by the Chief Inspector since the last inspection. The issues reported to the Chief Inspector related to concerns that one member of agency staff working in the designated centre did not have the appropriate Garda vetting in place. This inspection found these concerns to be validated however records showed that once the provider was made aware that the staff member did not the appropriate Garda vetting in place they were no longer allowed to work in the centre until appropriate vetting was obtained. When this could not be obtained the member of staff did not return to the centre however inspectors were not assured that the provider had made the appropriate referral to the Nursing and Midwifery professional body to alert them of same. This was done following the inspection.. These findings are discussed under Regulations 8: Protection and Regulation 23: Governance and Management.

The provider of Esker Lodge Nursing Home is Esker Lodge Limited. The centre has a clearly defined management structure, which consisted of the registered provider representative who is a director of the company, the person in charge (PIC), the assistant director of nursing (ADON) and clinical nurse manager (CNM). The remainder of the team consists of staff nurses, housekeeping, catering, administration, maintenance and activity support.

The provider maintained a statement of purpose which described the services and facilities offered by the provider to meet the requirements of Schedule 1 of the Regulations. There were a small number of amendments required to ensure that this document was accurate and transparent and these issues are discussed under

Regulation 3: Statement of Purpose. The provider submitted an updated Statement of Purpose following the inspection.

Records reviewed on inspection confirmed that management meetings were well structured and supported effective oversight of the service. Management meetings were held on a regular basis and covered key aspects of the service such as audits, safeguarding, policies, health and safety, notifications , complaints and residents rights. There was a well-established audit schedule in place to monitor the standards of care provided. Results of audits regularly confirmed high levels of compliance and where improvements were identified there were action plans in place to address the issues identified.

While, in the main oversight was effective, there were some areas that required improvement such as fire safety precautions and safeguarding vulnerable residents. There was a review of quality and safety of care for 2023 which covered key aspects of service provision. The overall results of a resident survey for 2023 showed a 93% satisfaction rate among residents using the service. This document also set out the providers plans for improvements to the service for 2024.

The inspector reviewed a sample of residents' contracts for the provision of services and found that contracts accurately described the service provided and the charges for the service.

There were sufficient numbers of staff available in the designated centre on both days of the inspection to meet the assessed needs of the residents. Arrangements were in place to maintain staffing levels to cover staff absences. A review of rosters confirmed that all absences had been filled. The provider was currently recruiting for health care positions to cover anticipated staff departures.

There was a comprehensive training programme in place which incorporated a selection of both face to face and online training. Records confirmed that all staff were up to date with their mandatory training in safeguarding, fire safety and manual handling. Supplementary training included training on infection prevention and control, medication management, wound management, dysphagia and cardio-pulmonary resuscitation (CPR), care planning communication and human rights. The provider had established networks with the local community and in particular with nursing home integrated services who provided addition training in the centre around falls prevention and catheterisation.

There was a complaints policy in place which did not incorporate all of the legislative changes to Regulation 34: Complaints which came into effect in March 2023. A review of records confirmed that there was low levels of complaints received in this service. There was one complaint received since the last inspection which had been closed out to the satisfaction of the complainant.

The provider had a risk management policy in this centre. The centre maintained a risk register, which identified various risks arising to the residents and included control measures to mitigate the risks. The provider had systems in place to ensure that accidents and incidents occurring in this centre were reported, managed, and notified to the Chief Inspector. The centre had a low number of notifications,

however, the inspectors found that a three-day notification had not been submitted to the Chief Inspector, this is discussed further under Regulation 31: Notifications of incidents.

Regulation 15: Staffing

There were sufficient numbers of staff available with the required skill mix to meet the assessed needs of the residents in the designated centre. A review of the rosters confirmed that staff numbers were consistent with those set out in the centre's statement of purpose.

Judgment: Compliant

Regulation 16: Training and staff development

A review of staff training documentation confirmed that all staff working in the designated centre were up-to-date with their mandatory training. This included training in fire safety which was provided on an annual basis, while training in manual handling and safeguarding was provided in accordance with the designated centre's policies. There was a range of supplementary training available for staff to attend such as wound management, medication management, dementia, infection prevention and control, dysphasia and cardio-pulmonary resuscitation (CPR).

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the registered provider had management systems in place to monitor the quality of the service provided however some actions were required to ensure that these systems were sufficient to ensure the services provided are safe, appropriate and consistent. For example:

- The oversight of safeguarding policies and procedures did not ensure that all procedures were consistently implemented to protect residents.
- The oversight of fire safety precautions including fire drills did not identify the deficits found by inspectors on this inspection.
- Service levels agreements with employment agencies did not provide the necessary assurances that staff were suitably vetted before they were employed in the designated centre.

- The provider was in breach of condition 1 of their registration by storing residents mobility equipment in an area which impeded residents ability to access their balcony area.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A review of a number of contracts for the provision of services confirmed that residents had a written contract of care that outlined the services to be provided and the fees to be charged, including fees for additional services.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had a statement of purpose in place updated in November 2023 which included the information set out in Schedule 1 of the regulations. However this document required a number of changes to accurately reflect the current service, for example,

- A more transparent and accurate representation of the number of whole time equivalents for staff working in the designated centre.
- The procedure for handling complaints, this is discussed in more detail under Regulation 34.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The registered provider failed to notify the Chief Inspector that a staff member employed on a temporary agency basis was subject of review by a professional body.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was an accessible complaints policy and procedure in place for dealing with complaints however this policy and procedure had not been updated to incorporate all amendments made to this regulation by recent statutory legislation SI 628. For example:

- The policy did not include the provision of a written response to the complainant following an investigation into their complaint within the specified timeframe identified under Regulation 34
- The policy did not include provision of a written response to the complainant following a request for a review of the outcome of the provider's response to their complaint within the specified timeframe identified under Regulation 34.

Judgment: Substantially compliant

Quality and safety

For the most part residents living in this centre experienced a good quality of life and received timely support from a caring staff team. Residents' health and social care needs were met through well-established access to health care services and a planned programme of social care interventions. However, the inspectors also found that more focus and effort were now required to ensure that the policies and procedures designed to protect residents from abuse were consistently implemented so that staff working in the centre were Garda vetted before starting work in the centre in order to protect vulnerable residents.

Overall,care plans were well written and provided the required information for staff to be able to ensure care interventions met the needs of the residents. Inspectors found however that a care plan relating to the management of a residents stoma care required more detailed information, this is described further under regulation 5: individualised assessment and care planning.

The provider had made a number of improvements to the premises which had improved the lived environment for residents. A comprehensive programme of redecoration was ongoing in the centre, and the ground floor of the building was being repainted at the time of the inspection. The walls were painted with a two-tone colour effect to enrich the lighting and atmosphere in the dementia-specific unit. Various photo albums were also hung on these walls, which created a sense of familiarity and comfort for the residents. The inspectors were informed that the colours were chosen after consultation with residents to create a welcoming and reassuring atmosphere for the residents. However,other areas of the centre required repair and redecoration to bring them up to the same standard. Furthermore the

provider had failed to identify adequate storage on the second floor for residents' equipment.

The provider had installed a roof light in a resident's bedroom which improved access to natural light and improved the ambiance of this room. A trellis was about to be installed with flowers to brighten up the view from the bedroom window. The provider had engaged with the resident living in this room concerning the changes made and confirmed the resident was was happy with these changes.

The provider had comprehensive fire safety precautions in place however the oversight of fire drills did not ensure that simulated fire evacuation practices were carried out in all compartments to ensure the evacuation procedures were effective in all areas.

The inspectors observed that residents on all the floors were provided with a range of activities in line with their choices and abilities to participate. There was an activity schedule available on each floor, and staff were allocated to support residents engage in the activity programme.

This centre provided residents with access to television, radio, newspapers, and various magazines. Residents' meetings were held regularly, and the meeting minutes indicated that they were consulted regarding the organisation of this centre. Residents had access to independent advocacy services, and posters to raise awareness of advocacy services were placed in various locations of this centre.

Residents had access to the garden areas on the ground floor and could sit out in these areas when they wished. However, on the evening of the first day of inspection, residents' access to the secure balcony area on the second floor was found to be restricted. Access to this balcony area was further restricted due to resident mobility equipment blocking the second access point to this facility. While, inspectors acknowledge that the provider informed them that they had tried improve access to this area, the mechanism used to access the balcony was overly complicated for residents.

This meant that residents accommodated on the second floor did not have unhindered access to communal areas of their home and restricted them to either stay on the unit or travel down to the ground floor to access outside space. This arrangement did not ensure these residents had equal access to safe outside space as those residents living on the ground floor and did not uphold their rights to mobilise freely around their lived environment. This is a repeated finding from previous inspections.

Regulation 10: Communication difficulties

The inspectors observed that one resident who presented with communication needs had not been sufficiently supported to communicate freely in this centre. Although this resident's communication needs were clearly documented in their care

plan, two tablet devices required to assist and enhance communication were found not to be working during the inspection.

Judgment: Substantially compliant

Regulation 11: Visits

Visits were seen to take place in line with visiting guidelines. Visitors were seen attending the centre throughout the inspection. Discussions with residents and visitors confirmed that they were satisfied with the arrangements that were in place.

Judgment: Compliant

Regulation 17: Premises

Notwithstanding the works that had been completed to improve the lived environment for residents the premises did not comply with the requirements of Schedule 6 of the regulations;

- There was not sufficient appropriate storage on the second floor for items of resident equipment.
- A number of doors were scuffed and required repair and repainting
- Walls on the first floor required repainting.

In addition, inspectors found delays for internal repair to fixtures and fittings for example,the window in a resident bathroom had been broken for two weeks and the resident had placed a towel on the window to prevent cold air from entering their bedroom.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While there was evidence of oversight of fire safety in this centre, records describing simulated evacuations did not provide assurances that fire drills were adequately reviewed to ensure that fire drills demonstrated that staff could evacuate residents in a timely manner to a place of safety,

· All of the simulated fire evacuations were carried out on the first floor of the building and staff had not practiced evacuating residents from the fire compartments on the ground and second floors.

In addition, Inspectors found,

· There was tree overgrowth and hanging branches which had the potential to impact on an evacuation of the first floor fire escape stairs.

· There was no signage indicating the storage of oxygen in the office on the ground floor.

· One fire door was wedged open on the second floor.

· The inspectors noted that some fire doors on the first and second floors were damaged and had not been maintained, which could compromise the ability of these fire doors to contain smoke and fire in the event of a fire emergency.

Judgment: Substantially compliant

Regulation 6: Health care

The inspectors found that residents were generally well supported in accessing their general practitioners (GPs) from local practices, health and social care professionals, and specialist medical and nursing services.

Judgment: Compliant

Regulation 8: Protection

The provider failed to take all reasonable measures to protect residents from abuse. For example,

- A review of records maintained by the provider confirmed that one agency staff member staff did not have the required Garda vetting disclosure in place prior to working in the designated centre. Similar non compliance findings were found on a previous inspection carried out in this centre in October 2022.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents did not have unrestricted access to all areas of their home, for example

· Residents were unable to access a balcony area on the second floor of the designated centre due to the storage of resident mobility equipment preventing them entering the balcony.

· The second access point to this balcony area was over complicated and did not promote easy access for residents accessing their balcony area.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed a sample of assessments and care plans and found that residents had care plans developed to meet the assessed needs of residents identified on both pre and on comprehensive assessments. However, one resident's care plan required additional information as it did not contain the level of detail needed to guide staff in the management of a stoma site (an opening on the abdomen connected to the digestive or urinary system) and identifying potential complications.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Substantially compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant

Compliance Plan for Esker Lodge Nursing Home OSV-0000135

Inspection ID: MON-0042771

Date of inspection: 29/05/2024

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A new policy which includes an internal SOP has been created and implemented in respect of the use of agency staff. In addition, a Service Level Agreement has been drawn up with each of the preferred agencies to ensure that copies of Garda Vetting Disclosures are provided in advance of the agency staff member being placed in employment. –completed 30.7.24 The new finance / operations manager has started in post. A new operational management meeting template has been drawn up to incorporate more in-depth fire safety oversight in monthly operational management meetings and related minutes. – completed 6.7.24	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: A revised and updated Statement of Purpose was submitted to the Authority post-inspection on 26.6.24. This included changes to the WTE table on page 4 with regard to the numbers of staff employed separately in the catering, housekeeping and laundry functions . Also changes to the complaints procedure on page 37 to provide greater clarity on response timelines following submission of a complaint/ request for a complaints' review were included and a summary of the complaints procedure was updated for ease of reference – Completed 26.6.24.	

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
An NF08 notification was submitted to the Authority – completed 10.7.24.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints policy had been extensively reviewed in March 2023 to ensure that it incorporated all the requirements of S.I. No. 628 of 2022. Minor amendments to provide greater clarity on the timelines for response to complaints and reviews of complaints were then added, a summary of the process was updated for ease of use and amendments were submitted to the Authority and included in the Statement of Purpose and Function – Completed 26.6.24.

Regulation 10: Communication difficulties	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication difficulties:
A full review has been completed in relation to the communication care plan for this resident. A SOP (standard operating procedure) has been put in place to ensure that devices provided to support communication are charged at all times and an additional prompt to staff has been added to this resident's care plan. This has been spot-checked to ensure the SOP is being adhered to. Staff continue to use alternative methods including a comprehensive communication book for this resident to supplement the use of the communication tablets. The SOP was completed on 30.5.24 – complete.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Provider had already engaged an architect to ascertain potential solutions to address to provide enhanced storage as part of a wider capital expenditure and redevelopment plan. Interim planning permission for new storage was submitted on 26.7.24. The planning permission aims to build a new storage room on the second-floor services balcony and will be completed by March 2025 subject to planning permission approval. In the interim, an existing linen storage room on the second floor has been identified as a temporary storage area. This is scheduled to be repurposed as an equipment storage room. To date there has been consultation with residents and resident agreement for storage of additional personal items such as individual laundry and incontinence wear in residents rooms. Additional storage space has been implemented which does not impact residents' communal areas for a back up supply of linen . A mitigation plan is in place in case cohorting is required. Additional information and clarifications have been provided to the Authority in relation to fire safety measures while the linen store is temporarily repurposed for hoist storage. If the Authority is sufficiently assured then the Provider will apply for a variation of condition to repurpose the store until the new permanent store on the second floor can be completed. As already stated planning permission was submitted on 26.7.24. Preparation in relation to converting the linen store to a hoist store was completed on 30.7.24. An additional review of fire safety procedures and precautions was completed on 10.8.24. Additional information regarding this was forwarded to the Authority on 13.8.24. The planning to build a new storage room on the second-floor services balcony subject to receipt of planning permission approval by 31 January 2025 will be completed by 31 March 2025.

• An ongoing programme of redecoration and upgrading is underway throughout the centre with an expected completion date of 31.12.24

• The bathroom window in the residents' ensuite was repaired on 29.5.24.

• A new system for logging and monitoring maintenance issues has commenced from 30.6.24. There is daily reporting of maintenance tasks identified by staff and undertaken by the maintenance department. Progress and closing out of the maintenance actions is reviewed and tracked by the newly appointed Operations Manager. Further oversight of the maintenance function occurs at operational governance and management meetings at scheduled two monthly intervals. In addition, staff have been reminded of the need to identify any already reported maintenance items that are as yet unresolved i.e. premises issues using the new escalation process, liaising directly with the Operations Manager. A regular review of time taken to close out maintenance issues is addressed and minuted as part of the operational governance and management meetings – Completed 30.7.24.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: • The tree which had fallen the day before the inspection has now been trimmed back and overhanging branches removed on 11.7.24 - complete. • Signage has been placed on the door of the office on the ground floor – effective from 1.7.24 - complete • An email has been sent to all staff to remind them to be vigilant in relation to use of items to wedge a door open – effective from 12.7.24 complete • A new door closing solution has been implemented on the second floor sitting room door – completed 14.8.24 • There is an ongoing programme of preventative maintenance for fire doors. All preventative maintenance for the ground floor was completed prior to the inspection in May. The remaining doors are part of a preventative maintenance schedule due to be completed 31.08.24. • The fire drill process and associated template has been re-designed to ensure that drills cover a variation of scenarios i.e. horizontal and vertical drills on all floors & compartments of the home with reference to the individual residents' PEEP in each compartment. This was completed on 16.7.24 • Routine fire drills are conducted internally on a monthly basis which have been enhanced and updated to ensure effective rotation of the types of fire scenarios practiced and the compartments used – completed 16.7.24 and ongoing • In addition we are conducting a 'nighttime scenario' fire drill to ensure that residents could be safely evacuated. This was completed successfully within acceptable timeframes for a compartment on the second floor. Completed 10.8.24	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: A new policy has been created and implemented in respect of the use of agency staff which includes an internal SOP. In addition, a Service Level Agreement has been drawn up and shared with each of the preferred agencies to ensure that copies of Garda Vetting Disclosures are provided in advance of the agency staff member being placed in employment. – SLA & policy finalized on 31.7.24	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights:	

The second-floor balcony door in the sitting room has an access control system which has been reviewed again to ensure enhanced ease of use for residents. The internal alarm was removed and an external alarm was installed. This allows residents to access the balcony independently without an internal alarm alerting and supports residents to have unrestricted access to the second-floor balcony area which they can access independently via the sitting room. Completed 14.8.24.

Planning permission has been submitted to create new storage on the 2nd floor internal balcony which is used for access to services only and will not affect available outdoor space for residents on this floor – submitted 26.7.24 with a view to completion by March 2025 if permission is granted during the expected timeframe.

Resident assistive equipment other than hoists that was stored in an access corridor to the second-floor balcony has now been relocated where possible – completed 30.7.24
An interim plan has been submitted to the Authority to utilize the existing linen store which can be repurposed for storage of hoists. This information to the Authority was submitted on 30.7.24 and 13.8.24.

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:
The resident's care plan has been reviewed and updated and now includes detailed information to guide staff on the management and care of a stoma site – completed 4.6.24.

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 10(1)	The registered provider shall ensure that a resident, who has communication difficulties may, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre concerned, communicate freely.	Substantially Compliant	Yellow	30/05/2024
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	31/03/2025
Regulation 23(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	30/07/2024

	place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	31/08/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	16/07/2024
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	26/06/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs,	Not Compliant	Orange	10/07/2024

	the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.			
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	26/06/2024
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Substantially Compliant	Yellow	26/06/2024
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	04/06/2024

Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	31/07/2024
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	14/08/2024