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:	Greystones Nursing Home
Name of provider:	Greystones Nursing Home Limited
Address of centre:	Church Road, Greystones, Wicklow
Type of inspection:	Unannounced
Date of inspection:	18 October 2022
Centre ID:	OSV-0000045
Fieldwork ID:	MON-0038123

About the designated centre

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

The centre is based in a town and is close to shops, and local public transport networks. The designated centre provides care and accommodation to male and female residents over the age of 18. It provides a service to residents with a wide range of needs including palliative care, dementia care, acquired brain injury and physical disability. The provider offers long-term and short-term accommodation, respite and convalescence care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	44

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 18 October 2022	09:30hrs to 18:30hrs	Mary Veale	Lead
Tuesday 25 October 2022	11:45hrs to 19:15hrs	Niall Whelton	Support

What residents told us and what inspectors observed

This was a pleasant centre where residents for the most part enjoyed a good quality of life and were supported to be independent. There was a welcoming and homely atmosphere in the centre. Residents' rights and dignity was supported and promoted by kind staff. Care was led by the needs and preferences of the residents who were happy and well cared for in the centre. The overall feedback from residents' was of satisfaction with the care and service provided. Most residents' were very positive about their experience of living in Greystones Nursing Home. The inspectors greeted the majority of residents on the days of inspection and spoke at length with six residents. The inspectors spent time observing residents' daily lives and care practices in order to gain insight into the experience of those living in Greystones Nursing Home.

On arrival the inspectors were met by a member of the administration team and guided through the centre's infection control procedures before entering the building. The front door was restricted and only accessible by key code. Residents could leave the centre as they pleased with the assistance of staff to enter and exit the centre. Alcohol gel was available in the reception hall and throughout the centre. Since the previous inspection in January 2022, works had been completed to replace the centres main house roof and windows.

Following an introductory meeting with the nurse in charge the inspectors were accompanied on a tour of the premises. The inspector spoke with and observed residents' in the communal areas and their bedrooms. The design and layout of the premises met the individual and communal needs of the residents'. The centre consisted of two distinct buildings, the main house and the Sea Patrick wing. The original house dated from the Victorian period which was a former hotel and the Sea Patrick wing was a three storey extension. The original house retained many of its Victorian features, for example; high ceilings, stair case, coving, ornate fireplaces and sash windows with shutters. The entrance hall contained a piano and photographs of the local area. Communal rooms in the main house consisted of a living room, dining rooms and an activity room which all looked out on to the centres driveway and garden. The ground floor of the main house also had a smoking room. There was living room space, dining rooms, a quiet room and a hairdressing room in the Sea Patrick wing. On the day of inspections it was observed that residents in the Sea Patrick wing used the space at the entrance to Sea Patrick wing and the dinning space. The living room spaces in the Sea Patrick wing were observed not used by residents thought out the days of inspection.

There was a continuous schedule of redecorating improvements works taking place. Over the days of inspection, works were under way to redecorate the main reception area and hall. The bedrooms in the main house had been redecorated, new curtains had been fitted, rooms had been painted and ensuite rooms had new flooring and polyvinyl chloride (PVC) wall panelling installed. Most of the bedrooms in the main house had new bedside lockers with lockable storage space, drawers,

double wardrobes and bed tables for each resident. Pressure reliving specialist cushions and mattresses, low to floor beds and other supportive equipment was seen in residents' bedrooms. Residents' bedrooms were clean, tidy and were personal to the resident's containing family photographs, art pieces and personal belongings.

Personal care was being delivered in many of the residents' bedrooms and observation showed that this was provided in a kind and respectful manner. Residents very complementary of the staff and services they received. Residents' said they felt safe and trusted staff. Residents' told the inspectors that staff were always available to assist with their personal care. However, one resident told the inspectors that the "banging loudly of doors" when staff were entering and exiting residents bedrooms to provide care was disturbing when they were resting or sleeping.

Most residents said they enjoyed the food and stated that there was always a choice of meals and that snacks were available at any time. Residents had access to cold water dispensers and jugs of cordial were observed in residents' bedrooms over the days of inspection. Some residents had small refrigerators in their rooms to keep their drinks and snacks cool. The lunch time experience on Sea Patrick wing was observed on the first day of inspection. The meal time experience was a social occasion with some residents observed bringing their own beverages, engaging in conversations and enjoying each others company. However; one resident described that their tea was cold in the morning when breakfast was served in their bedroom.

A laundry service was provided for the residents. All residents' who the inspector spoke with were happy with the laundry service and there were no reports of items of clothing missing.

The majority of residents' spoken to said they were very happy with the activities programme in the centre and some preferred their own company but were not bored as they had access to books, televisions, Wi-Fi, and visits from friends and family. The monthly activities programme was displayed outside the activities room in the centre. For residents who could not attend group activities, one to one activities were provided. Over the inspection days, residents were observed partaking in an exercise classes and a relaxation therapy session. The hairdresser attended the centre weekly. The inspectors observed residents having good humoured banter with each other. The inspectors observed many residents walking around the centre and one resident told the inspectors that they walked into the local town of Greystones most days. The inspectors observed residents reading newspapers, watching television, listening to the radio, and engaging in conversation. Books and board games were available to residents. Residents, were observed to enjoy friendships with peers throughout the two days.

The inspectors observed that visiting was facilitated over the two days of inspection. The inspectors spoke with a family members and a friends of resident who were visiting. The visitors told the inspectors that there was no booking system in place and that they could call to the centre anytime. Visitors spoken to were very

complementary of the staff and the care that their family members received.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection carried out to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 as amended and to follow up on the actions from the previous inspection. At the time of the inspection there were 20 vacant beds in the centre. The provider had progressed some areas of the compliance plan following the previous inspection in January 2022. Improvements were found in relation to Regulation 15; staffing and areas of Regulation 27; infection prevention and control. On this inspection, actions were required by the registered provider to address Regulation 23; governance and management, Regulation 17; premises and Regulation 28; fire precautions. Areas of improvement were required in relation to Regulation 5; individual assessment and care planning, Regulation 16; training and staff development, Regulation 21; records and Regulation 27 infection prevention and control.

This inspection was initially scheduled to take place over one day, however due to concerns identified in relation to fire safety, a second day of inspection, focused on fire precautions was scheduled. Improvements required to fire precautions are discussed in the quality and safety section of the report. The systems in place to monitor the quality and safety of the service required improvement. Risks found on inspection in relation to fire safety and had not been identified by the centre's quality systems. This potentially impacted on the safety of all residents and staff. To date the service has been reactive with managing fire risks. Inspectors reviewed the actions required from the previous inspections in January 2022, June 2020 and October 2019 which identified ongoing non-compliance with regulation 28 fire precautions. Management systems required review, as significant risks were found again with fire doors and automatic closure devices in the centre. Following the inspection an urgent compliance plan was issued to the registered provider requesting assurances to mitigate the fire safety risks and ensure the service was effectively monitored and safe.

The registered provider had applied to renew the registration of GreyStones Nursing Home. The application was timely made, appropriate fee's were paid and prescribed documentation was submitted to support the application to renew registration.

Greystones Nursing Home Limited was the registered provider for Greystones Nursing Home. The company had two directors who were responsible for the provision of care and services. The nursing home was part of the Evergreen care group which had nine designated centres for older persons. The registered provider

representative was a company director and was available daily to the management team in the centre. The regional operations manager supported the person in charge of the centre. Shared group resources were available, for example, human resources. Since the inspection in January 2022 the centre had, had two changes to the person in charge and the operations manager was the current person in charge. The centres application to renew its registration outlined a proposed new person in charge who was appropriately qualified, and had worked in the centre for over seven years. The management structure was clear and the person in charge was supported by a clinical nurse manager, a team of nurses, healthcare assistants, activity staff, housekeeping, catering, administration staff and maintenance staff.

Lines of authority and accountability were clearly defined however, there was no deputising arrangements in place for the person in charge when they were off duty. There had been a high turnover of staff in the centre in 2021 and the provider had ongoing recruitment efforts in place to maintain safe and consistent staffing levels. In order to ensure the care needs of residents were met the provider was employing agency staff to back fill the shifts and these staff were regular attendees in the centre. Inspectors noted staffing levels were in accordance with the centre's statement of purpose but equally the centres beds were at reduced occupancy. Inspectors were assured there were sufficient staff on duty to meet resident’s needs on the days of inspection.

There were auditing schedules in place and inspectors viewed samples of clinical audits that had been completed, however, action plans did not inform improvements or learning and there was evidence that poor practices persisted. Audits of medication management and wound management consistently found the same problems over a period of time. Similarly, learning identified in fire drills was not transferred to inform subsequent drills and this was a lost opportunity to improve the effectiveness of the service. This is discussed further under Regulation 23: governance and management.

There was poor oversight of training requirements in the centre. The inspectors reviewed the centre's training matrix. A significant number of clinical staff had not completed safe-guarding, behaviour that is challenging and fire safety training. This is discussed further under Regulation 16: staff training and development. The majority of clinical staff had completed infection prevention and control training.

Requested records were made available to inspectors throughout the inspection days and most records were appropriately maintained, safe and accessible. Improvements were required in staff records and in the adherence of the centres policy to follow its process of obtaining and verifying information in relation to the employment history of some staff employed in the centre .The provider was undertaking to review this and update these records. This is discussed further under Regulation 21: records.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre’s policies. Policies and procedures as set out in schedule

5 were in place and up to date.

Registration Regulation 4: Application for registration or renewal of registration

All documents requested for renewal of registration were submitted in a timely manner.

Judgment: Compliant

Registration Regulation 8: Annual fee payable by the registered provider of a designated centre for older people

All the requested fees were received.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was required to solely be employed to carry out the role of the person in charge in this centre.

Judgment: Substantially compliant

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the day of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Not all staff had access to appropriate training to support them to perform their respective roles. For example, ten staff required training in safeguarding, 21 staff had not completed fire training in line with the centres mandatory training requirements and records available identified that nine staff had not completed fire

safety training. 21 staff had also not completed training in managing behaviour that is challenging appropriate to their role.

Actions were required to ensure that staff have access training in managing behaviours that is challenging, fire safety and safe guarding.

Judgment: Not compliant

Regulation 21: Records

Actions were required to ensure that staff records contained all information as outlined in schedule 2 of the care and welfare of residents in designated centres for older people Regulations 2013.

- In a sample of four staff files viewed, two of the staff files did not have a full employment history. Actions were required to ensure a full employment history of any gaps was completed for all staff files to ensure that staff records were in line with schedule 2 requirements.

Judgment: Substantially compliant

Regulation 22: Insurance

There was a valid contract of insurance against injury to residents and additional liabilities.

Judgment: Compliant

Regulation 23: Governance and management

Actions were required to ensure effective management systems were in place to ensure that the service was safe, appropriate managed and effectively monitored. For example:

- Audit action plans were not comprehensive enough to drive quality improvement. For example; medication management audits viewed identified the same findings and recommendations with no improvements since the previous inspection in January 2022.
- There was no evidence of cascading of learning through the governance structure. For example; minutes of meetings viewed outlined the agenda items, there was no evident of discussions or communication with staff, no

improvements were identified from KPI's or audits and there was no evidence of actions required or time lines.

- Management systems for oversight of fire safety required review, for example; smoke containment risks associated with bed room doors identified in the centre had not been implemented to ensure effective oversight of the quality and safety of care to residents.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspector viewed a number of contracts of care which outlined details of the service to be provided and any additional fees to be paid.

Judgment: Compliant

Regulation 3: Statement of purpose

Amendments were made to the centre's statement of purpose during the inspection. The statement now contained all of the information set out in schedule 1 of the regulations and in accordance with the guidance.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre’s policies.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies and procedures as set out in schedule 5 were in place, up to date and available to all staff in the centre.

Judgment: Compliant

Quality and safety

Residents received good standards of health care and their rights and preferences were supported. However; poor understanding of the risks with fire containment and evacuation were impacting on the safety and well-being of residents and staff. Further improvements were also required with care planning, premises and infection control risks.

The provider was required to take urgent action to ensure residents safety and protection against the risk of fire. Following the first day of inspection, an urgent compliance plan was issued to the provider to address risks associated with:

- fire containment and deficits to fire doors
- the measures in place to safely evacuate residents when staffing levels were lowest

By day two, remedial work was underway to address deficits to fire doors and a further fire drill had been completed. Notwithstanding the action taken between the first and second day of inspection, further risks were identified on day two; immediate action was required to mitigate these risks with regard to the storage arrangements for oxygen cylinders and the management of keys for exits locked with a key. These are explored in more detail under regulation 28.

Improvements were found in the condition of parts of the premises, for example, works had been completed to replace the roof and windows in the main house , most bedrooms and a bathroom in the main house had been redecorated since the previous inspection. However, areas of the centre were showing signs of wear and tear, for example; areas of the centre corridors had scuffed and damaged walls, door frames and radiators. Walls in some of the bedrooms were damaged and required painting. The condition of the premises is intrinsically linked to infection prevention and control as damaged and scuffed surfaces cannot be cleaned and pose a risk to the spread of infection. All en-suite toilets had grab rails and call bells fitted. Improvements were required in relation to the centres premises this will be discussed further under Regulation 17.

Visiting had returned to pre-pandemic visiting arrangements in the centre. There were ongoing safety procedures in place. For example, temperature checks and signature log. Residents could receive visitors in their bedrooms and the centres communal areas . Visitors could visit at any time and there was no booking system for visiting.

The centre was an agent for five of the resident's pensions. Residents had access to and control over their monies. Residents who were unable to manage their finances were assisted by a care representative or family member. All transactions were

accounted for electronically and double signed by the resident/representative and a staff member. There was ample storage in bedrooms for residents' personal clothing and belongings. Laundry was provided on-site and some residents chose to have their clothing laundered at home.

The centre had a risk management policy that contained actions and measures to control specified risks and which met the criteria set out in regulation 26. The centre's risk register contained information about active risks and control measures to mitigate these risks. The risk registered contained site specific risks such as restrictive practice , risk of smoking and the risk of residents absconding.

Staff were observed to have good hygiene practices and correct use of personal protective equipment (PPE). Sufficient housekeeping resources were in place on the days of inspection. Housekeeping staff were knowledgeable of correct cleaning and infection control procedures. The cleaning schedules and records were viewed on inspection. Intensive cleaning schedules had been incorporated into the regular weekly cleaning programme in the centre. The centre had a curtain cleaning schedule. Improvements had been made to the layout of the laundry since the previous inspection and further construction plans were proposed so as used laundry could be segregated in line with best practice guidelines and the laundry work way flow from dirty to clean laundry will be further improved to prevent a risk of cross contamination. The centre's infection prevention control policy had been reviewed and included covid-19 measures. There was evidence of quarterly infection prevention control (IPC) audits completed. However, some improvements were required in relation to infection prevention and control, this will be discussed further in the report.

There was a good standard of care planning in the centre. In samples of care plans viewed residents' needs were comprehensively assessed by validated risk assessment tools. Care plans were person centred and routinely reviewed. However; from the sample of nursing notes viewed it was not evident that four monthly reviews of care plans with residents had taken place.

Residents were supported to access appropriate health care services in accordance with their assessed need and preference. General Practitioners (GP's) attended the centre and residents had regular medical reviews. Residents also had access to a consultant geriatrician, a psychiatric team, nurse specialists and palliative home care services. A range of allied health professionals were accessible to residents as required an in accordance with their assessed needs, for example, speech and language therapist, dietician and chiropodist. A physiotherapist attended the centre weekly to provide individual assessments and group exercises. A mobile x-ray service was observed on the first day of inspection in the centre. Residents had access to local dental and optician services. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

There was a policy in place for the prevention, detection and response to allegations or suspicions of abuse. Approximately 65% of staff required refresher training in safeguarding of vulnerable adults, however the impact of this risk was low as staff were familiar with the types and signs of abuse and with the procedures for

reporting suspected abuse. The provider assured the inspector that all staff had valid Garda vetting disclosures in place.

Residents' rights and choices were respected and residents were actively involved in the organisation of the service. Resident meetings and informal feedback from residents informed the organisation of the service. Residents were consulted with about their individual care needs and had access to independent advocacy if they wished. Privacy curtains were in all shared rooms and privacy locks were fitted to bathrooms to promote and support resident who wished to undertake activities in private. There was a varied and fun activities programmes. Residents has access to daily national newspapers, WIFI, books, televisions, and radio's. Residents were very complimentary about the centres activity programme.

Regulation 11: Visits

Indoor visiting had resumed in line with the most up to date guidance for residential centres. The centre had arrangements in pace to ensure the ongoing safety of residents.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate space in their bedrooms to store their clothes and display their possessions. Residents clothes were laundered in the centre and the residents had access and control over their personal possessions and finances.

Judgment: Compliant

Regulation 17: Premises

Action were required to ensure compliance with regulation 17 and the matters set out in schedule 6, for example:

- Parts of the centre required painting and repair to ensure it could be effectively cleaned, such as radiators, walls, and skirting boards.
- A review of the centres hot water system was required as hot water was not available in two bedrooms.
- A review of the centres light fixtures was required as light covers were missing to a number of light fittings.
- The ceiling in room 8 and on the corridor adjacent required repair as a water

leak had damaged the ceiling.
- A review of the centres doors was required as the closing force on some fire doors was excessive and created a risk of falls and injury to staff and residents.
- The centres linen room and storage rooms required review as they were cluttered with items such as resident assistive equipment, staff training equipment and PPE. This posed a safety risk to staff working in the centre.

Judgment: Not compliant

Regulation 26: Risk management

Arrangements were in place to guide staff on the identification and management of risks. The centre had a risk management policy which contained appropriate guidance on identification and management of risks.

Judgment: Compliant

Regulation 27: Infection control

Actions were required to ensure the environment was as safe as possible for residents and staff and in line with IPC. For Example;

- A review of the centres shower chairs and commodes was required as a number of shower chairs and commodes contained rust on the leg or wheel area. This posed a risk of cross contamination as staff could not effectively clean the rusted parts of the shower chairs and commodes.
- The centres bins for disposal of incontinence products required replacing as these bins were hand operated, some were visible dirty which posed a high risk of contamination and risk of transmission of infection.
- Bedpans and commode pans stored in the sluice room in Seapatrick required review as some were dirty.
- Aspergillosis risk assessment was not available for the work being carried out on an internal stairway. There was a plastic barrier put up, however gaps were noted around the edge presenting a risk of airborne infection.

Judgment: Not compliant

Regulation 28: Fire precautions

Following the first day of inspection, an urgent compliance plan was issued to the provider to address risks associated with effectiveness and maintenance of fire doors and the measures in place to safely evacuate residents when staffing levels were lowest.

In addition to the above the provider was not taking adequate precautions against the risk of fire, nor adequately reviewing fire precautions, for example:

- The process for the identification and management of fire safety risks was not adequate.
- Poor practices were observed regarding the storage arrangements for oxygen cylinders and was not in line with the centres own policy. For example, inspectors saw five cylinders stored behind the main reception, adjacent to combustible material and potential sources of ignition such as hoist batteries on charge and electronic devices. Immediate action was required and the person in charge arranged for the cylinders to be moved to more suitable location.
- Some store rooms contained excessive storage; one was noted to be full and the inspector was unable to access the room. Large volumes of unorganised combustible storage presents a risk of a fire escalating rapidly should a fire start.
- the lint screens in the dryers were noted to have a build up of dry lint.
- Assurance was required regarding the assessments of residents who smoke. The furniture within the smoking room was noted to have scorch marks and had no apparent label to identify that they were suitably fire retardant. They were immediately removed from the smoking room during the inspection.
- A review of the smoking risk assessments for residents who smoked was required so as control measures for the safety and supervision of these residents could be identified , implemented and assured.
- Large electrical panels were located on a bedroom corridor and were not enclosed in fire resisting construction
- It was not evident what systems were in place to adequately review fire precautions in the centre.

The means of escape were not adequate, for example:

- There were steps outside a fire exit from an escape stairway; this exit also provided escape for residents at ground floor.
- There were two exits from Seapatrick which required a key to open the exit door. The management of the keys to these exit doors was not adequate. While there was a back up key in a break glass unit beside each exit, there was confusion reqarding the location of the primary key to open the exit. Immediate action was required during the second day of inspection to address this.
- Escape signage was not adequate; inspectors observed escape routes where adequate exit signage was not provided
- The lift enclosure in Seapatrick opened directly to the bedroom corridors at both levels. It was confirmed during the feedback meeting that fire doors were being fitted to protect the bedroom corridors.

- The escape corridor from two bedrooms was not adequately protected from fire. There was a PVC screen, behind which was a staff room and store, neither of which were fitted with fire doors.
- The escape path leading from the exit from the rear escape stairs was obstructed with garden furniture
- the route to the assembly point to the front of the building was not accessible.

The arrangements for maintaining fire equipment was not effective:

- During the first day of inspection, deficits to fire doors were identified, including damaged or inactive automatic fire door closers, missing heat and smoke seals, excessive gaps to the bottom of fire doors, warped, damaged or poorly fitting doors. By day two, significant improvements were noted and this work was ongoing.
- While a service log demonstrated that the emergency lighting system was being serviced, the frequency did not ensure that the system was serviced quarterly as required, and the service records were not available.
- Not all service records for the fire detection and alarm system were available but evidence in the register indicated that it was being serviced at the appropriate intervals.
- Not all fire safety checks in the centres own fire safety register were being logged and some not at the appropriate frequency. For example, the monthly checks of the fire extinguishers was not logged.

The arrangements for containing fire were not adequate, for example:

- Further assurances were required regarding the effectiveness of fire doors in place. While upgrade works were ongoing, inspectors noted the absence of fire doors to fire risk rooms, in particular the lift motor room adjacent to the lift. It was confirmed during the feedback meeting that new fire doors had been measured and would be fitted the following day. Fire doors were also absent from the staff room and adjacent store room
- Floor plans displayed identified the fire compartment boundaries; however, further assurance regarding the integrity of the fire compartments was required to ensure they provide an effective barrier to the spread of fire during the adopted phased evacuation strategy.
- The wall surrounding the door to the kitchen visibly moved when the fire door closed; this may not provide effective fire containment to the kitchen enclosure.
- The fire door to a number of rooms were not fitted with an automatic closing device to ensure the door would be closed in the event of a fire. For example, the office for the person in charge and a number of store rooms.
- Service penetrations were noted in construction providing a barrier to fire which were not sealed up.
- Further assurance was required regarding the effectiveness of the fire rated construction protecting escape corridors.

The arrangements for detecting fire were not adequate, for example:

- Some rooms were not fitted with smoke detection, for example, a store opening from the sluice room and the store adjacent to the staff canteen room.
- The category of fire detection and alarm system was not detailed on the service records. The service records available indicated that upgrading will be required to provide the necessary standard for a nursing home.

The arrangements for evacuating residents required improvement:

- Drill records reviewed did not contain sufficient information to demonstrate that the evacuation procedure was adequately tested. There was no drill available to demonstrate the safe evacuation of the higher risk areas, the largest compartment or that all escape routes had been tested. For example, staff told the inspector that evacuation had not been practiced on the rear escape stairs from Seapatrick at first floor.
- There were two fire compartments, one at ground floor and the other at first, shown as two separate fire compartments on the displayed floor plans, however they were connected via the stairway in Seapatrick with no fire containment separating them.
- Evacuation by wheelchair was identified for some residents, where escape routes included stepped routes.

The procedures to follow in the event of a fire and fire compartment floor plans were displayed in the front building, but not in Seapatrick to the rear.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plan reviews were comprehensively completed on a four monthly basis to ensure care was appropriate to the resident's changing needs however it was not always documented if the resident or their care representative were involved in the reviews in line with the regulations.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. GP’s routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health

professional as appropriate.

Judgment: Compliant

Regulation 8: Protection

All reasonable measures to protect residents from abuse required review, specifically staff training needs.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents’ rights and choice were promoted and respected within the confines of the centre. Activities were provided in accordance with the needs’ and preference of residents and there were daily opportunities for residents to participate in group or individual activities. Facilities promoted privacy and service provision was directed by the needs of the residents.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Registration Regulation 8: Annual fee payable by the registered provider of a designated centre for older people	Compliant
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not 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 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Greystones Nursing Home OSV-0000045

Inspection ID: MON-0038123

Date of inspection: 25/10/2022

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: Greystones Nursing Home have provided all details relating to the new person in charge who is working full time at the centre, is appropriately qualified and has worked in the centre for the past 7 years.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff have completed their annual fire training since the inspection. This session had been booked a number of times but due to outbreaks etc, it had been postponed. This has been completed. We have identified those staff that have not completed their safeguarding training and these staff members will have this completed by the end of December at the latest. The safeguarding training that a number of staff have completed with HSEland has a validity date of 2 years with it, so whilst not all staff have completed it this year, their certifications are within date. We will ensure that all of our newer staff members have this training completed as part of their induction process. We will ensure that more staff complete their dementia & managing challenging behaviour training within the first quarter of 2023.	

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Our administration staff have reviewed all staff files and have completed a checklist to ensure that all relevant information is filed accordingly. All gaps in staff files and employment history have been closed off.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
All Senior staff will complete the HSELand audit training which will assist equipping staff with the nuances of audit procedure. We will ensure that all audits have a follow up/learning report included, with a timeline attached to promote staff involvement.
Fire equipment management will now be part of the weekly onsite meeting between the pic & maintenance dept. All findings will be discussed and a timeline for any repairs or replacements will be decided at these meetings. Since the inspection, a full weekly/monthly/quarterly checklist has been drawn up and is being completed onsite.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
As identified by the inspector on the day, there is work to be completed on the premises, however as also acknowledged by the inspectors – substantial work has already been completed and is in the process of completion this year/early in the New Year. We are working closely with our engineers/builders to ensure that all refurbishments are completed with minimum disruption to our Residents. We have already this year done the following.
Reroofed & insulated the home.
Replaced a number of our sash windows in the MH & pvc windows in SP
We have upgraded the plumbing system – although further works are still outstanding.
We have refurbished and upgraded our kitchen.
We have refurbished a number of bedrooms – including curtains, chairs, flooring, painting and furniture.
All fire door closers have been adjusted to ensure a smooth closing system.

There is a continual painting/upkeep programme in the centre and a number of high traffic areas have been identified as being a priority for repainting. We do anticipate a high level of redecoration works to be be completed in Greystones Nursing Home over the coming year which will enable not only our staff to ensure a high quality upkeep of the home but also to improve the living standards for our Residents. Since the inspection we have addressed the following items identified during the inspection: Painting & repair of walls, radiators & skirting boards – part of the programme for the new year when remedial works are complete. The hot water system has been reviewed and the issue that lead to 2 rooms having delayed hot water, has been identified. A full review of all of the light fixtures has been completed and light covers are intact on all lights. The ceiling area upstairs in MH which requires repair due to water leak, is on our programme for redecoration. All of the fire door closers have been assessed and adjusted accordingly to ensure a smooth safe close. We are in the process of reviewing the linen and storage rooms to declutter items that had been stored during our works thus far this year. Our current ongoing works are as follows: To complete our laundry refurbishment Review of all shower chairs/commodes to evaluate the number to be replaced in the new year.	
Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: As detailed above – we do have a year round painting/upkeep programme in place. We will be reviewing all of our showerchairs & commodes & pans and replacing those of which are beyond repair/use. We will be replacing our current incontinence bins with smaller easy to clean/maintain foot pedal operated bins. An aspergillosis risk assessment has been completed and has been added to our Risk register.	
Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• We have reviewed and strengthened our fire safety risk checklists & this is a topic which is discussed at our weekly fire alarm testing.
• The oxygen cylinders identified by the inspector during the inspection were removed at the time.
• As mentioned under Regulation 17, we are in the process of reviewing our store rooms, any items not currently in use will either be stored safely or disposed of.
• Our laundry staff will check the dryers daily to remove any lint.
• We do have risk assessments in place for all Residents who are smokers, these have been reviewed and updated as necessary. The furniture with the scorch marks was removed from the smoking room during the inspection & suitable furniture is now present. The smoking room risk assessment has been updated.
• The fire resisting containment for the electrical panels along the corridor will be addressed in the new year as part of our redecoration programme.
• Our fire precautions systems/procedures are reviewed at every fire training session throughout the year which takes place in the home. In addition to this, the staff have a daily checklist to ensure that our fire exits are clear. We also conduct a weekly fire alarm sounding and during this, the fire team assembles and the management of both the fire alarm panel and the correct usage of fire extinguishers is reviewed.
Methods of Escape:
· Our procedure for fire evacuation is via horizontal evacuation. Our staff are trained to move Residents to safety via our "fire zones" to distance themselves safely from the risk of a spreading fire. Exiting the home entirely is the last resort. To aid this type of evacuation should it become essential – all beds are fitted with fire ski sheets to enable staff to move Residents from a fire zone, encased in a protective mattress.
· Each of the fire door exits have a specific key. This key is located on the nurses key ring and has been clearly identified and is handed over at each shift change to the oncoming nurse.
· Escape signage has been replaced throughout the home.
· As confirmed during the feedback meeting the fire doors have been fitted to the lift enclosure in Seapatrick.
· The corridor adjacent to the staff room will be addressed as part of our refurbishment plans for 2023.
· All garden furniture has been removed from the garden path leading from the fire escape in SP.
· The route to the assembly point to the front of the Home is fully accessible.

Arrangements for Maintaining Fire Equipment:
· We have adjusted the deficits to our existing fire doors.
· Our emergency lighting system is serviced quarterly and we have ensured that the paperwork to support this is kept with all fire related information. This applies also to the service records for the fire detection and alarm system.
· We have strengthened our own fire checklists to ensure that all weekly/monthly/quarterly checks are completed as planned.
Arrangements for Containing Fire:
· As mentioned, the fire doors have been fitted to the lift enclosure. We are in the process of engaging with a company to supply suitable fire doors to the home – in particular the MH where the door and frames are outsized/special order due to the age

of the building.
· The fire compartments are under review and will be addressed by a suitably qualified engineer during the course of our refurbishment in the new year.
· The wall surrounding the door to the kitchen has been re-enforced to ensure effective fire containment.
· All service penetrations have been sealed.
· The effectiveness of the fire rated construction protecting the escape corridors will be assessed and upgraded as necessary during the course of our refurbishment plans.
Arrangements for Detecting Fire:
o Smoke detectors will be fitted to all rooms.
o The fire detection and alarm system is part of our review in the new year.
Arrangements for Evacuating Residents:
· We have conducted fire drills since the inspection, with our staff and with the fire trainer. We will continue to conduct active fire drills to ensure that all staff are familiar with all routes available to them in the event of an evacuation from the home, not just horizontal evacuation.
· The fire compartments are under review and will be addressed by a suitably qualified engineer during the course of our refurbishment in the new year.
· All PEEPS will be reviewed to ensure that a practical evacuation is identified for all Residents.
· The procedure to follow in the event of a fire and the compartment floor plans are back in place in SeaPatrick.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
We will ensure that our close involvement with our Resident and with their Next of kin (as permitted) will be documented on our nursing software system.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
As mentioned in Regulation 16: All staff will have completed their safeguarding training by the end of December.

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 14(2)(a)	The person in charge may be the registered provider where the registered provider concerned is a registered medical practitioner who is solely employed in carrying on the business of the designated centre concerned.	Substantially Compliant	Yellow	30/09/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	28/02/2023
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	31/12/2023
Regulation 21(1)	The registered provider shall	Substantially Compliant	Yellow	31/12/2022

	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.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/01/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/03/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/06/2023

Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/12/2022
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/11/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/12/2022
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	31/12/2022
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire	Not Compliant	Orange	30/11/2022

	control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	30/11/2022
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	30/11/2022
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are	Not Compliant	Orange	30/11/2022

	displayed in a prominent place in the designated centre.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/12/2022
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Substantially Compliant	Yellow	31/12/2022