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:	Moorehall Lodge Balbriggan
Name of provider:	MHLB Limited
Address of centre:	Bath Road, Balbriggan, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	27 February 2024
Centre ID:	OSV-0008302
Fieldwork ID:	MON-0042289

About the designated centre

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

The following information has been submitted by the registered provider and describes the service they provide: Moorehall Lodge Balbriggan is a purpose built facility which is located on the coastline and is within a short walking distance of many of the local shops, banks, churches and other facilities. The centre is laid out over four floors and can accommodate 102 residents with 94 single and four twin rooms located on the ground, first and second floor of the centre. There are no bedrooms on the third floor, but locates administration offices, staff facilities, a hairdressing salon, a reflective room and large family room overlooking the sea. The centre's residents also benefit from a large enclosed garden with unrestricted access. The centre is part of the Virtue integrated Elder Care Group, and aims to provide long term, respite, transitional and convalescent residential care for resident in a homely environment that promotes privacy, dignity and choice within a building that is safe and clean, comfortable and welcoming. Each floor benefits from living rooms, lounge areas, break out spaces and dining facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	66

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 27 February 2024	08:30hrs to 17:00hrs	Geraldine Flannery	Lead
Tuesday 27 February 2024	08:30hrs to 17:00hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

Inspectors found that in general, staff were working towards improving the quality of life and promote the rights and choices of residents in the centre. Inspectors met with many residents during the inspection, and spoke with approximately 20 per cent of residents and 10 per cent of visitors in more detail to gain insight into their experience of living in Moorehall Lodge Balbriggan.

Overall, feedback was complimentary, and many residents spoken with, expressed satisfaction about the standard of care provided. Residents reported that overall, the service was good and that they were happy living in the centre. Relatives were mostly very positive about the way their loved one was taken care of and spoke about the great efforts that were made by staff 'to ensure they had everything they needed'. Notwithstanding the positive feedback, some relatives expressed concern relating to the care of residents, especially when being cared for by non regular staff who were not familiar with the residents' needs. Also, a number of visitors described that at times they found it difficult to verbally communicate with some staff about their relatives care needs due to a language barrier.

Inspectors highlighted these concerns to management on the day of inspection. Inspectors were told that overall the reliance on agency staff had decreased over the past few months. However, on occasions due to staff vacancies, agency staff were employed to care for residents. Management were aware of the concerns regarding communication barriers and were working with staff to provide them with the necessary supports. Inspectors saw that effective communication training for staff was ongoing.

Throughout the morning of the inspection there was a busy atmosphere in the centre. Some residents were observed enjoying each other's company in the communal dayrooms, while other residents were observed sitting in their bedroom waiting for assistance from staff. Staff were observed busily attending to residents requests for assistance. The residents described how staff supported them to select their clothing, maintain their individual style and appearance.

The premises was designed and laid out to meet the needs of the residents. It comprised of four floors with sufficient private and communal space for residents to relax in. A number of stairs and lifts were available to support movement between floors.

The centre was bright and well maintained throughout. Resident bedrooms were found to be clean and organised. Inspectors observed that many residents had pictures, photographs and other personal items displayed in their bedroom, which gave a homely atmosphere. Residents who spoke with inspectors were happy with the size, layout and décor of their rooms. An enclosed courtyard was easily accessible by the residents. It had safe wide paths for residents to safely mobilise

along and view the planting.

Residents had access to television, radio, newspapers and books. There was an activity schedule in place that reflected the activities taking place while the inspectors were present. The centre's hairdresser was in attendance on the day of inspection. The hairdressing room was well equipped and residents were seen enjoying this as a social occasion. Advocacy services were available to all residents that requested them.

The inspectors observed the lunchtime experience and found that the meals provided appeared appetising. Residents were complimentary about the food served and confirmed that they were always afforded choice. The menu was displayed and the tables were laid out with cutlery and condiments for the residents to access easily. Inspectors observed adequate staff offering encouragement and assistance to residents.

Laundry facilities were available on site. Residents informed the inspectors that they sent their laundry for washing and received it back clean and fresh. Clothing was labelled with the resident's name to prevent loss.

The inspectors observed visitors coming to and from the centre throughout the day. They visited residents in their bedrooms and in the day rooms. Visitors confirmed they were welcomed to the home at any time. One visitor expressed dissatisfaction at the length of time it took to gain entry and exit to the centre at the weekends. They informed the inspectors that there was no receptionist at weekends and would have to wait for other staff to open the door coming in and going out. Inspectors highlighted this to management on the day of inspection and were informed that they were currently reviewing access to and from the centre out-of-hours.

Inspectors identified some examples of good practice in the prevention and control of infection. Staff spoken with were knowledgeable of the signs and symptoms of infection and knew how and when to report any concerns regarding a resident.

Inspectors observed that the provider had a number of effective assurance processes in place in relation to the standard of environmental hygiene. These included cleaning specifications and checklists, flat mops and colour coded cloths to reduce the risk of cross infection. The cleaning carts were clean and equipped with a locked compartment for the storage of chemicals. They had a physical partition between clean mop heads and soiled cloths.

All areas of the centre were included on the daily cleaning schedule. A deep cleaning schedule had been introduced whereby all resident bedrooms received a deep clean each month.

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

Capacity and capability

This inspection took place over one day by two inspectors of social services. The findings from this inspection were that action was required in the areas of governance and management, assessment and care planning, training and staff development, records and infection prevention and control to support the provision of a safe and quality service to residents.

This was an unannounced inspection. The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 (as amended). In preparing for this inspection, the inspectors reviewed actions from the last inspection, the information provided by the provider and the person in charge and unsolicited information received by the Chief Inspector of Social Services.

Although this inspection found that there were governance and management structures in place, improved oversight by the provider was necessary to ensure the effective and safe delivery of care in accordance with the centre's statement of purpose. There had been frequent changes to the person in charge which impacted on the overall stability of the governance and management arrangements in the designated centre. The Chief Inspector of Social Services had been notified of a second change of the person in charge within one year.

The person in charge appointed in April 2023 had resigned. The current person in charge commenced at the end of November 2023. They facilitated the inspection in an open manner and demonstrated good knowledge regarding their role and responsibility. They were articulate regarding governance and management of the service, resident care and well-being and quality improvement initiative. They were striving to establish a systematic approach of overseeing the standard and quality of care being provided. This approach aimed to give the management team an oversight of all areas of practice. However, for some areas of practice such as nursing documentation, its oversight to date was not effective.

The registered provider was MHLB Limited. The nursing home was part of a larger nursing home group Virtue. A senior management team was in place to provide managerial support at group level. The person in charge was responsible for the local day to day operations in the centre. Three clinical nurse managers (CNM) provided support to the person in charge. The assistant director of nursing (ADON) post had been vacant since November 2023, however the inspectors were informed that the position was filled and due to start within six weeks. Staff members who spoke with the inspectors confirmed that the person-in-charge was supportive of their individual roles.

The annual review of the quality and safety of the service for 2023 and quality improvement plan for 2024 was unavailable for review on the day of inspection. Inspectors requested a copy to be submitted to the Chief Inspector following the

inspection.

There were adequate staffing resources to ensure the effective delivery of care in accordance with the statement of purpose, and to meet residents' individual needs. The training matrix reviewed did not provide a clear overview of staff training. Management informed inspectors that they were currently in the process of changing systems. The available training matrix demonstrated that some staff did not have attendance dates documented for some training, this will be further discussed under Regulation 16.

Records reviewed on the day of inspection were stored securely within the designated centre. However, due to a lack of storage within the centre some resident records were stored in an off-site location, this will be further discussed under Regulation 21: Records.

Overall, the documents reviewed met the legislative requirements including contracts of care, complaints procedure and insurance. However, the information for residents did not fully meet the legislative requirements and will be discussed under the relevant regulation.

Regulation 14: Persons in charge

The person in charge was a registered nurse and worked full time in the centre. They demonstrated a good knowledge of their responsibility in promoting a rights-based approach to care and was very active in the governance and overall day-to-day management of the centre.

Judgment: Compliant

Regulation 15: Staffing

There was sufficient staff on duty to meet the needs of the 66 residents taking into account the size and layout of the designated centre. There was at least one registered nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix available on the day of the inspection did not provide a clear overview of staff training. There were gaps with no attendance dates documented

for some staff. For example, 20% of staff members did not have any attendance dates documented for manual handling and 6% of staff did not have attendance dates documented for safeguarding of vulnerable residents.

The inspectors requested that assurances were submitted to the Chief Inspector following the inspection. The training matrix submitted one day after the inspection demonstrated that the provider had a training schedule in place. It demonstrated that 100% of staff had manual handling and on-line safeguarding training, 59% of staff had attended safeguarding workshop, 98% of staff had fire training, 64% of staff had effective communication training. There were scheduled planned dates for all outstanding training in the weeks following the inspection.

Judgment: Substantially compliant

Regulation 21: Records

On the morning of the inspection, inspectors provided a list of documents to be made available for review. However, inspectors experienced significant delays in obtaining some of the requested documents. The inspectors requested that documents be submitted to the Chief Inspector following the inspection, including training matrix and copy of the annual review for 2023 including quality improvement plan for 2024.

Records of residents who had ceased to reside in the designated centre, were not retained in the designated centre for a period of not less than 7 years. This resulted in some Schedule 3 records not being readily available for inspection.

Judgment: Substantially compliant

Regulation 22: Insurance

There was an appropriate contract of insurance in place that protected residents' against injury and against other risks, including loss or damage to their property.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place did not ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example;

- The management systems in place to address previously identified gaps in care planning documentation were not effective, as outlined under Regulation 5; Individual assessment and care plan.
- The annual review of the quality and safety of care delivered to residents for 2023 was unavailable on the day of inspection.
- The oversight of storage arrangements required strengthening. For example; effective information governance systems were not in place to ensure appropriate storage and availability of all records set out in Schedule 3 for a period of not less than 7 years.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed four contracts of care between the resident and the registered provider and saw that they clearly set out the terms and conditions of the resident's residency in the centre and any additional fees. The contract also clearly stated the bedroom to be occupied, and the occupancy number of the room.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was on display in a prominent position within the centre. The complaints policy and procedure identified the person to deal with the complaints and outlined the complaints process. It included a review process should the complainant be dissatisfied with the outcome of the complaints process.

Judgment: Compliant

Quality and safety

Overall, inspectors found that residents were supported to have a good quality of life which was respectful of their wishes and choices. However, action was required to ensure the ongoing quality and safety of the service was closely monitored, as outlined under the relevant regulations.

Residents' care plans and daily nursing notes were recorded on an electronic documentation system. An assessment of residents health and social care needs was

completed on admission and ensured that residents' individual care and support needs were being identified and could be met. However, the inspectors reviewed a sample of residents' care plans and found gaps in the updating of care records which meant that key information was not made available to aid a comprehensive review of residents care. This will be discussed further under Regulation 5; Individual assessment and care planning.

There were arrangements in place to safeguard residents from abuse. All staff spoken with were clear about their role in protecting residents from abuse and of the procedures for reporting concerns. The registered provider did not act as a pension-agent for residents at the time of inspection. Residents were supported where possible to manage their own accounts and property while also ensuring that safeguards were in place to protect them and prevent financial abuse. Visiting was observed to be unrestricted, and residents could receive visitors in either their private accommodation or a designated visitor area, if they wished.

A residents' guide was available and included a summary of services available, the complaints procedure, visiting arrangements and terms and conditions of residency in the nursing home. However, it did not fully comply with the regulations and will be outlined under Regulation 20; Information for residents.

A risk management policy and risk register was available and reviewed regularly. A risk register included potential risks identified in the centre and the management of risks such as abuse, unexplained absence and accidental injury.

Inspectors identified some examples of good practice in the prevention and control of infection. For example, waste, used laundry and linen was segregated in line with national guidelines. Staff were observed to have the correct use of personal protective equipment (PPE). However, staff did not have access to safety engineered sharps devices and will be discussed further under Regulation 27. There was clear identification of resident's that were colonised with a multi drug resistant organisms (MDRO) and care plans had sufficient detail to enable person centred care and safe practices.

The provider had implemented a number of antimicrobial stewardship measures. The volume of antibiotic use was monitored each month. This data was analysed and used to inform practice. Staff were aware of the national "Skip the Dip" initiative to reduce the use of urine dipsticks but no posters or signage was seen on the day of inspection.

Inspectors observed barriers to effective hand hygiene practice. For example, there were insufficient numbers of alcohol hand gel dispensers. A ratio of one alcohol hand gel dispenser to four resident beds was observed. National guidelines recommend that alcohol hand gel is readily available at point of care to promote effective hand hygiene. There was no easy access to hand hygiene sinks, staff reported using the communal bathroom or residents sink to wash their hands if they were visibly soiled.

The ancillary facilities in the centre did not fully support good infection prevention and control practices for example the sluice and medication room were very small.

The medication room had limited storage facilities which meant that boxes of sterile products were stored on top of each other on a high shelf that meant cleaning of surfaces was difficult and this may cause more issues when the centre is full to capacity; this is a repeat finding from an inspection in 2022. The sluice was small in size and did not have a sink to clean dirty equipment. The hand hygiene sink in the sluice was very small and did not meet the specifications of a clinical hand hygiene sink but it was clean and in good repair.

Regulation 11: Visits

The registered provider had arrangements in place for residents' to receive visitors. Visits were not restricted and there was adequate space for residents to meet their visitors in areas other than their bedrooms if they wished.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were facilitated to have access to and retain control over their personal property, possessions and finances. They had access to adequate lockable space to store and maintain personal possessions. Clothes were laundered regularly and promptly returned.

Judgment: Compliant

Regulation 20: Information for residents

Information on advocacy services was not outlined in the residents' guide.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a comprehensive risk management policy and risk register in place which assessed all identified risks (potential and actual), and outlined the measures and actions in place to mitigate and control such risks.

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;

- Alcohol hand gel was not readily available at point of care for staff to sanitise their hands this reduces the spread of infection between residents.
- Easy access to hand washing facilities was not available for staff to wash their hands if visibly soiled this reduces the spread of infection between residents.
- The needles used for injections and drawing up medication lacked safety devices. This omission increases the risk of needle stick injuries which may leave staff exposed to blood borne viruses.
- The medication room on the first floor was too small to prepare medication that may need two nurses to assist. The storage in this room was not enough to hold the supplies of dressings and sterile products hence they were stacked on top of each other, overtime this may lead to contamination of sterile products if the area cannot be cleaned properly.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Staff were not documenting records contemporaneously and accurately in line with good standards of record-keeping. This is a repeat finding from the previous inspection. For example:

- While nutritional assessments had been completed on residents with weight loss, the care plans were not always updated to reflect the changes in the weight management plan. A care plan was not updated to reflect the current Malnutrition Universal Screening Tool (MUST) score on resident that was losing weight. A resident with MUST score of 2 was documented as 0 on the care plan. A record from a dietitian which was relevant to direct residents care was located below historical entries that were no longer relevant.
- Recording of information in relation to care offered to residents or refused was not completed in a consistent manner. This resulted in a failing to provide a complex overview of the resident's day spent, the current condition of the resident or the plan for care.

The compliance plan submitted to the Chief Inspector after the last inspection, gave assurances that training would be provided to staff on the importance of ensuring that daily documentation was reflective of residents current needs and included in

the documentation audit tool. However, the audit tool was ineffective as the gaps in the documentation had not been identified and rectified prior to the inspection.

Judgment: Not compliant

Regulation 8: Protection

All reasonable measures were in place to protect residents from abuse. A safeguarding policy detailed the roles and responsibilities and appropriate steps for staff to take should a concern arise. The inspectors reviewed a sample of staff files and all files reviewed had obtained Garda vetting prior to commencing employment.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Moorehall Lodge Balbriggan OSV-0008302

Inspection ID: MON-0042289

Date of inspection: 27/02/2024

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: The training matrix will continue to be updated as staff training is completed thus ensuring that the training Matrix remains a live document. The training plan, training matrix and any gaps identified in Mandatory or other required training will continue to be monitored, analyzed, and actioned via weekly management meeting. Communication of scheduled training events will be communicated effectively and directly with staff in a timely manner thus ensuring maximum attendance whilst facilitating roster planning. Date completed: 28/02/2024 and ongoing.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Following the inspection, room TF016 (previously the designated Senior Admin and HR office) is now the designated Archives Storeroom, thus ensuring all records of deceased or discharged residents are retained and available for review in Moorehall Lodge Balbriggan for a period of not less than 7 years. (Appendix 1: Updated Third floor plan to reflect the above change and will be reflected in Statement of Purpose) Completed: 26/03/2024. Alternative location will be in place for HR admin personnel by June 30, 2024. The management team will ensure going forward that all required regulatory documents and records will be readily available for all future inspections. All documents are now suitably and appropriately stored facilitating ease of retrieval for all documents.	

Completed on 26/03/2024.
The compliance actions required in relation to the Training Matrix is discussed under Regulation 16.
The annual review for 2023 including the associated 2024 quality improvement plan was emailed as part of the HIQA compliance plan on 27/03/2024.
Going forward the required annual review will be completed by 30th January of each calendar year.

Date completed: 26/03/2024.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Each CNM has oversight of a designated House including ensuring that all completing individual residnets care plan audits thus ensuring that resident individual clinical risk assessments and their respective care plans are updated and reflective of the individual residents holistic needs with resident change of needs and in accordance with regulation 5 and. The resulting quality improvement plan will reflect actions required to ensure care plans are compliant and accurate to reflect current needs of the residents.
Date to be completed: 12th April 2024.
Monthly audits of care plans will be ongoing as part of the internal auditing schedule to continue to monitor compliance with Regulation 5.The audits will be completed alternating by the CNMs ,ADON and DON ensuring audits are completed robustly and non biased. The associated findings of the audit will be reviewed by the managemnt team in conjunction with the respective Quality Improvement plans ensuring that person responsible and Close out date are clealry indicated on the Quality Improvement plan.The associated Quality Improvement plans will also be reviewed to ensure that all required actions are closed out as per appropriate date of plan.
The management team have received Completion of Audit training from the Group Training and Clinical coordinator on the 28/02/2024,thus ensuring the quality and findings of audit are reflective and any high risk findings are escalated appropriately and in a timely manner.
Some of the findings and the required actions identified in Regulation 23 are also identified and included in the compliance plan under Regulation 16 and 21.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents: Information on the Advocacy Services available to residents is now included in The Resident Guide. Date completed: 26/03/2024.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: An audit was completed of the location and availability of hand sanitisers following the inspection. Wall mounted alcohol hand sanitizers are currently being installed to ensure availability to staff directly outside every residents bedroom and communal toilet facility. Date completed: 29th March 2024 The medication room on the first floor was too small to prepare medication that may need two nurses to assist. The storage in this room was not enough to hold the supplies of dressings and sterile products hence they were stacked on top of each other, overtime this may lead to contamination of sterile products if the area cannot be cleaned properly. The RPR reviewed current use and storage of medication room. The issue of overstocking medication in the current medication room has been addressed. The medication room on the first floor has been decluttered and now stores the appropriate levels of medication. The storage space has been cleared to ensure that there is now adequate space to store dressings, sterile products, and to prepare medication with the assistance of two nurses if required as confirmed by a medication preparation simulation with RPR and Nurses on duty on 17th April 2024. The procedure for ordering monthly medication has been reinforced with all nurses and the CNM to prevent overstocking in the future. The current medication audit tool has been updated on 17th April 2024 to include monitoring of medication ordering and storage practices, with a specific focus on ensuring adequate supplies are maintained without overstocking. The storage of medication rooms has also been added to the medication audit checklist to ensure ongoing compliance. We wish to clarify and provide assurance that the two L-shaped lounge rooms are designated for resident use only, and alternative facilities will be in place for HR admin personnel by June 30, 2024. Date to be completed: 30th June 2024 The capital project manager in conjunction with the Director of Nursing is currently	

identifying suitable and appropriate locations to support the installation of the additional clinical hand wash sinks within each of the three Houses.

Date to be completed: 30th June 2024

Safety engineered needles are now in place and in use in the centre. All non-safety engineered needles have been removed.
This practice will continue to be monitored via the internal auditing process.

Date completed: 26/03/2024

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The care plan audit tool was reviewed and further ammended to include :Residents refusal of care recorded,daily resident records are refelctive of how the residents spend their day,residents current careplans are fully reflective of the residnets current clinical risk assessments . audit Monthly audits of care plans will be ongoing as part of the internal auditing schedule to continue to monitor compliance with Regulation 5.
Date to be completed: 19th April 2024.
The management team have received Completion of Audit training from the Group Training and Clinical coordinator on the 28/02/2024,thus ensuring the quality and findings of audit are reflective and any high risk findings are escalated appropriately and in a timely manner.
Each CNM has oversight of a Household and completing 5 individual residents care plan audits per week to ensure all resident care plans and resident notes are fully reflective of residents current needs and on going plan of care and at intervlas not exceeding 4 months.The quality improvement plan developed post audit will detail specific actions required,person responsible and time to be completed by.
Dare completed :12th April 2024.
A staff nurse meeting occurred on Thursday 21/03/2024 to re-iterate actions required to meet and sustain complaince with Regulation 5 Individual Assessment and Care Plan.
A care plan resource pack is now available to all nurses to support and guide them on the care plan creation and review process and person centred nursing progress notes.
Date completed: 12/04/2024
A Bespoke assessment, care plan and nursing documentation training is scheduled and mandatory for all nurses which will be delivered by the Group Clinical and Training development manager in conjunction with the Project Manager on-site. The Training content includes the requirement for 1)completion of contemperaneous documentation following review and updating of individual residents care plans, 2)clinical risk assessments to reflect residents current needs, specific interventions required to direct care and 3) the requirement to update individual resident care plans following any

individual resident review by any member of the Allied Health professional team.
Date completed: 18th April 2024 and scheduled for 24th April 2024.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	28/02/2024
Regulation 20(2)(e)	A guide prepared under paragraph (a) shall include information regarding independent advocacy services.	Substantially Compliant	Yellow	26/03/2024
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	26/03/2024
Regulation 21(3)	Records kept in accordance with this section and set out in Schedule 3 shall be retained for a period of not less than 7 years after the resident	Substantially Compliant	Yellow	26/03/2024

	has ceased to reside in the designated centre concerned.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	26/03/2024
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	12/04/2024
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Orange	27/03/2024
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with	Not Compliant	Orange	27/03/2024

	residents and their families.			
Regulation 23(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the Chief Inspector.	Not Compliant	Orange	27/03/2024
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.	Substantially Compliant	Yellow	30/06/2024
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	24/04/2024