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:	Ratoath Manor Nursing Home
Name of provider:	Ratoath Nursing Home Limited
Address of centre:	Ratoath, Meath
Type of inspection:	Unannounced
Date of inspection:	14 August 2024
Centre ID:	OSV-0000152
Fieldwork ID:	MON-0044589

About the designated centre

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

Ratoath Manor Nursing Home is set in the village of Ratoath in County Meath. The two-storey premises was originally built in the 1820s and is located in landscaped gardens. It now provides accommodation to 60 male and female residents over 18 years of age. Residents are admitted to the centre on a long-term residential, respite and convalescence care basis. The service provides care to residents with conditions that affect their physical and psychological function. Residents of all dependency levels are provided for. Residents are accommodated in single and twin bedrooms across three units; St Oliver's Unit, St Patrick's Unit and Ground Floor Unit. A proportion of these bedrooms have en-suite sanitary facilities. Communal shower rooms, bathrooms and toilets are available throughout the building. A variety of communal rooms are provided for residents' use across both floors, including sitting, dining and recreational facilities and an oratory. A number of outdoor areas are also available, including large gardens on the ground floor and two internal courtyards on the first floor. The registered provider employs a staff team consisting of managers, registered nurses, care assistants, activity coordination, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	57

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 14 August 2024	09:00hrs to 17:25hrs	Frank Barrett	Lead
Wednesday 14 August 2024	09:00hrs to 17:25hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place over one day by two inspectors of social services. Based on the observations of the inspectors and discussions with residents, Ratoath Manor was a nice place to live, where residents were supported to have a good quality of life and had many opportunities for social engagement and meaningful activities.

There was a relaxed atmosphere within the centre as evidenced by residents moving freely and unrestricted throughout the centre. It was evident that management and staff knew the residents well and were familiar with each residents' daily routine and preferences.

Inspectors spoke with eight residents living in the centre. All were very complimentary in their feedback and expressed satisfaction about the standard of care provided.

Inspectors observed that residents rights and dignity was supported and promoted with examples of kind, discreet, and person-centred interventions between staff and residents throughout the day. Residents living with a diagnosis of dementia or cognitive impairment who could not communicate their needs appeared to be relaxed and enjoyed being in the company of staff.

Visitors were observed attending the centre on the day of the inspection. The inspectors spoke with four visitors during the inspection. Visitors were very complementary of the staff and the care that their family members received.

Ratoath Manor is located within a 200 year old listed historic building. The location, design and layout of the centre was generally suitable for its stated purpose and met residents' individual and collective needs.

Resident accommodation was divided into three areas, the Ground Floor comprising 21 beds, St. Patrick's Nursing Unit which comprised 18 beds and St. Oliver's Nursing Unit which contained 21 beds. Access between floors was facilitated by a passenger lift and stairs.

There was plenty of suitable communal spaces throughout the centre including day rooms, dining rooms, lounges, relaxation rooms, a chapel and a hair and beauty salon. However, inspectors also observed the inappropriate storage of clean supplies and personal protective equipment (PPE) within a communal bathroom on the first floor.

The outdoor space included a patio and acres of landscaped gardens for outdoor walks and recreational activities. However, all areas could not be safely used it its

full potential as some of the external seating and walkways required repair and upgrading.

The roof garden included dementia friendly artwork with stimulating murals surrounding the perimeter. A private church was located inside the nursing home and mass is hosted each Saturday.

The ancillary facilities generally supported effective infection prevention and control. For example, staff had access to a dedicated housekeeping rooms on both floors for storage and preparation of cleaning trolleys and equipment. However, access from this room to ground floor bedrooms was via the dining room which was not ideal from an infection prevention and control perspective.

The main kitchen was clean and of adequate in size to cater for resident's needs. Residents were very complimentary of the food choices and homemade meals made on site by the kitchen staff. Toilets for catering staff were in addition to and separate from toilets for other staff.

Laundry and resident clothing was laundered on-site. The infrastructure of the laundry with separate rooms for washing and drying, supported the functional separation of the clean and dirty phases of the laundering process. Residents said that they were happy with the laundry service and there were no reports of items of clothing missing.

The three sluice rooms were clean and well maintained. However, four staff members said that they emptied the contents of urinals and commodes into toilets prior to bringing them to the sluice room for decontamination. This practice posed a risk of cross infection.

Six additional clinical hand wash sinks had been installed following the last inspection to facilitate staff hand hygiene. Alcohol hand gel was readily accessible at outside resident bedrooms.

While the centre generally provided a homely environment for residents, some of the décor and finishes were showing signs of minor wear and tear. However, the provider was endeavouring to improve existing facilities and physical infrastructure at the centre through ongoing maintenance and painting.

During a walk-around with management, a persistent buzzing was heard from the main electrical panel distribution board in an electrical room, this had not been identified by the provider. Therefore no actions had been taken to respond to this fire risk. The door to the dining room on the first floor had a battery type door holder in place, which was not working on the day of inspection. This would mean that the door could not be held open to release on sounding of the alarm. The provider committed to having these issues looked at as soon as possible.

The next two sections of the report, capacity and capability and quality and safety will describe the provider's levels of compliance with the Health Act 2007 and the

Care and Welfare Regulations 2013. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

This was an unannounced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to review the restrictive conditions which the Chief Inspector of Social Services had attached to the registration of Ratoath Manor Nursing Home. The condition required the registered provider to "take adequate precautions against the risk of fire and make adequate arrangements in respect of fire safety management in the designated centre to the satisfaction of the Chief Inspector not later than 30th April 2024". The provider had submitted an application to remove this condition, outlining works completed to comply with the condition. The provider had also addressed the findings of the last inspection. Overall, inspectors found sustained improvements governance and management arrangements to ensure that residents received person-centred care and support. However, further improvements were required under five regulations in order to be fully compliant. These included governance and management, infection control, premises and fire precautions.

Ratoath Manor Nursing Home Limited is the registered provider of Ratoath Manor Nursing Home. There was a clearly defined management structure in place with identified lines of authority and accountability. The person in charge was responsible for the day-to-day operations of the centre.

At the time of the inspection the assistant director of nursing position was vacant. In the interim of this position being filled on 31 August 2024, the person in charge was supported in their role by a member of the Silver Stream Group Management Team who attended the centre each day. There were deputising arrangements in place for when the person in charge was absent. A number of other management supports were available within the centre and also as part of the wider group structure Silver Stream Healthcare Group, including human resources, health and finance management supports.

At operational level, within the centre there were clinical and administrative supports to the person in charge including a clinical nurse manager and administration personnel. Nursing and care staffing and skill mix on the day of inspection appeared to be appropriate to meet the care needs of the residents living in the centre.

Communications systems were in place, as evidence was provided of regular governance meetings with the regional manager and with staff to keep them up to date with changes in the centre. A weekly clinical care quality indicator report was compiled and reported to the Clinical Governance and Operations Manager. The

report included data on accidents or incidents, use of restrictive practices, skin integrity, nutritional status, antibiotic use and rates of infection. A schedule of fire safety audits were also in place at the centre, and fire safety was noted as a standing agenda item on internal governance meetings.

The provider had nominated a staff member to the role of infection prevention and control link practitioners to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre.

A quarterly schedule of infection prevention and control audits was also in place. Audits were not routinely scored, tracked and trended to monitor progress. The findings from local audits generally reflected the findings on the day of the inspection.

There were sufficient numbers of housekeeping staff to meet the infection prevention and control needs of the centre. Cleaning records viewed confirmed that all areas were not cleaned each day.

An extensive programme of works had been carried out to improve fire safety in the centre. The provider had put in place improvements to fire detection and emergency lighting, fire containment concerns including upgrades to fire doors, fitting of fire safety signage, as outlined on a fire safety risk assessment completed at the centre in December 2022. While it was evident that significant improvement had been made, some items remained incomplete from the risk assessment for example, locked gates on the external exit routes, and the use of an evacuation lobby as an internal smoking room as outlined in Regulation 23 Governance and Management.

The provider had a number of assurance processes in place in relation to the standard of environmental hygiene. These included cleaning specifications and checklists and color coded cloths to reduce the chance of cross infection.

Surveillance of healthcare associated infection (HCAI) and multi-drug resistant organism (MDRO) colonisation was routinely undertaken and recorded. However a review of acute hospital discharge letters and laboratory reports found that staff had failed to identify a small number of residents that were colonised with Extended Spectrum Beta-Lactamase (ESBL) and Vancomycin-resistant Enterococci (VRE). Findings in the regard are presented under regulation 23.

The provider had completed a Legionella risk assessment and staff confirmed that the control programme had been implemented. Routine testing for Legionella in hot and cold water systems was undertaken to monitor the effectiveness of the controls.

Efforts to integrate Schedule 5 policies and procedures into practice were underpinned by mandatory education and training. An suite of mandatory training was available to all staff in the centre and the majority of staff were up to date with training including, fire safety and infection prevention and control. Inspectors were informed that on-site training facilitated by an infection prevention and control specialist had been scheduled

Regulation 15: Staffing

Through a review of staffing rosters and the observations of inspectors, it was evident that the registered provider had ensured that the number and skill-mix of staff was appropriate, having regard to the needs of residents and the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Efforts to integrate infection prevention and control guidelines into practice were underpinned by mandatory infection prevention and control education and training. A review of training records indicated that all staff were up to date with mandatory infection prevention and control training.

Judgment: Compliant

Regulation 23: Governance and management

Infection prevention and control and antimicrobial stewardship governance arrangements generally ensured the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship however further action is required to be fully compliant. For example, surveillance of MDRO colonisation was undertaken, however records viewed were not accurate. As a result appropriate care plans outlining infection control and antimicrobial stewardship measures were not in place for a small number of residents.

Fire safety audits were found to be ineffective as some fire risks were not identified by the provider which were identified by the inspector for example:

- An internal smoking area was in place with a protected escape route, in a lobby which the ground floor escape route discharged into as well as a secondary exit route for the first floor. This presented a fire risk within the escape route as well as a potential obstruction to the escape route.
- The provider was required to investigate the constant buzzing from an electrical distribution room and provider assurance that any necessary actions were taken to respond to this fire risk. This had not been identified on fire safety audits.
- External security gates on the exits from the garden space at the rear were locked with a combination lock, however, the combination was not readily available, and staff working at the centre did not know the correct

combination. Management committed on the inspection day to ensuring that all staff had access to the combination of this lock, and that a plan would be put in place to put in place a lock which would de-activate on sounding of the fire alarm.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had managed two outbreaks of infection in 2024 to date. A review of notifications found that the person in charge of the designated centre notified the Chief Inspector of outbreaks of any notifiable infection as set out in paragraph 7(1)(e) of Schedule 4 of the regulations, within three working days of their occurrence

Judgment: Compliant

Quality and safety

Overall, inspectors were assured that the quality of service and quality of care received by residents was of a high standard. There was a rights-based approach to care; both staff and management promoted and respected the rights and choices of residents living in the centre. Resident said that they could choose when to get up, how to spend their day and when to rest.

Residents had access to advocacy services and were consulted in relation to the running of the centre. There was an extensive choice of daily activities to suit all tastes and interests. Social outings were encouraged and facilitated. For example; residents, staff and visitors had recently enjoyed the annual BBQ and a resident told inspectors that they were looking forward to an upcoming pilgrimage to Lourdes.

There were no visiting restrictions in place. Signage reminded visitors not to come to the centre if they were showing signs and symptoms of infection.

Residents' nursing care and healthcare needs were met to a good standard. Residents had timely access to general practitioners (GPs), allied health professionals, specialist medical and nursing services including psychiatry of older age

Some positive indicators of quality care were identified on inspection. For example, there was a low prevalence of residents with chronic wounds. The risk of urinary

catheter associated infections were also eliminated as there were no residents with indwelling urinary catheters in the centre.

A sample of care plans and assessments for residents were reviewed. Comprehensive assessments were completed for residents on or before admission to the centre. Care plans based on assessments were completed no later than 48 hours after the resident's admission to the centre and reviewed at intervals not exceeding four months. Overall, the standard of care planning was good and described person centred and evidenced based interventions to meet the assessed needs of residents. However, appropriate information was not recorded in three care plans to effectively guide and direct the care of three residents colonised with MDROs. Finding this this regard are presented under regulation 23.

Some examples of antimicrobial stewardship practice were identified. For example, antibiotic use was monitored and tracked each month. There was a low level of prophylactic antibiotic use within the centre, which is good practice.

Prescribers had access to relevant laboratory results required to support timely decision-making for optimal use of antibiotics. A review of resident files found that clinical samples for culture and sensitivity were sent for laboratory analysis as required. However, the overall antimicrobial stewardship programme needed to be further developed, strengthened and supported in order to progress. Findings in this regard are presented under regulation 6; healthcare.

The National Transfer Document and Health Profile for Residential Care Facilities was used when residents were transferred to acute care. This document contained details of health-care associated infections and colonisation to support sharing of and access to information within and between services.

The location, design and layout of the centre was generally suitable for its stated purpose and met residents' individual and collective needs. However storage facilities required review. For example, there was a lack of appropriate storage space within the centre, resulting in the storage of equipment and supplies in external storage containers which were not registered as part of the designated centre. Some of the external space available for the use of residents were not safe for residents to use. Some external furniture, and garden space was not suitable for use by residents due to damaged furniture, overgrown gardens and steep sides to one pathway. Internally, the centre required some upkeep works, but overall was well maintained in line with the protected nature of the structure. Findings in this regard are presented under regulations 17; premises.

Staff working in the centre had managed two outbreaks of notifiable infections in 2024 to date. Staff spoken with were knowledgeable of the signs and symptoms of infection and knew how and when to report any concerns regarding a resident. Appropriate use of personal protective equipment (PPE) was observed during the course of the inspection. While it may be impossible to prevent all outbreaks, the outbreak reports confirmed that the early identification and careful management of these outbreaks had contained and limited the spread of infection among residents and staff.

Fire safety upgrade works had been undertaken to protect residents from the risk of fire. An extensive programme of upgrades to the fire detection, emergency lighting, fire doors and fire safety signage was evident on this inspection. However, there were still outstanding items which were not fully complete on the day of the inspection. Remaining issues were noted in all of the above categories. This meant that final sign-off was not available for all of these items, to assure inspectors that the works had been completed.

A programme of extensive fire drills was being carried out at the centre, to ensure staff familiarity with all aspects of residents evacuation. Fire drill records indicated that areas where staff required further training was being focused on and resolved after the completion of the drills. This gave staff the knowledge required to complete evacuations effectively in the event of a fire. Further fire safety issues are discussed under regulation 28; Fire Precautions.

Regulation 11: Visits

There were no visiting restrictions in place and visitors were observed coming and going to the centre on the day of inspection. Visitors confirmed that visits were encouraged and facilitated in the centre. Residents were able to meet with visitors in private or in the communal spaces through out the centre.

Judgment: Compliant

Regulation 17: Premises

The registered provider generally provided premises which were appropriate to the number and needs of the residents living there.

Improvement was required on the part of the registered provider, having regard to the needs of the residents of the designated centre, to ensure that the premises conformed to all the matters as set out in Schedule 6. For example:

- There was a lack of appropriate storage space in the centre resulting in the inappropriate storage of clean supplies within a communal bathroom on the first floor and clinical equipment and supplies in an external storage unit which was not part of the designated centre.
- External seating provided for use by residents along pathways, was damaged to a point beyond which they would be safe to use. Some of the wooden benches were rotting, and structurally unsafe and exposed fixings in the timber presented a risk to residents who might inadvertently attempt to use them.

- Some of the garden spaces were not maintained to a level which would be suitable for residents with limited mobility. A section of garden space beside a walkway along a stream was overgrown with shrubbery. The sides of the embankment along the stream was also very steep, with no edge protection. Shrubbery was also encroaching on perimeter pathways which would restrict their use by residetns staff and visitors.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

The inspectors reviewed residents' records and saw that where the resident was temporarily absent from a designated centre, relevant information about the resident was provided to the receiving designated centre or hospital. Upon residents' return to the designated centre, the staff ensured that all relevant information was obtained from the discharge service, hospital and health and social care professionals.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27 infection control and the National Standards for infection prevention and control in community services (2018), however further action is required to be fully compliant. For example;

- Staff reported that they manually decanted the contents of commodes/ bedpans into toilets prior to being placed in the bedpan washer for decontamination. This increased the risk of environmental contamination and the spread of MDRO colonisation.
- Housekeeping staff used the dining room on the ground floor as a thoroughfare to and from the housekeeping room. This posed a risk of cross contamination.
- Equipment was generally clean with some exceptions. For example, a commode basin, a commode chair, a shower seat and some privacy curtains were unclean.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Overall, significant improvement in fire safety was noted at the centre during this inspection. Notwithstanding the works programme completed and underway by the registered provider, some fire safety issues remain and required improvement. For example:

Improvements were required to ensure that adequate precautions were in place against the risk of fire, for example:

- Inspectors observed a exhaust flue from a kerosene boiler that was discharging from the boiler room, to the space under a timber panelled "bridge" to the service courtyard.

Improvements were required on the part of the registered provider to provide adequate means of escape, including emergency lighting, for example:

- Emergency lighting was not adequate on the external escape route. Emergency lighting directional signage was not in place on exit from the first floor dining room. This had been identified as a requirement on the FSRA, however, it was not completed

Improvements were required to ensure that adequate arrangements were in place for detecting and containing fires for example:

- The fire detection system had been upgraded to a category L1 system. There were rooms opening on to the protected escape route which did not have fire detection measures for example, A ground floor sluice room and an under stairs storage space on the ground floor
- Electrical distribution boards, were not contained within fire rated construction.
- Painted over smoke seals and hinges reduce their effectiveness in the event of a fire, and present a risk of fire smoke, and fumes passing through containment lines.
- An under stairs storage space near the ground floor nurses station, was fitted with fire doors, however, the construction within the storage space did not appear to be fire rated. These issues had been identified on the 2022 FSRA, and were not completed.
- A newly fitted fire door into the kitchen on the ground floor, was fitted with a ventilation louver, which is a ventilation grille fitted within the door. This louver would compromise the integrity of the containment of the door.
- A first floor bathroom door did not appear to be a fire rated door. The glass panel above the door was not in place.
- A ground floor store room was fitted with large fire doors. However, the doors were not sealed to the walls behind the door frames. There were service pipes within the room which penetrated the walls, and were not sealed to contain fires.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Overall, the standard of care planning was good and described person centred and evidenced based interventions to meet the assessed needs of residents. Based on a sample of care plans viewed, it was evident to inspectors that validated risk assessments were regularly completed to assess clinical risks such as risk of malnutrition, falls and wounds.

Judgment: Compliant

Regulation 6: Health care

While antibiotic usage was recorded and tracked, there was limited evidence of multidisciplinary targeted antimicrobial stewardship quality improvement initiatives. For example, there was a continued reliance on the use of dipstick urinalysis for assessing evidence of urinary tract infection and effectiveness of antibiotic treatment. This was contrary to national guidelines which advise that inappropriate use of dipstick testing can lead to unnecessary antibiotic prescribing which does not benefit the resident and may cause harm including antibiotic resistance and *Clostridioides difficile* infection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Restrictions during the recent outbreak were proportionate to the risks. Individual residents were cared for in isolation when they were infectious, while visits and social activity between residents continued for the majority of residents during outbreaks with practical precautions in place.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ratoath Manor Nursing Home OSV-0000152

Inspection ID: MON-0044589

Date of inspection: 14/08/2024

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: To ensure compliance the Registered Provider will have the following implemented and actioned as required: • Procedures were reviewed to ensure all residents with known colonisation's of multi drug resistant organisms are alerted to staff on duty. • 'Skip the Dip' campaign was implemented with all staff. • The PIC will audit and review the incidence and prevalence of infections at Ratoath Manor Nursing Home. • We have requested a consultant Fire Engineer to review, and risk assess the internal resident smoking area. • All electrical distribution rooms have been evaluated. An electrical change over panel which was making a buzzing noise is scheduled to be made redundant, this has been confirmed by the electrical contractor executing the work, they assure it does not currently present as a fire risk. • The external security gates are now scheduled to have a magnetic lock fitted, this will release when the fire alarm sounds. • Further to our fire engineer fire risk assessments we added the following internal reviews, that include, fire door assessments on an ongoing basis. Facilities Engineering & Estates Manager and Director of Clinical Quality & Governance along with the PIC, completes a full walkabout review, to include a review of all fire safety checks every 4-6 weeks. A weekly fire alarm test is conducted by triggering various devices. Emergency lighting is inspected on a weekly visual basis as well as its quarterly 3-hour test.	
Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: To ensure compliance the Registered Provider will have the following implemented and actioned as required: • A full review of the storage areas has taken place, designated areas have been determined and staff informed. This will be reviewed by PIC and by the RPR Team to ensure ongoing compliance. • The outdoor seating will be repaired and replaced as required. • The garden spaces have been reviewed and a landscaping plan has commenced. These areas will be maintained to ensure residents, staff and visitors can safely avail of the outside amenities.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: To ensure compliance the Registered Provider will have the following implemented and actioned as required: • Staff education sessions on how to correctly use a bedpan washer have taken place and will continue. The PIC and their management team will oversee and ensure compliance. • A suitable location for housekeeping needs on the ground floor has been established. • The PIC has a detailed cleaning schedule in place and they and their team will oversee and ensure compliance.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Regulation 28: Fire precautions Substantially Compliant Outline how you are going to come into compliance with Regulation 28: Fire precautions: To ensure compliance the Registered Provider will have the following implemented and actioned as required: • The exhaust flue from the boiler room will be diverted to not discharge under the timber panel bridge. • Further to the existing emergency lighting on external escape routes additional emergency lighting has been established. • A new directional sign from the first-floor dining room will be placed.	

• To further increase the detecting and containing of fire additional fire detection will be introduced on the ground floor sluice room and under the stairs.
• All electrical distribution boards will be reviewed and appropriate containment introduced.
• Fire door reviews are completed monthly by our own Technical Service Personnel / Fire Door Carpenter, addresses issues found and reports issues on a monthly basis to PIC and RPR team.
• Understairs storage spaces will be reviewed by our consultant fire engineer with appropriate steps taken as necessary.
• The new fire door in the kitchen will be reviewed by our consultant fire engineer with appropriate steps taken as necessary.
• The first floor bathroom door with the missing glass panel will be reviewed by our consultant fire engineer with appropriate steps taken as necessary.
• A fire stopping contractor will be engaged with to carry out remedial works as required to the Ground Floor store room with pipes.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
To ensure compliance the Registered Provider and PIC will have the following implemented and actioned as required:
• Procedures were reviewed to ensure all residents with known colonisation's of multi drug resistant organisms are alerted to staff on duty.
• 'Skip the Dip' campaign was implemented with all staff.
The PIC will audit and review the incidence and prevalence of infections in the centre

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 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 place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	01/01/2025
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	31/12/2024

	associated infections published by the 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	31/12/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/12/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/12/2024
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued	Substantially Compliant	Yellow	08/10/2024

	by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			