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:	Firstcare Blainroe Lodge
Name of provider:	Firstcare Blainroe Lodge Limited
Address of centre:	Coast Road, Blainroe, Wicklow, Wicklow
Type of inspection:	Unannounced
Date of inspection:	25 October 2023
Centre ID:	OSV-0000016
Fieldwork ID:	MON-0041703

About the designated centre

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

Firstcare Blainroe Lodge Nursing Home has four floors; a lower ground, ground, first and second floor. The centre can accommodate 72 residents. Residential accommodation is across the four floors which are accessed by a lift and stairs. According to their statement of purpose, Firstcare Blainroe Lodge is a community based setting committed to providing person-centred care that is evidence based. They aim to ensure that all residents live in an environment that is comfortable, safe and clean, with the greatest dignity, support and respect possible, awarded to them by a team of appropriately qualified and trained staff. Care can be provided for adults over the age of 18 years with general care needs within the low, medium, high and maximum categories. A pre-admission assessment is completed in order to determine whether or not the service can meet the potential resident's needs. Twenty-four-hour nursing care is provided. In total, there are 38 single rooms with full en-suite facilities, 25 single rooms with toilet and wash-hand basin and two additional single rooms with wash-hand basins. There are three twin rooms with toilet and wash-hand basin facilities. Many of the rooms have been personalised with family photos and memorabilia. Additional toilets and bathrooms were located around the building. There were adequate communal areas and private areas for residents to receive visitors. Other areas include a kitchen, laundry, oratory, hairdressing salon, smoking room and activities room. There are several well-maintained enclosed garden areas for residents' use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	64

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 25 October 2023	08:50hrs to 17:15hrs	Bairbre Moynihan	Lead
Thursday 26 October 2023	08:35hrs to 17:20hrs	Bairbre Moynihan	Lead

What residents told us and what inspectors observed

The inspector greeted and chatted to a number of residents in the centre to elicit their experiences of living in Firstcare Blainroe Lodge. Residents were positive in their feedback about the care they received and the staff. However, some residents expressed their concerns to the inspector about the level of staffing.

This was an unannounced inspection carried out over two days to monitor ongoing regulatory compliance with the regulations and standards. The inspector was greeted by the person in charge and following an introductory meeting was guided on a tour of the premises.

Firstcare Blainroe Lodge is registered to accommodate 72 residents with eight vacancies on the day of inspection. The centre is laid out over four floors. The lower ground floor (Bayside), contained six single rooms. The ground floor contained two units - Brittas and Seafield. Brittas contained 16 single rooms, an open plan sitting and dining room, activities room, a "faux" bar and oratory. Seafield was the newest unit in the centre, purpose built, containing a wide corridor, 26 single rooms, a snoezelen and open plan sitting and dining room. The first floor (Silverstrand) was a dementia specific unit, with 13 single rooms and three twin rooms. Seaview (second floor) contained seven single rooms. All rooms in the centre contained a sink and toilet and the majority included a shower. Those without showering facilities had access to bathrooms on each floor. The residents in Brittas and Seafield had access to two external gardens. The doors to the enclosed external garden at the reception area were open at all times and residents were observed mobilising out to this area. The enclosed external gardens were well maintained. Residents rooms were personalised with photographs and personal belongings. The centre had a dedicated hairdressing salon and the hairdresser attended on Tuesdays.

On the first day of inspection one activities co-ordinator was on duty for 64 residents. Given the size and layout of the centre it was difficult for one person to do meaningful activities with residents over four floors. Notwithstanding this, the inspector was informed that an activities staff member was recently recruited. Furthermore, a review of the activities was undertaken in August by an external provider with recommendations made which included removal of mass, the hairdresser and visitors as activities from the schedule. The activities schedule was on display at the entrance to the centre. The majority of residents attended the sitting and dining area in Brittas. Activities observed included a quiz, bingo and baking scones. Residents were particularly excited about the scones and these were served to residents in the afternoon with a cup of tea. In addition, an art class took place on a Wednesday facilitated by an external provider. However, residents in Seafield spent long periods in bed and no activities were observed with these residents over the two days of inspection. The centre had decorations throughout in preparation for Halloween.

Residents' were consulted about the centre through residents' meetings and satisfaction surveys. The centre had appointed a resident who was the residents' ambassador. Residents' meetings took place monthly with a small number of residents attending. Items discussed included; activities and the food. Residents highlighted in September that breakfast was "getting later each month" and the action plan included requesting staff to heat up the breakfast. Residents were provided with information on advocacy services. A satisfaction survey was completed in 2022 with a 26.7% response rated. Feedback was generally positive about the life and care in the centre, however, 15.4% of respondents were not satisfied with the "care provided for dependent people to help with eating" and while an action was devised from this feedback and it was stated as being completed this was also a finding on inspection.

The inspector observed the dining experience. Residents were provided with a choice at mealtimes including residents who were on a modified diet. The menu was on display at the entrance to Brittas and Seafield dining areas. Snacks and fluids were provided to residents at regular intervals throughout the day. Residents were complimentary about the food and it was evident that they enjoyed the social occasion at mealtimes. Improvements were required which are discussed under the domain of quality and safety.

The next two sections of the report present the findings of this inspection in relation to governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This was a two day unannounced inspection to monitor ongoing compliance with the regulations and standards and to follow-up on information received since the last inspection. Additionally, the inspector assessed the overall governance of the centre and established whether actions outlined in the centre's compliance plan from October 2022 were implemented. Overall, the inspector found that some of the actions had been implemented for example; hand hygiene sinks were compliant with the required specifications and were installed in a number of locations throughout the centre. In addition, the sluice room in Silverstrand was now a dedicated sluice room and a sluice hopper was placed in the sluice room in Seafield. Four non-compliances were identified on this inspection in Regulations 15: Staffing, 23: Governance and management, 27: Infection Control and 28: Fire Precautions.

Firstcare Blainroe Lodge Limited is the registered provider for Firstcare Blainroe Lodge. The centre is part of a wider group who own and run a number of centres throughout Ireland. The lines of accountability and responsibility were outlined to the inspector. The person in charge reported to a regional operations manager who in turn reported to a company director. The inspector was informed that the regional manager attended on-site weekly. The person in charge worked full-time and was

supported in their role by an assistant director of nursing who was in a full-time supernumerary post. Two clinical nurse managers were assigned one day per week in a supernumary capacity and worked on alternate weekends. Staff nurses, health care assistants, housekeeping, catering, activities staff, administration and laundry staff were all part of the team. Gaps were identified between the statement of purpose and the actual staffing levels. Residents and staff informed the inspector that staffing shortages were impacting on residents' quality of life in the centre. Residents described to the inspector about having to wait to receive care and delays in receiving their medications. Complaints reviewed indicated that staffing and care issues were a recurring theme. Adding to staff shortages was a high level of unplanned leave. Management had not identified a staff shortage as a concern and stated that the issue was the allocation of staff. Notwithstanding this, the inspector was informed and documentation confirmed that admissions to the centre were paused temporarily.

Improvements were identified in staff training. Staff had access to education and training appropriate to their role, however improvements were required in the supervision of staff in the centre. A training matrix was provided to the inspector. All staff had completed training in safeguarding, medication management, dementia training, restrictive practices and hand hygiene. A small number of gaps were identified in fire safety training and responsive behaviours.

The registered provider had completed an annual review for 2022 which was aligned to the themes of the National Standards for Residential Care Settings for Older People in Ireland and included a time bound action plan. Areas for improvement included care planning training for staff and the installation of clinical hand hygiene sinks. Under a number of standards in the annual review an action identified, was to facilitate residents to maintain links with the community through social outings and events. This was ongoing at the time of inspection with the inspector informed of one outing that had taken place. Systems of communication were in place. The person in charge provided a comprehensive monthly report to the operations manager linked to each standard. Monthly staff nurse meetings and two monthly healthcare assistant meetings took place. The registered provider had an audit schedule in place. Audits were comprehensive, identified issues and contained action plans. Notwithstanding the good practices, oversight of issues identified on inspection had not been actioned such as infection control and premises issues. Incidents were reported electronically with the majority of incidents being falls related. Trending of the falls was taking place but further analysis was required in order to identify learning from the falls. All incidents were reported to the Office of the Chief Inspector in line with regulations.

The registered provider had a complaints procedure in place which was on display at the entrance to the centre and at the entrance to the first floor at the stairwell. The procedure did not contain the timelines for response to a complaint but the procedure was updated and amended while the inspector was onsite. A log of all complaints was maintained. Complaints were investigated and responded to within agreed timelines and the outcome of the complaint and satisfaction or otherwise of the complainant was documented.

Regulation 15: Staffing

The registered provider did not ensure that the number and skill mix of staff was appropriate having regard to the needs of the residents assessed in accordance with Regulation 5.

The centre's statement of purpose outlined two staffing models of 70% occupancy and 100% occupancy. On the day of inspection the centre was at 88% occupancy. Gaps between actual staffing levels and what the centre was registered against in the statement of purpose included:

- The centre had a deficit of approximately 1.5 WTE staff nurses for an occupancy of 88% residents
- There were 6 WTE healthcare assistant vacancies.
- Two catering posts were vacant and this gap was being supplemented by healthcare assistants which removed the healthcare assistant from caring duties for that day.
- A high level of unplanned leave was further impacting on staff shortages. This was highlighted to the inspector by management and staff.

The staff vacancies and unplanned leave were impacting on residents' care observed on the day of inspection. For example; residents were not receiving assistance with their meals and meals were left in front of them, two residents reported to the inspector that there were delays in them receiving their medication and residents' requiring assistance with toileting were not attended to in a timely manner.

Judgment: Not compliant

Regulation 16: Training and staff development

Gaps were identified in training and staff development. For example;

- There was inadequate supervision of staff with the inspector observing residents meals being left in front of them and residents' incontinence wear requiring attention.
- Approximately 10% of staff fire training was out of date or not completed.
- Approximately 10% of staff training in responsive behaviour was not completed. However, the inspector was informed that this was booked.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure that staffing resources in the centre were in accordance with the centre's statement of purpose, as discussed under regulation 15: Staffing.

The management systems in the centre required strengthening to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- While individual complaints were managed in line with the regulation, tracking and trending of complaints was not taking place to identify emerging themes such as complaints relating to care issues and staffing.
- Oversight of issues identified on inspection required strengthening such as issues in relation to the premises and infection control.
- Management had undertaken an audit of falls in the centre, however, while the audit identified a trend with the timing of the falls this was not explored further to identify if there was a deficit in staffing during these times or if the trends were in relation to other factors in the centre and the audit was not accompanied by a time bound action plan.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of contracts of care were reviewed. All information required under the regulation was contained in the contracts of care viewed.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and notification events, as set out in Schedule 4 of the regulations, were notified to the Chief Inspector of Social Services within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure and policy were updated in line with the changes under S.I. 628 of 2022. The person in charge was the nominated person to deal with complaints. The registered provider maintained a log of complaints and these were reviewed, investigated, responded to and the satisfaction or otherwise of the complainant was documented in line with the regulation.

Judgment: Compliant

Quality and safety

Overall, residents expressed dissatisfaction with the level of staffing in the centre. However, residents were complimentary about the staff and how hard they worked. Improvements were observed in care planning and fire drills. On this inspection additional improvements were required in Regulation 28: Fire Precautions, 17: Premises, 18: Food and nutrition, 27: Infection control and 9: Residents' Rights.

Resident's had access to medical and nursing care. Health and social care providers reviewed residents when referred with management stating that there was minimal waiting times. However, not all residents who were eligible for national screening services were referred in a timely manner. Residents' assessments were undertaken using a variety of validated tools and care plans were developed following these assessments. Care plans viewed by the inspector were comprehensive and person-centred. Care plans were updated four monthly in line with regulations and were sufficiently detailed to guide staff in the provision of person-centred care. There was evidence that the care plans were reviewed by staff.

The centre was bright and airy with pictures lining the walls and assistive handrails throughout. Residents' rooms were spacious with ample storage for residents' belongings. However, infection control and premises are interdependent and deficits in the maintenance of the centre were providing a challenging environment for staff to maintain effective infection control practices. An environmental audit completed in September 2023 identified many of the issues identified on inspection. However, the actions were not time bound and the solution to many of the issues identified was the appointment of a new housekeeping supervisor. Notwithstanding this, the registered provider had an up-to-date infection control policy in place. In addition, areas identified on the last inspection such as the hoist slings were now single resident use only and cleaning bottles contained the date when the product was filled. There was no inappropriate storage of linen trolleys identified on this inspection.

The registered provider had introduced a change to the dining experience for residents. The role of the healthcare assistant now included the distribution of meals from a bain marie. Management and staff stated that the healthcare assistant was only assisgned to this role for the day and did not do caring duties while carrying out this role. However, this removed one healthcare assistant each day from caring

duties. Sufficient staff were on duty in Brittas to assist residents with eating, however, two staff were assigned to Seafield for approximately 21 residents with the majority of residents in bed or their bedroom requiring assistance and supervision. Similarily staff assigned to Silverstrand assisted residents in Seaview and a resident's breakfast and lunch were observed in front of a resident and no staff available to assist.

The fire alarm system met the L1 standard which is in line with the current guidance for existing designated centres. Signage to guide staff on the evacuation routes was clear and on display in a number of locations throughout the centre. Each resident had a personal emergency evacuation plan in place which was located in residents' wardrobes. The fire detection and alarm systems and emergency lighting had preventative maintenance completed at recommended intervals. Daily, weekly and monthly checks of, for example; means of escape were generally completed within the time frames. Smoking assessments and care plans were in place for residents that smoked. A sample of fire doors were checked and gaps were noted in a number. Furthermore, management provided the inspector with a monthly audit of fire doors which identified that a number of doors had a gap between the door and the frame or gaps under the door. Management stated and documentation confirmed that an assessment of the work required was being completed on 1 November 2023 with a plan to commence work on 20 November 2023. Four fire drills were completed in 2023. Night time scenario evacuations were completed and comprehensive fire drill reports were available detailing the number of residents in the compartment, mode of evacuation and the length of time it took to evacuate residents, however no drill had taken place in the largest compartment. This and additional findings are detailed under Regulation: 28.

The registered provider had an up-to-date policy on managing behaviours that challenge. Overall there was a very person-centred approach to managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were knowledgeable and skilled at identifying and preventing episodes of responsive behaviours and behavioural assessments were regularly carried out. It was evident from speaking to staff that chemical restraint was used as a last resort. These assessments mostly informed effective care planning. Further good practices are detailed under the regulation.

Independent advocacy services were available to residents and the contact details for these were on display. Residents religious rights were respected and both a priest and reverend were facilitated to attend. Social assessments were completed for each resident and individual details regarding a residents' past occupation, hobbies and interests was completed. However there were challenges in adequate provision of activities due to limited availability of activity staff, staffing deficits as outlined under Regulation 15 and the challenges presented by the design and layout of the centre.

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example;

- General wear and tear was noted throughout the centre. For example; walls, architraves and doors were scuffed, chipped and damaged.
- The inspector observed a bell ringing for longer than five minutes and on investigation they were informed that there was no resident in the room and that an issue with the bells ringing for no reason was an ongoing issue in the centre. Meeting minutes confirmed that this was escalated to management at a meeting on 15 October but it remained outstanding on the day of inspection.
- Surfaces and shelving in the medication room and day room in Silverstrand and treatment room in Seafield were in a state of disrepair. This did not aide effective cleaning.
- A resident's room in Seaview had a water leak recently. Stains on the ceiling and bubbling on the wall were identified and had not been addressed at the time of inspection.
- Flooring in an assisted bathroom in Bayside was marked and damaged.
- Twin rooms in the centre were occupied by one resident, however, they required review to ensure that residents' did not have to cross over in another residents' bedspace to access their personal belongings.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The inspector observed that there was not an adequate number of staff available at mealtimes to assist residents. For example; two staff were available to assist 21 residents in Seafield at lunchtime on the second day of inspection. Furthermore, the inspector observed two further incidences of residents' meals in front of them and no staff member available to assist.

Judgment: Substantially compliant

Regulation 27: Infection control

Improvements were required to ensure procedures were consistent with the national standards for infection prevention control in community services. For example;

- Minor work was being carried out in the sluice room in Silverstrand. The inspector observed an excessive amount of dust from the work. The room was not decommissioned during this time.

- The hair salon was unclean. Hair was noted in plug holes, on chairs and excessive dust and debris was observed under the sinks.
- Yellow clinical waste bags were contained within white waste bins in sluice rooms. The inspector was informed and an email confirmed that yellow clinical waste bins were ordered.
- The kitchenettes including the ovens in Seafield, Brittas and Silverstrand were unclean.
- The janitorial sink in the cleaner's room in Seafield was stained and contained debris.
- The cleaner's store in Brittas contained no janitorial sink or hand hygiene sink.
- Dried red staining was observed in the smoking room on the walk around. This was brought to the attention of the person in charge and was addressed while the inspector was on-site.
- The hand hygiene sinks in the sluice rooms were not compliant with the required specifications.
- The medication trolley in Silverstrand was rusted, in a state of disrepair and hair was wrapped around the wheels.
- The water outlet in two hand hygiene sinks in Seafield were stained and unclean.

Judgment: Not compliant

Regulation 28: Fire precautions

Improvements were required by the provider to ensure adequate precautions against the risk of fire:

- An audit reviewed by an inspector identified that a number of doors throughout the centre had gaps or were not fully engaging. This would make them in effective in the event of a fire.
- In line with findings from the inspection in October 2022 staff were unclear on the evacuation procedure on the first floor.
- The smoking room in the centre did not contain an ashtray.
- A release button on a fire door was broken in Silverstrand.
- A hoist battery was charging beside an oxygen cylinder in the medication room in Silverstrand introducing a fire risk. This was brought to the attention of the person in charge during the inspection.
- No fire evacuation of the largest compartment with night time staffing levels had taken place in 2023.
- A resident was seated at the entrance to a compartment door and in the event of a fire the fire doors would be unable to close.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed a sample of residents' care plans and assessments tools. These were seen to contain sufficient information to guide staff in caring for the medical and nursing needs of residents. These were updated four monthly in line with the requirements under the regulations.

Validated risk assessment tools were used to identify specific clinical risks, such as risk of falls, pressure ulceration and malnutrition. In addition, smoking risk assessments had been completed in residents that smoked.

Judgment: Compliant

Regulation 6: Health care

Residents' health and well-being was promoted and residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as physiotherapy, occupational therapy, dietitian and speech and language, as required. Weights and observations were completed monthly or more regularly if required. Residents with weight loss were identified and referred to a dietitian.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Some residents had responsive behaviours. Behavioural assessments were completed and informed an holistic approach to managing residents' responsive behaviours.

The centre maintained a restrictive practices register which outlined practices in use that could impact on the freedom of a resident. Where restrictive practices were in use they were risk assessed and alternatives were trialled and least restrictive options were used.

Judgment: Compliant

Regulation 9: Residents' rights

Action was required by the registered provider to ensure that all residents' have opportunities to participate in activities in accordance with their interests and capabilities. An area to be addressed included: • Residents in Seafield were observed for long periods in their room or in bed with minimal stimulation.
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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Firstcare Blainroe Lodge OSV-0000016

Inspection ID: MON-0041703

Date of inspection: 26/10/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider Representative will ensure that staffing is at all times in accordance with the Statement of Purpose, including the rostering of agency/relief staff to address any shortfalls. Staffing rosters are prepared by the Person in Charge, monitored weekly by the Regional Director and overseen by the Registered Provider Representative to ensure compliance (complete and ongoing). A dedicated recruitment plan, coordinated by the local HR Manager and managed by the Person in Charge has ensured the recuitment of four staff nurses (due to take up post on 18 December 2023). Recruitment will continue until all vacant posts are filled and staffing is in accordance with the Statement of Purpose. The Person in Charge supported by the local HR manager have met with relevant staff to address unplanned absences. This is monitored weekly by the Person in Charge and overseen by the Regional Director (complete and ongoing). A reorganisation of the staffing allocation at mealtimes by the Person In Charge coupled with the introduction of protected meal times and further staff training has enhanced the dining experience for residents (complete). The impact of these changes is being monitored weekly and reviewed at monthly governance meetings by the Regional Director (complete and ongoing).	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Immediately following the inspection, the Person in Charge revised the supervision arrangements in place for mealtimes. Senior healthcare assistants under the direction of	

the Person in Charge or designate now provide direct oversight and supervision of staff during mealtimes to ensure the assessed needs and wishes of each individual resident is addressed.

The Person in Charge provided training to staff on resident's nutritional and continence care. This is reinforced daily through staff handovers and the care provided is monitored daily by the Person in Charge, ADON or CNM and at monthly governance meetings by the Regional Director.

The oversight of training to address the findings of this inspection and to ensure timely updates in future is the responsibility of the Person in Charge and has been monitored at monthly Clinical Governance Meetings by the Regional Director with effect from 31 October 2023.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Registered Provider Representative will ensure that staffing is at all times in accordance with the Statement of Purpose, including the rostering of agency/relief staff to address any shortfalls. Staffing rosters are prepared by the Person in Charge, monitored weekly by the Regional Director and overseen by the Registered Provider Representative to ensure compliance (complete and ongoing). A dedicated recruitment plan is in place to fill all vacant posts and recruitment will continue until staffing is in line with the Statement of Purpose.
The Person In Charge has strengthened the approach to auditing allowing for an improvement in tracking and identification of trends including complaints, falls and issues relating to the environment. Audit outcomes and analysis of trends is reviewed by the Regional Director at monthly governance meetings with actions taken where appropriate.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A schedule of refurbishment works will commence in Q1 2024 to address the environmental concerns identified at the time of inspection in Seafield, Silverstrand and Bayside; and the issues identified with the nurse call system.
A new end-of-day sheet has been introduced for onsite maintenance staff to clearly identify tasks completed and escalated. This sheet is sent to the Facilities Manager and

Person in Charge for oversight. This end of day sheet was implemented on 27 October 2023. Any findings from call bell checks are included and monitored at Monthly Governance Meetings by the Regional Director.
By 31 Janaury 2024, the layout of twin bedrooms will be fully re-configured to comply with the requirements of the regulations thereby enabling both residents to access personal belongings in private.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
A reorganisation of the staffing allocation at mealtimes by the Person In Charge coupled with the introduction of protected meal times and further staff training has enhanced the dining experience for residents (complete). The impact of these changes is monitored weekly by the Regional Director and reviewed at monthly governance meetings.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The training and supervision of housekeeping staff will be enhanced to include further training on cleaning methodology, use of chemicals for oven cleaning and the importance of accurate documentation of cleaning schedules. This will be undertaken by the Housekeeping Supervisor, overseen by the Person In Charge and completed by 31 December 2023.

Visual checks of the premises are conducted daily by Person in Charge (or designate) with any issues identified escalated to Housekeeping staff and actioned accordingly

Replacement medication trollies are on order from the pharmacy provider (due by 31 December 2023) and by 30 June 2024, all sinks will fully comply with the required specifications.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Compartmental Fire Evacuation Training for staff including night staff commenced on 13 December 2023 and will be complete by 31 January 2024. The Person in Charge, supported by the Regional Director ensures implementation of the training and the management of ongoing fire drills including evacuation of the largest compartment with night time staffing levels. External contractors have been employed to review & correct fire doors within the centre; this will be completed by 15 December 2023. Revised daily, weekly and monthly audits are now in place which include visual inspection of the environment, the fire alarm, fire equipment and fire doors. These audits are carried out by the maintenance staff and documented in the General Fire Register. This is in effect from 27 October 2023. The Person In-Charge is responsible for addressing any issues identified and this is monitored at Monthly Governance Meetings by the Regional Director. An ashtray was placed in the smoking room on the day of inspection and the battery charging in the medication room in Silverstrand was immediately relocated to the nurses station.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: A Quality Improvement Programme (QIP) has commenced to provide an enhanced level of activities for all residents in accordance with their interests and capabilities. This is led by the Person in Charge, supported by the Regional Director and an experienced Activity Coordinator. The QIP is evaluated at Monthly Governance Meetings by the Regional Director and will be complete by 31 January 2024.	

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.	Not Compliant	Orange	18/12/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/12/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Substantially Compliant	Yellow	30/06/2024

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Yellow	30/11/2023
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	31/12/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/12/2023
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	Not Compliant	Orange	30/06/2024

	Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	15/12/2023
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	15/12/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be	Substantially Compliant	Yellow	31/01/2024

	followed should the clothes of a resident catch fire.			
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	31/01/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/01/2024
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	31/01/2024