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:	Ballard Lodge
Name of provider:	Dulinaois Limited
Address of centre:	Ballard Lodge NH, Borris Road, Portlaoise, Laois
Type of inspection:	Unannounced
Date of inspection:	20 June 2024
Centre ID:	OSV-0005507
Fieldwork ID:	MON-0043973

About the designated centre

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

Ballard Lodge Nursing Home is a purpose-built, single-storey residential service for older persons. The centre is situated within a short driving distance from Portlaoise town in a rural community setting. The centre provides accommodation for a maximum of 24 male and female residents aged over 18 years of age. Residents' accommodation consists of 24 single bedrooms. Five single bedrooms are fitted with full en-suite facilities and one single bedroom is fitted with an en-suite toilet and wash basin. A wash basin sink is fitted in all other residents' bedrooms. Communal toilet and washing facilities were provider at intervals throughout the centre. Residents had access to a communal sitting room, a dining room and a safe outdoor courtyard. The centre provides long-term, respite and convalescence care for residents with chronic illness, dementia and palliative care needs. The provider employs a staff team of registered nurses, care assistants, maintenance, housekeeping and catering staff to meet residents' needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	24

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 20 June 2024	09:15hrs to 17:30hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Residents living in Ballard Lodge told the inspector that they felt safe living in the centre and that staff were kind and polite to them. The inspector found that residents received a satisfactory standard of person-centred care from a team of staff who knew their individual needs and preferences. Residents expressed high levels of satisfaction with the service, including the provision of meaningful and engaging activities that supported them to develop good social relationships with other residents and staff.

The inspector arrived unannounced to the centre and was met by the person in charge. Following an introductory meeting with the person in charge and persons participating in the management of the centre, the inspector walked through the centre to review the premises and meet with residents and staff. There was a calm, relaxed and homely atmosphere in the centre.

The inspector spent time in the different areas of the centre chatting with residents and observing the quality of staff interactions with residents. Staff interactions were respectful and person-centred. Staff assisted residents in an attentive and supportive manner. Staff who spoke with the inspector demonstrated a good knowledge of residents' individual needs and preferences.

Residents overall feedback was that Ballard Lodge was a pleasant and safe place to life. Residents stated that staff and management were responsive to their needs and they did not have to wait long for their call bells to be answered. Residents added that staff 'would always be checking how you are getting on' so you 'would not need to be using the call bell much'. Residents were complimentary of all the staff in the centre. Residents spoke about the centre, describing it as small but emphasised that this characteristic is what made it feel homely.

Conversations with residents and staff showed that residents liked to guide their own care, engage in activities of their choosing, and were supported by staff to make choices about their daily lives. Residents described how they felt relaxed living in the centre. When asked what made them feel this way, they spoke about how they felt that the environment and atmosphere made them feel like this was their home. Residents told the inspector that they could go to bed at a time of their choosing, and could also have the foods that they like.

Residents were observed walking independently around the centre, spending time alone in their bedroom and chatting to one another in the communal day room. Other residents were observed to spend time in the external garden area.

The provider had carried out some maintenance works and redecoration of the premises. A new communal shower room had been installed to improve the facilities available to residents. Some redecoration of walls had been completed in the reception area and adjoining corridor. Nonetheless, the inspector observed that the

premises was not maintained in a satisfactory state of repair. Doors and walls in bedrooms, communal areas and toilet facilities were visibly damaged and consequently appeared unclean. The inspector observed that communal toilet and shower facilities were used to store equipment such as mobility aids. This impacted on the accessibility of the facilities for residents.

While the communal areas occupied by residents were clean, there were some areas of the premises that were not clean. Floor coverings were in a poor state of repair in numerous areas, and consequently appeared unclean due to a build-up of dirt and debris, particularly where floor transition strips were placed. The inspector observed a lack of facilities to support effective cleaning and infection prevention and control. Cleaning equipment such as mops, and cleaning agents were stored and prepared in an unsuitable external storage building.

The inspector also noted some fire safety concerns on the walk around of the centre. A number of doors that were visibly damaged or not closing correctly. Some essential smoke seals were also damaged, and automatic door closure devices had been disabled. This may compromise the function of the doors to contain the spread of smoke and fire in the event of a fire emergency.

The dining experience was observed to be a social occasion for residents. Residents were complimentary about the food served in the centre, and confirmed that they were always afforded choice. Residents told the inspector that they could also request something that was not on the menu. Staff were observed to engage with residents during meal times and provide discreet assistance and support to residents, if necessary. Residents in all areas had access to snacks and drinks, outside of regular mealtimes.

Residents were engaged in activities throughout the day. There was a detailed activity schedule on display to support residents to choose what activities they would like to participate in. The inspector observed the interactions between residents and staff during activities and found that staff supported residents to enjoy the social aspect of activities. There was a blend of group and one-to-one activities throughout the day. Residents were seen going for walks outside the centre, accompanied by staff. In the afternoon, a lively game of bingo was held. Residents told the inspector that there was always something enjoyable occurring in the centre.

Residents also said that they felt that their feedback was listened to at residents' meetings, and that their rights were respected.

The following sections of this report details the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

This was an unannounced inspection, carried out over one day, by an inspector of social services to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).
- review an application to renew registration of the centre.
- review notifications submitted by the provider in relation to adverse incidents involving residents.

The findings of this inspection were that the provider had an established management structure that was responsible and accountable for the provision of safe and quality care to residents. However, this inspection found that there were aspects of the management systems that were not robust and did not provide adequate assurance that a safe, consistent and quality service was provided. The inspector found that the allocation of resources to improve key aspects of the service, the systems to evaluate and improve the service, and the management oversight of risk, infection prevention and control, the premises, and fire safety required action to ensure compliance with the regulations.

Dulinaoise Limited is the registered provider of this centre. The provider is comprised of two directors who are both persons participating in the management of the centre and are actively involved in the daily operation of the service. One of the directors represents the provider in engagement with the Chief Inspector. Within the centre, the person in charge was supported by a clinical nurse manager, and a team of nursing, health care and support staff.

Lines of accountability and responsibility were not fully defined. While responsibility for key aspects of the service were delegated among the management personnel, it was unclear who was accountability for ensuring known risks and deficits in the service were appropriately managed. For example, while the management personnel were aware of deficits in the maintenance of the premises, there was no evidence that action had been planned or taken to address the deficits.

The provider had management systems in place to monitor, evaluate and improve the quality and safety of the service provided to residents. This included analysis of adverse incidents, and monthly monitoring of quality of care indicators such as residents nutritional care needs. An audit schedule examining key areas including resident assessment and care planning, aspects of resident health care, medication management, infection prevention and control, environmental checks, and fire safety was in place. However, a review of completed audits found that some audits were not effectively used to identify risks and deficits in the service. For example, infection prevention and control audits assessed compliance with the facilities to support effective management of infection in the centre. Each completed audit achieved high levels of compliance, with no quality improvement required, despite there being inadequate facilities to support effective infection prevention and control such as dedicated clinical hand-wash sinks. This impacted on the provider's ability to appropriately identify, monitor and improve the service.

There were systems in place to monitor and respond to risks that may impact on the safety and welfare of residents. The risk management systems were informed by an up-to-date risk management policy. A review of the risk register evidenced that some clinical and environmental risks were assessed and reviewed at quarterly intervals. However, the risk register did not contain some of the known risks in the centre such as risks associated with fire containment regarding the impaired integrity of fire doors. The exclusion of known risks from the centre's active risk register impacted on the centre's ability to appropriately manage risk.

There were systems in place to record and investigate incidents and accidents involving residents. A review of incident records evidenced that incidents were appropriately recorded and investigated. Records showed that immediate action was taken in response to adverse incidents involving residents, and improvement actions were developed following incident analysis to minimise the risk of further adverse incidents occurring.

Record management systems comprised of both electronic and paper-based systems. A review of staffing records found that all staff personnel files contained a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021. However, not all files contained the information specified in Schedule 2 of the regulations. For example, some records did not contain details of relevant qualifications, or references for some staff. Additionally, nursing care records were not consistently maintained in line with the requirements of Schedule 3 of the regulations. For example, records of treatment provided to residents following a fall were not consistently maintained.

All residents were issued with a contract for the provision of services. However, the fee's charged for services not covered by the Nursing Home Support Scheme were not detailed in residents contracts of care, as required by the regulations.

The centre had adequate staffing resources available to ensure resident's care and support needs were met. On the day of the inspection, there were sufficient numbers of qualified staff available to support residents' assessed needs.

Staff had access to training, including refresher training, as part of a continuous professional development programme. A review of staff training records evidenced that all staff had up-to-date training and education in safeguarding of vulnerable people, fire safety, infection prevention and control, and supporting residents living with dementia and responsive behaviour. Staff demonstrated an awareness of their training with regard to the safeguarding of vulnerable people, and the procedure to commence in the event of a fire emergency. However, staff were not appropriately supervised to ensure infection prevention and control practices and procedures were implemented in line with best practice guidance. This was reflected in the poor cleaning and decontamination processes observed during the inspection.

Arrangements were in place to supervise and support staff and there were formal induction and performance appraisal processes in place to support staff.

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

personnel involved in the management of complaints. The complaints procedure was displayed in the centre and residents and staff were aware of the procedure. A review of the records of complaints received by the centre and found that they were appropriately managed, in line with the requirements of the regulations.

Regulation 15: Staffing

On the day of inspection, the staffing numbers and skill mix were appropriate to meet the needs of residents in line with the statement of purpose. There was sufficient nursing staff on duty at all times, and they were supported by a team of health care staff. The staffing compliment also included catering, housekeeping, and management staff.

Judgment: Compliant

Regulation 16: Training and staff development

While all staff had received training in relation to infection prevention and control, the inspector was not assured that staff were appropriately supervised to implement effective infection prevention and control practices. This was evidenced by the poor practice observed with the poor cleaning procedure, decontamination processes, and the management of waste.

Judgment: Substantially compliant

Regulation 21: Records

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

- The nursing record for resident's health and treatment given, following an incident in which a resident suffered harm was not always appropriately documented, and investigated. There was inconsistent documentation that appropriate assessment, treatment and care was delivered to residents following a fall.
- Records required under Schedule 2 of the regulations were not appropriately maintained. Two staff files did not contain two written references or relevant qualifications.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had not ensured there was a clearly defined management structure in place, with clear lines of accountability and responsibility. For example, it was unclear who held overall accountability and responsibility for key aspects of the service that included the management of risk, the oversight of records, fire safety, and infection prevention and control. This resulted in ineffective action being taken to address risks to residents.

The overall governance and management of the centre was not fully effective. Management systems were not sufficiently robust to ensure the service was safe, appropriate, consistent and effectively monitored. For example,

- The systems in place to monitor, evaluate, and improve the quality of the service were not fully effective in identifying deficits and risks in the service. For example, completed audits with regard to the premises, physical environment, and infection prevention and control reflected full-compliance and did not identify aspects of the service that required quality improvement.
- Risk management systems were not effectively implemented. The centre's risk register did not contain known risks in the centre such as the risks associated with the impaired integrity of fire doors awaiting remedial action. Additionally, risk assessments were not utilised to underpin decision making as required by the centre's risk management policy. For example, an appropriate risk assessment had not been completed in relation to automatic door closure devices prior to discontinuing their use.
- Supervision of aspects of care, particularly in relation to maintenance and cleaning was not effective and negatively impacted on the quality of the care environment.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of residents contracts were reviewed and did not comply with the requirements of the regulations.

Some residents contracts for the provision of services did not contain details of the fees to be charged for all services provided to residents. For example, the contracts did not contain details of the fee's for additional services charged to residents that are not covered under the Nursing Home Support Scheme.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had an accessible and effective procedure in place for dealing with complaints. The complaints procedure detailed the personnel responsible for the management of complaints and specified the time-frame for the resolution of complaints.

Arrangements were in place to support a person making a complaint to understand the complaints procedure, and additional supports and services were made available to assist with the making of a complaint.

Judgment: Compliant

Quality and safety

Overall, residents' health and social care needs were maintained by a satisfactory standard of evidenced-based care and support from a team of staff who knew their individual needs and preferences. Residents were satisfied with their access to health care and reported feeling safe and content living in the centre. Nonetheless, there were aspects of the premises and associated facilities that were in a poor state of repair and did not support effective infection prevention and control management. A review of fire safety systems found that residents were not fully protected from the risk of fire.

A review of fire precautions found that arrangements were in place for the testing and maintenance of the fire alarm system, emergency lighting and fire-fighting equipment. Residents personal emergency evacuation plans (PEEP) were up-to-date to ensure the safe and timely evacuation of residents in the event of a fire emergency. Staff detailed their participation in simulated evacuation drills that included evacuation of the largest compartment using minimum staff levels and described the procedure of horizontal evacuation in the centre. The fire register for the centre included in-house maintenance checks, and these were completed by the staff. However, some of the records reviewed did not identify the deficits in the integrity of some fire doors. While the provider had previously carried out remedial works to some fire doors, a number of bedroom and corridor doors contained significant gaps between the bottom of the door and the floor, thus posing a risk to containment measures in the event of a fire. In recognition of deficits in the systems of fire containment, the provider had engaged the services of a competent person to comprehensively assess the fire safety systems in the centre.

The provider had taken some action with regard to the maintenance of the premises. An additional communal shower room had been installed, and redecoration of the reception area had been completed. However, there were parts of the premises that did not meet the care and safety needs of the residents. There were numerous areas of the premises such as bedrooms, bathroom facilities, and communal areas that were not maintained in a satisfactory state of repair. Walls were visibly damaged and not suitably decorated. Facilities in use by residents, such as private and communal toilet facilities, were also poorly maintained.

The centre was found to be visibly clean in areas occupied by residents such as the communal dayroom and dining room, with the exception of areas of the centre where deficits in the premises, such as impaired floor coverings, compromised effective cleaning. Staff spoken with were knowledgeable regarding the established cleaning procedure in the centre. However, the cleaning procedure was not in line with best-practice guidance to support effective infection prevention and control. The inspector observed poor practice in relation to the management of waste and toileting aids, and inappropriate storage of equipment in communal showers. Additionally, there was no dedicated room for the storage or preparation of cleaning agents or equipment, and there were an inadequate amount of clinical hand wash sinks in the centre.

A sample of residents' assessment and care plans were reviewed. Residents' needs were assessed on admission to the centre through validated assessment tools in conjunction with information gathered from the residents and, where appropriate, their relative. The information was used to develop care plans that provided person-centred information on the current care needs of the residents.

The needs of residents, who had difficulty communicating, were identified and staff supported residents to communicate their views and needs directly. Residents who required supportive equipment to communicate were provided with such equipment. Residents care plans reflected their communication needs and preferences.

A review of residents' records found that residents had access to a general practitioner (GP) of their choice, as requested or required. Arrangements were in place for residents to access the expertise of health and social care professionals for further assessment. The recommendations of health and social care professionals was observed to be implemented, and reviewed frequently to ensure the care plan was effective.

Resident's nutritional care needs were appropriately assessed to inform nutritional care plans. These care plans detailed residents' dietary requirements, the frequency of monitoring of residents weights, and the level of assistance each resident required during meal-times. There were appropriate referral pathways in place for the assessment of residents identified as being at risk of malnutrition.

Residents rights were promoted in the centre. Residents were free to exercise choice in how they spent their day. Activities were observed to be provided by dedicated activities staff, with the support of health care staff. Residents told the inspector that they were satisfied with the activities on offer and enjoyed the social

aspect of group activities. There were opportunities for the residents to meet with the management team and provide feedback on the quality of the service.

Visiting was observed to be unrestricted, and residents could receive visitors in either their private accommodation or a communal areas, if they wished.

Regulation 10: Communication difficulties

The registered provider had arrangements in place to ensure residents who experienced communications difficulties were appropriately assessed, and supported to enable residents to make informed choices and decisions.

Staff demonstrated an appropriate knowledge of each residents communications needs, and the aids required by some residents to support their needs, in line with the residents individual care plan.

Judgment: Compliant

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 17: Premises

There were areas of the premises that were in a poor state of repair, both internally and externally. For example,

- Walls along corridors and in bedrooms were visibly stained, chipped, cracked, and damaged.
- Multiple doors and skirting were scuffed, chipped and damaged.
- Some bedroom doors did not have functioning locks to support residents to secure their bedroom if they wished.
- Floor coverings in some areas were not appropriately maintained. For example, the floor covering in a communal shower had come away from the wall, while the floor lining outside a communal shower was visibly damaged. Additionally, metal floor transition strips were dislodged in a number of areas creating a trip hazard.

- There were broken tiles covering a drain pipe in the laundry, and glass was observed to be cracked in the window of a staff toilet.
- Storage facilities were inadequate and resulted in the inappropriate storage of resident's personal care items in communal toilets. For example, a basin in a communal toilet contained multiple bottles of shampoo, shower gel and sponges.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were provided with wholesome and nutritious food choices for their meals and snacks, and refreshments were made available at the residents request. Menus were developed in consideration with residents individual likes, preferences and, where necessary, their specific dietary or therapeutic diet requirements, as detailed in the resident's care plan.

Daily menus were displayed in suitable formats, and in appropriate locations so that residents knew what was available at meal-times. There was adequate numbers of staff available to assist residents with their meals.

There were adequate arrangements in place to monitor residents at risk of malnutrition or dehydration. This included frequent weights, maintaining a food intake monitoring chart, and timely referral to dietetic, and speech and language services.

Judgment: Compliant

Regulation 27: Infection control

Infection prevention and control procedures were not consistent with the National Standards for Infection Prevention and Control (IPC) in community settings published by HIQA. This was evidenced by;

- Poor oversight of the cleaning procedure and the quality of environmental hygiene. For example, hand sanitiser dispensers were visibly unclean throughout the centre. There were poorly maintained areas of the premises that impacted on effective cleaning where floors and surfaces of furniture were damaged.
- Staff were using cleaning and disinfectant processes that were not in line with best practice guidelines. For example, cleaning mops were shared between a number of bedrooms before being changed. This posed a risk of cross infection.

The environment and equipment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- The centre did not have a dedicated room for the storage of cleaning equipment or preparation of cleaning chemicals. Equipment and chemical were stored in an external general storage building with no facilities to dispose of waste water.
- Facilities to support effective hand hygiene were not appropriate for the care environment. With the exception of sinks within communal toilets, there were no clinical hand was sinks available for staff use. Sinks within residents rooms were dual purpose used by both residents and staff. This practice increased the risk of cross infection.
- Facilities to support the safe disposal of commode and urinal contents within the sluice room were not in place. This created a risk of cross infection.
- Support equipment used by residents were not appropriately stored. For example, urinals were observed on the floor of residents' bedrooms.

Judgment: Not compliant

Regulation 28: Fire precautions

Arrangements for the containment of fire were not adequate. For example;

- The deficits to fire doors presented a risk to the fire containment of the centre. A number of fire doors were observed to be impaired. For example, some did not close fully while other doors were stuck on the floor when opened. There were missing heat and smoke seals and gaps observed between some doors. This may compromise the function of the fire doors to contain the spread of smoke and fire.
- A number of automatic door closures had been disabled or were not functioning correctly. While mitigating actions were in place to ensure doors were closed in the event of a fire emergency, there was no time-bound action plan in place to address the risks.

Adequate arrangements had not been made for detecting fires.

- Buildings to the rear of the main building were not provided with fire detection. This included storage areas used to store cleaning equipment and chemicals, resident aids and appliances. This meant that there would be no warning if a fire started in that area.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Residents' care plans were developed following assessment of need using validated assessment tools. Care plans were observed to be person-centred, and updated at regular intervals.

Judgment: Compliant

Regulation 6: Health care

Residents had access to appropriate health and social care professional support to meet their needs. Residents had a choice of general practitioner (GP) who attended the centre, as required or requested.

Services, such as physiotherapy, were available to residents weekly and services such as tissue viability nursing expertise, speech and language and dietetics were available through a system of referral.

Judgment: Compliant

Regulation 9: Residents' rights

Staff demonstrated an understanding of residents' rights and supported residents to exercise their rights and choice, and the ethos of care was person-centred. Residents' choice was respected and facilitated in the centre.

There were facilities for residents to participate in a variety of activities such as art and crafts, bingo, exercise classes and live music events. Residents complimented the provision of activities in the centre and the social aspect of the activities on offer.

Residents attended regular meetings and contributed to the organisation of the service. Residents confirmed that their feedback was used to improve the quality of the service they received.

Residents were informed of independent advocacy services and were supported to access those services as required or requested.

A variety of daily national and local newspapers were available to residents. Religious services were facilitated regularly.

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	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	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 9: Residents' rights	Compliant

Compliance Plan for Ballard Lodge OSV-0005507

Inspection ID: MON-0043973

Date of inspection: 20/06/2024

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Effective cleaning, decontamination and management of waste procedures and processes have been reviewed & updated, discussed with appropriate staff and are currently being implemented. This is being managed and overseen by the staff nurse on duty & the Person in Charge.

Staff are supervised by the nurse on duty to ensure appropriate processes & procedures are implemented and completed in line with best practice guidance.

Spot checks are completed to ensure cleaning supports effective infection prevention & control management. The staff nurse on duty is responsible for the oversight of effective infection prevention and control of the centre, supported by the PIC.

Infection prevention and control audits are completed regularly with associated action plans that link directly with the centre's quality improvement plan.

A meeting was held with all staff on the 11/07/2024 and further in-service training has been organized for effective infection control management.

A new Sluice machine has been ordered which will ensure appropriate management of waste products from commodes and urinals and prevent any risk of cross contamination. Staff will be trained in safe usage and managing waste products on arrival of machine.

A new pre-soaked flat top mop system & trolley was delivered in July 2024. Education for use of this new system was given to all staff on the 26/07/2024.

The PIC will oversee the implementation process with new cleaning systems and procedures to ensure staff are completing all in line with best practice guidance.

The PIC and Provider are responsible for the monitoring of the systems and processes.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Staff involved and responsible for resident safety and care have been informed of the essential details that must be recorded in residents' files relating to recording of health treatment. These are to include the process following an incident that involves a resident, especially which has resulted in harm, and the level of information to be recorded to reflect the actual assessment, care and treatment that was received.

Staff have also received further support in the use of the electronic record system to record appropriately and maintain these records to ensure accurate and up to date information reflecting actual care received. This was completed on 24th & 25th June 2024, & included documentation of incident reports & use of forms.
Staff have also been informed of the importance of maintaining consistent and adequate documentation for all resident records and ensuring all resident care plans and assessments are reviewed and updated following an incident.
A detailed investigation will be completed following every incident regardless of severity with details of the investigation & outcome documented.
All falls are analysed on a monthly basis to identify common trends, learning outcomes and effective corrective and preventative actions.

All falls are audited on a quarterly basis with an associated action plan which links directly with the centre's quality improvement plan to ensure the PIC and Persons participating in management have good governance and oversight of the incident management process. Resident assessments, risk assessments, care plans and progress notes will be audited on a quarterly basis with an updated audit system being implemented. This, in conjunction with the analysis, will ensure all required processes and documentation are being managed and monitored effectively for good oversight and governance.

Staff files are monitored regularly to ensure the requirements under Schedule 2 are being complied with. This process is overseen by the PIC and the Provider to ensure good governance of staff records.
A recruitment checklist is being implemented for staff files to ensure all required documentation is received and filed appropriately for accurate and up to date records.

All nurses' PIN records & qualifications are available in the centre. All required information under Schedule 2 for staff files is now in place in each staff file and available within the centre. The PIC and the Provider are responsible for the governance of the systems and processes.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
There is now a clearly defined management structure in place which identifies responsibility and accountability for all required areas, including management of risk, oversight of records and fire safety. This will ensure that any actions identified are appropriately completed to address risks for residents.
Management systems have been reviewed. There are now appropriate systems in place for governance and oversight of audit management process & risk management process. Relevant risk assessments are completed to inform decisions related to health, safety and risk of residents and supervision to ensure high quality and safety in care, specifically relating to maintenance and cleaning. The PIC will oversee the monitoring of the systems and processes. The PIC & the Provider are responsible for the governance of systems and processes.

A monthly & quarterly audit system is currently being implemented with associated action plans which will link with the centre's quality improvement plan. Also, an appropriate analysis template is being implemented that will identify common tends, learning outcomes, corrective and preventative actions to ensure effective risk management systems. Any actions from the analysis will be included in the centre's quality improvement plan.
Risk assessments will be completed when any decision is being considered that relates to the health & safety of the centre and the residents. Appropriate controls will be included in the risk assessment and on the centre's risk register. This will ensure the provider has regular, accurate and up to date information relating to the overall governance and management of the centre and will review all plans and records during site visits. The risk register is currently being reviewed and updated to ensure all risks identified are included and appropriately risk rated and that the document is accessible for all staff.

The PIC has responsibility for the governance and management of the centre, in conjunction with the Provider who has responsibility for the governance of the systems and processes.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
Each resident's contract of care now includes specific details of charges for additional services that are not covered by the Nursing Home Support Scheme – families/representatives and residents are made aware of these charges through discussion on admission and when signing the contract of care. The

resident/family/representative maintain a copy and the nursing home keeps a copy in the resident's file. Any changes or additions to charges are discussed with residents/families/representatives prior to implementation & a record is maintained of these discussions. The PIC is responsible for the governance of the process and monitoring of the system.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A detailed plan for maintenance, repair and upkeep of the premises/centre is being developed. This will be managed and monitored through regular health & safety walkabouts that include records of the state of repairs and cleanliness to ensure good quality environmental hygiene for all aspects of the centre. It will include dates for completion discussed with maintenance staff.

Included in the maintenance plan are-
- Repair and painting of walls of corridors and bedrooms that are visibly stained, chipped, cracked & damaged
- Doors and skirting that are scuffed, chipped and damaged
- Bedroom doors that locks are not currently functioning to be replaced
- Floor coverings that require maintenance, communal shower area
- Floor lining damaged outside shower
- Metal floor transition strip that has been dislodged
- Broken tiles around drainpipe in the laundry
- Glass cracked in staff toilet
- Inadequate storage of resident's personal care items

A lot of these have been completed to date, some are in the process of being completed – all of which are identified in the plan.

Updated to date –
- Floor coverings in all areas identified are currently being replaced
- Broken tiles removed from outside drain and new drain covering in place
- Cracked glass in staff toilet has been replaced
- Shelves in communal bathrooms have been removed and all resident's personal care items are now stored in resident' individual bedrooms
- Metal floor transition strips have been replaced

The PIC in conjunction with the Provider has responsibility for the oversight of the maintenance plan, this is discussed during site visits with the provider when the plan is reviewed and updated to ensure care and safety needs of all residents are met and supports effective infection prevention and control management.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

The process and oversight of effective cleaning procedures and environmental hygiene has been reviewed and new procedures with monitoring implemented. This is overseen by the nurse on duty and all staff have been informed of the appropriate process and procedure and spot checks will be completed.

There is a maintenance plan being developed to address all areas for maintenance and upkeep of the premises, this is being managed by the PIC in conjunction with the Provider. Ongoing monitoring of the health and safety and environmental hygiene has been implemented and will ensure the safety of residents.

As part of the maintenance plan the hand sanitisers that required change have all been changed and monitoring implemented to ensure all are kept clean & in good state of repair.

Floors and surfaces of furniture that are damaged have been included on the maintenance plan and some have already been repaired This will ensure effective cleaning of the centre & provide a safe home for the residents. The PIC and Provider have responsibility for the governance and management oversight of the plan, it will be discussed during Provider meetings with the PIC.

The PIC is responsible for the oversight of effective infection prevention and control of the centre, supported by the Provider. Infection prevention and control audits are completed regularly with associated action plans that link directly with the centre's quality improvement plan.

A meeting was held with all staff on the 11/07/2024 and further in-service training has been organized for effective infection control management.

A new Sluice machine has been ordered which will ensure appropriate management of waste products from commodes and urinals and prevent any risk of cross contamination. Staff will be trained in safe usage and managing waste products on arrival of the machine.

A new pre-soaked flat top mop system & trolley was delivered in July 2024. Education for use of this new system was provided by the 26/07/2024. Staff have been informed, as part of the new procedure, that cleaning mops must not be shared between bedrooms and to be changed after each resident's bedroom usage. This will be monitored by the nurse on duty & PIC.

The nurse on duty will oversee the implementation process with new cleaning systems and procedures to ensure staff are completing all in line with best practice guidance. The PIC and Provider are responsible for the monitoring of the systems and processes.

A dedicated room for storage of cleaning trolley and products to be sourced and

connected to minimise the risk of transmitting health care infections by providing facilities for disposal of wastewater safely.

Clinical hand wash sinks will be included in the maintenance plan to support effective hand hygiene for staff and to reduce the risk of cross infection from current dual-purpose use of sinks in residents' rooms by staff.

Support equipment used by residents will be appropriately stored, holders for urinals have been sourced and implemented for use by residents in their bedrooms.

Regular walkabouts will include monitoring of health & safety, state of repair, cleanliness and environmental hygiene for the centre, the PIC is responsible for this process and it is monitored by the Nurse on duty on a daily basis.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Arrangements are being implemented to ensure all deficits of fire doors, seals and closures are addressed, gaps are being repaired and new heat & smoke seals completed, automatic door closures are being individually checked to ensure functioning appropriately and risk assessments completed for any decisions to disable the automatic closure of any fire doors.
This will be included in the risk register for the centre.
Actions that have been implemented to ensure fire doors close in the event of a fire have now been reviewed and timeframes with expected outcomes included in action plan.
Any impaired fire doors will be repaired/changed as required under the guidance of the fire engineer.
All staff have been informed of doors identified and they will ensure that doors are kept closed.

A Fire engineer has been engaged by the Provider to inspect the premises and will be working with the builder to implement and oversee all required changes, this will be monitored by the PIC and the provider as part of the centre's maintenance plan.

The building to the rear of the main building will be connected to the fire system to ensure there are adequate arrangements in place to detect fire and provide sufficient warning should a fire start there.
The PIC and the provider are responsible for the safety of the premises and the residents and have governance over all the appropriate systems and processes to support this.

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	29/08/2024
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.	Not Compliant	Orange	30/11/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	15/07/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management	Substantially Compliant	Yellow	30/11/2024

	structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
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	30/11/2024
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Substantially Compliant	Yellow	15/07/2024
Regulation 24(2)(d)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of any other service of which the resident may choose to avail but which is not included in the Nursing Homes	Substantially Compliant	Yellow	15/07/2024

	Support Scheme or to which the resident is not entitled under any other health entitlement.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/11/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2024
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Substantially Compliant	Yellow	30/11/2024