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:	Laurel Lodge Nursing Home
Name of provider:	Templemichael Nursing Home Limited
Address of centre:	Templemichael, Longford, Longford
Type of inspection:	Unannounced
Date of inspection:	02 May 2023
Centre ID:	OSV-0005394
Fieldwork ID:	MON-0038871

About the designated centre

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

The designated centre providers 24 hour nursing care to 114 residents, male and female, who require long term and short term care (day care, convalescence, rehabilitation and respite). The centre is a two storey building containing three distinct lodges located on the outskirts of Longford town. Glencar Lodge is a 41 bed dementia specific unit. Lissadell Lodge is a 35 bed unit and Hazelwood lodge had 38 beds. The majority of bedrooms have full en-suite facilities. The centre is decorated and furnished to a high standard and a variety of sitting rooms and seated areas, dining rooms in each lodge, a spacious oratory/chapel, a meeting room and hair salon is available for residents use. Well-manicured secure and accessible garden courtyards are available along with a number of other surrounding outdoor planted areas. The centre's philosophy is one of optimization, aimed at facilitating residents to be the best that they can be, promoting independence and autonomy by placing residents at the centre of all decision making within a 'home from home' that is safe, caring and supportive.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	112

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 2 May 2023	09:45hrs to 17:00hrs	Rachel Seoighthe	Lead
Wednesday 3 May 2023	09:30hrs to 17:30hrs	Rachel Seoighthe	Lead
Tuesday 2 May 2023	09:30hrs to 17:00hrs	Catherine Rose Connolly Gargan	Support
Wednesday 3 May 2023	09:45hrs to 17:30hrs	Catherine Rose Connolly Gargan	Support

What residents told us and what inspectors observed

Overall, inspectors observed that while a number of residents in the centre enjoyed a good quality of life and their rights were respected, this was not found for other residents including residents accommodated in the dementia unit. Residents' quality of life in the dementia unit was impacted by restricted access to the outdoors and residents' own private space.

This inspection took place over two days. There were 112 residents accommodated in the centre on the first day of the inspection. On inspectors' unannounced arrival to the centre, they were greeted by a staff member who guided them through the required COVID-19 infection prevention and control measures, including completion of hand hygiene and a temperature check. Following an introductory meeting with the person in charge and the person representing the provider entity, the inspectors spent time walking through the centre where they met and spoke with residents as they prepared for the day.

Laurel Lodge Nursing Home provides long term and respite care for both male and female adults with a range of dependencies and needs.The designated centre can accommodate up to 114 residents in single and shared bedroom accommodation across three linked units; Hazelwood Lodge, Lissadell Lodge and Glencar Lodge. There were 112 residents living in the centre on the day of the inspection. Each unit contains a variety of communal areas including sitting rooms and dining rooms.These rooms were decorated in a homely and comfortable manner. Residents' bedroom accommodation was arranged on the ground floor level on both sides of a spacious reception area with which had grand piano and had comfortable seating throughout. There was access to television and call bells in all bedrooms. Handrails were in place on both sides of all corridors to ensure resident's safe mobility.

Inspectors observed that there was controlled access to Glencar Lodge, which was a dementia specific unit accommodating up to 41 residents. The dementia unit contained a number of communal spaces including a large dining room , a multi-sensory room and a large sitting room with doors that led out to one of three enclosed gardens. Items of traditional memorabilia and furnishings that were familiar to residents were displayed in a 'reminiscence kitchen' which was designed to replicate a traditional Irish cottage. Resident bedroom accommodation in Glencar Lodge consisted of single and twin rooms. Some residents bedroom doors were signposted with the names of birds, whilst others were painted in a variety of colours to replicate front doors, in order to assist residents with way-finding.

Inspectors found that some of the restrictive practices that were in place in the unit were overly restrictive and were not effective in managing some residents' responsive behaviours. For example, inspectors observed that two resident bedroom doors were locked using latches fitted to the top of doors. Inspectors were informed by the management team that bedroom doors were locked as a means to deter

residents who walk with purpose from entering other residents bedrooms without invitation. However, the inspectors observed that this practice restricted residents independence and choice as to when they could access their own private space. The inspectors spoke with one resident who was distressed because they had to seek out a member of staff to unlock the door each time they wanted to access their own bedroom . The inspectors also observed one resident who walked with purpose for long periods throughout the day was entering the bedrooms of other residents without invitation. The inspectors observed that the resident was not supervised.

The second day of the inspection was warm and sunny day and inspectors observed that residents living in the dementia unit had views of one secure garden from the communal sitting room. Two residents informed the inspectors that they wanted to go outside for a walk in this garden. When the inspectors asked care staff to open the sitting room doors so that residents could go out to the enclosed garden, the inspectors were informed that the doors were locked. Care staff advised the inspectors that Glencar lodge is a 'dementia unit' and residents could not go outside independently as there was a risk to their safety. Inspectors' observed that the double doors to the enclosed outdoor garden off the sitting room were locked and residents could not access a safe outdoor space without the assistance of staff to open the door. When inspectors asked staff to open the doors, they observed that the key retrieved by staff did not function. Although, staff did retrieve a correct key from the break glass unit adjacent to the doors following this, the door still failed to release automatically, due to a fault in a magnetic locking device mechanism. Furthermore, inspectors observed that staff were not aware of the function of the manual override "green box" to release the magnetic lock on the sitting room doors, as fire safety procedures were not displayed.

Inspectors observed a music activity being facilitated in the communal sitting room on the second day of the inspection and a small group of residents who were dancing with staff appeared to really enjoy this activity. While there was a lively atmosphere observed in this room, inspectors also observed a number of residents who weren't engaged in the activity at all. Inspectors observed three residents with higher support needs were seated at a table, one residents chair was positioned with their back to the activity. Inspectors observed that there were books and activity equipment placed on the table where the residents were seated, however as staff were busy supporting other residents in the room, there was limited interaction with this group of residents. Inspectors observed that residents with higher dependency needs who were not engaged in the music activity were not facilitated to participate in an alternative activity. Residents in Lissadell lodge were seen to participate in one to one activities and inspectors observed group activities such as an exercise class and a daily rosary on the first day of the inspection. Most residents appeared to be engaged and enjoying these activities.

Inspectors attended a resident meal service in Lissadell lodge and found that residents were in receipt of appropriate and timely support to enjoy their meal. Residents who required assistance with their eating and drinking were supported in a dignified manner by the staff supervising the meal service. Residents were provided with a choice of main meal and could also access alternative food should

they not like what was on the menu.

The maintenance systems that were in place required improvement as the inspectors found that a number of areas of the premises were not well maintained. Furthermore, inspectors observed that some items of resident mobility equipment were not kept in a good state of repair, such as pressure relieving equipment and specialised seating.

Residents had access to local and national newspapers, televisions and radios in their bedrooms and in the communal areas. Information regarding advocacy services was displayed in the centre and inspectors were informed that residents were supported access this service if required. Residents were supported to practice there religious faiths and mass was celebrated up to four times a week in the chapel within the centre.

Visiting was facilitated in line with national guidelines and inspectors observed a number of visitors coming and going throughout the day of the inspection.

The next two sections of the report will present the findings in relation to governance and management in the centre and how this impacts on the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed under the relevant regulations.

Capacity and capability

This was an unannounced risk inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in designated Centres for Older People) Regulations 2013 as amended. Inspectors followed up on the compliance plan from the previous inspection in November 2022 and found that improved compliance as found on the last inspection had not been sustained.

The inspectors also followed up on unsolicited information of concern that had been received prior to the inspection, which related to areas such as governance and management, quality of care provision and staffing. The inspectors' findings mostly substantiated these concerns. Inspectors found that the current governance and oversight of the designated centre was not effective and did not ensure that care and services were provided in line with the centre's statement of purpose. In addition, the risk management processes were not effective in ensuring that risks were identified and mitigated, particularly in relation to fire safety and medication management. Following this inspection, the provider was asked to submit an urgent action plan which required them to take immediate actions to ensure that adequate medicines management systems and fire precaution systems were in place.

Templemichael Nursing Home Limited is the registered provider of Laurel Lodge Nursing Home. A director of the company represents the provider entity. The management structure included a clinical operations manager, the centre's person in

charge and two clinical nurse managers (CNMs). An assistant director of nursing (ADON) post was included in the management structure however this position was vacant at the time of the inspection. Inspectors were told that the ADON duties were being covered by the clinical operations manager. Although the inspectors were assured that recruitment was in progress to fill the role, there were no clear time-lines for when an assistant director of nursing would be in post. On the day of the inspection, there was also a vacancy for a clinical nurse manager in the Glencar lodge. This role was vacant for three days and was being back-filled by a clinical nurse manager who was previously allocated to Hazelwood Lodge. The person in charge oversees a team of nurses,health care assistants, activity, administration, maintenance, domestic and catering staff.

Although there was management oversight of risks in the designated centre and these were discussed in senior management meetings, the inspectors found a number of risks which had not being identified or addressed by the provider. For example, significant non-compliance was found in relation to Regulation 28: Fire precautions. The provider had failed to identify and address serious deficits in relation to the fire safety system and significant risks to residents safety in the event of a fire in the centre. Furthermore, the inspectors found that there was inadequate oversight of medication management systems and risks found on the day of inspection in relation to the calculation and documentation of controlled medicines had not been identified or addressed by the management team. Additionally, there was a high incidence of residents falling in the centre, records viewed by inspectors showed that residents fell on 72 occasions from 11 January to 02 April 2023. 57 of these incidents of falls were not observed by staff. Although this was identified by the management team and use of call bells were identified as one of a number of contributory factors, inspectors were told no call bell audits had been completed for 2023 at the time of this inspection.

Inspectors found that there had been a significant turnover of staff since the previous inspection. It was evident that the provider and managers were working hard to recruit staff for the designated centre, however inspectors noted that a significant proportion of the staff on duty on the days of the inspection had been recruited recently with some still completing the centre's induction or probationary processes. There were particularly high numbers of new staff working in Glencar Lodge. As a result, inspectors were not assured that the allocation of the number and skill mix of staff available on the days of the inspection was sufficient to meet the needs of the residents.

Inspectors' observations and discussions with staff showed that not all staff had completed mandatory training in fire safety, patient moving and handling and safeguarding residents from abuse. This was validated in the staff training records that were reviewed by the inspectors. Furthermore, Inspectors found that the lack of appropriate training, support and supervision for staff especially new staff was impacting on the quality and safety of care provided to residents.

Inspectors observed environmental restraints within the centre which the provider had not notified to the Chief Inspector as per the requirements of Regulation 31. Furthermore some staff who spoke with the inspectors were not clear about what

constituted a restrictive practice. For example, staff did not recognise that keeping the doors locked to the enclosed garden leading from the day room in Glencar Lodge, was an overly restrictive practice in the absence of individualised resident risk assessments. Similarly, staff did not recognise that locking some residents out of their bedrooms on this unit was not acceptable and was overly restrictive.

An annual review of the quality and safety of the service in 2022 had been completed. This included an overview of key areas of the service. The review had been carried out in consultation with residents and included details of planned quality improvement initiatives.

Inspectors reviewed a sample of staff files and found that they contained all of the information required by Schedule 2 of the regulations.

Regulation 15: Staffing

Inspectors were not assured that there was a sufficient number of appropriately skilled staff to meet the assessed needs of residents and given the size and layout of the designated centre. For example:

- Inspectors found that on the days of the inspection, the deployment of available staff did not ensure that there was sufficient staff with the appropriate knowledge and skills to meet the needs of residents. As a consequence residents' clinical and social care needs were not adequately met. For example; the inspectors found that on the second day of the inspection 74% of care and nursing staff rostered to provide care and support to residents on the dementia unit over a 24 hour period had commenced in their roles less than three months prior to the inspection and were not trained in the provision of dementia care.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised to ensure that they carried out their work to the required standards. This was evidenced by the following findings;

- Staff did not recognise that the overly restrictive practices and routines infringed the rights of many of the residents living in the centre. For example, staff did not recognise that keeping the doors locked to the enclosed garden off the sitting room where most residents spent their day on Glencar Lodge was an overly restrictive practice in the absence of individualised resident risk assessments. Similarly, staff did not recognise that locking some residents out of their bedrooms on this unit was not acceptable and was overly restrictive.

- Dosage calculations and documentation of controlled medicines was not completed in accordance with professional standards at all times.

The inspectors were not had not assured that all staff were appropriately trained in line with their roles and responsibilities. This was evidenced by;

- The majority of staff working in the dementia specific unit had not completed training in dementia care.
- Not all staff had completed training on restrictive practices and as a result did not recognise that the overly restrictive practices and routines infringed the rights of many of the residents living in the dementia unit
- The inspectors' findings were that staff had training needs in wound management, and in assessment and care planning in order to bring about improved outcomes for residents as discussed under Regulations 5 and 6.
- 56 staff, including those newly recruited to the centre, had not completed mandatory yearly fire safety training.
- Training records viewed on the day of inspection showed that that eight staff had not completed up-to-date mandatory training in safeguarding residents from abuse.
- 15 staff had not completed up-to date mandatory patient moving and handling training, 14 other staff had not completed up to date practical patient moving and handling training.

Judgment: Not compliant

Regulation 21: Records

Not all residents' records were held securely. Inspectors found a box of residents' information stored in a designated smoking room for residents adjacent to the reception area. On the day of the inspection, the door to this room was not locked. Inspectors requested that action was taken immediately to remove the records to a secure area, this action was completed by the person in charge promptly on the day of inspection.

Not all staff employed to work with residents in the centre were included on the centre's staff duty roster. For example, the clinical nurse manager and a staff nurse working on Glencar lodge were not referenced in the staff duty roster on the day of the inspection.The staff duty roster reviewed did not contain the full names of some staff who were working in the centre

Judgment: Substantially compliant

Regulation 23: Governance and management

The management and oversight systems in place were not effective in maintaining compliance with the Health Act 2007 (Care and Welfare of resident in Designated Centres for Older People) Regulations 2013 and ensuring that care and services were delivered in line with the centre's statement of purpose. This is evidenced by the high number of non-compliances found on this inspection and the failure to sustain compliance with the regulations found on the previous inspection in November 2022.

The provider had not ensured that the designated centre had a fully resourced clinical management structure available to ensure the effective delivery of care in accordance with the centre's statement of purpose. As a consequence, this inspection found a deterioration in compliance in the centre which was impacting on the quality of life and safety of the residents. There had been two changes in senior management at assistant director of nursing level since the last inspection. At the time of this inspection, this senior role was being filled on a temporary basis by the provider's group clinical operations manager, pending successful recruitment of a new assistant director of nursing. Furthermore, the previous clinical nurse manager on Glencar Lodge had left and this post was vacant for three days, although it was being back filled temporarily by a clinical nurse manager from another unit.

The current staffing model was not sustainable which was evidenced by the high turnover of staff in the centre. Furthermore, the staffing strategy did not ensure that residents had continuity of care from a staff team who were familiar with their needs and preferences for their care and daily routines. This was validated by the records of a management meeting in March 2023 which recorded that the management team had identified that insufficient number of care staff resources was impacting on clinical supervision, as members of the management team were having to provide direct care. Additionally, meeting minutes reported that some staff who were newly recruited required more training and that scheduled fire training had been cancelled as there were insufficient staff available to release new staff to attend the required fire training. Although these risks had been identified by the management team, inspectors found that they had not been managed and effectively mitigated.

Inspectors found that risks were not managed appropriately and a number of risks had not been identified, appropriately addressed and effectively mitigated. This was evidenced by the following;

- Fire safety risks, including the risk to resident safety posed by fire doors that were not operating as required had not been identified and addressed.

The quality assurance systems that were in place did not ensure the quality and safety of the service was effectively monitored. This was impacting on clinical effectiveness and residents' safety and quality of life. Disparities between the high levels of compliance reported in the centre's own audits did not reflect the inspectors' observations during the inspection. For example,

- A dementia care audit completed in January 2023 found that Glencar lodge

was fully compliant and a suitable environment to care for residents with dementia, however this audit did not identify the overly restrictive use of environmental restraints in Glencar lodge

Furthermore, the inspectors found that the oversight of of medicines management was not robust. The centres own oversight systems had not identified any areas requiring improvements that inspectors found on this inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

While notifications were submitted within the specified time-frames and as required by the regulations, quarterly reports submitted to the Chief Inspector prior to the inspection did not include all of the restraints identified on this inspection. For example, the restraint posed to a number of residents due to locked doors to their private accommodation and to one outdoor garden area on the dementia specific unit.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Although the centre had policies and procedures as outlined in Schedule 5 of the regulations, the inspectors found that the following policies were not implemented in practice;

- Wound and skin care management
- Fire safety management
- Management of restrictive practices

Judgment: Substantially compliant

Quality and safety

Although residents were mostly content in the centre and satisfied with the service

provided, the inspectors found that significant action by the provider was necessary to ensure that management and oversight, including clinical oversight of the service was effective and that adequate fire safety systems were in place to ensure residents' safety in the event of a fire in the centre.

Inspectors found that the provider had failed to take adequate precautions to protect residents from risk of fire and action was required to bring the centre into compliance with Regulation 28, Fire precautions. The provider had failed to ensure that staff had access to appropriate fire safety training and that fire safety equipment checks were effective with identifying fire safety equipment that was not functioning. Due to the risks identified by inspectors to residents' safety and the absence of satisfactory assurances regarding residents' safe evacuation in the event of a fire in the centre, the provider was asked to submit an urgent compliance plan to address these non-compliances by 8 May 2023. These findings are discussed in further detail under Regulation 28. Fire precautions.

The provider was also required to take urgent action by 8 May 2023 to ensure residents were protected by safe medicines practices. The provider submitted an urgent compliance plan response to the office of the Chief Inspector within the required timeframes.

The inspectors reviewed a sample of residents' care records. Records showed that nursing staff used validated tools to carry out assessments of residents' needs prior to and on admission to the centre. These assessments included the risk of falls, malnutrition, assessment of cognition and dependency levels. However, inspectors found that some assessments were not always completed in a timely manner. Furthermore, a number of the care plans reviewed by the inspectors did not include sufficient up-to-date information in relation to residents' current needs. As a result, these care plans did not provide staff with adequate guidance and direction to provide safe and appropriate care as needed for residents.

Residents' records and their feedback confirmed that they had timely access to their general practitioners (GPs), this was validated by residents who spoke with the inspectors and reported that they could see their GP when they wished to do so. However, residents had limited access to occupational therapy services and the provider had not ensured that residents had access to this service in the designated centre.

A policy was available to guide staff on management of and use of restrictions in the centre .However, restrictive practices were not always managed in accordance with this policy and the national restraint policy guidelines.

A small number of residents presented with responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). While staff responded to these residents in a kind and caring way, the inspectors found that staff did not have the knowledge and skills to manage some resident's behaviours effectively.

A social activity programme was developed to ensure residents were supported to

continue to pursue their interests in line with their capacities. However, the current programme did not ensure that all residents had equal opportunities to participate in meaningful social activities and engagement in line with their preferences and abilities. This is discussed further under Regulation 9.

Staff had completed training in infection prevention and control specific to their role and notwithstanding the improvements made by the provider, the inspectors found that some staff practices were not in line with the National Standards for Prevention and Control of Healthcare Associated Infections as published by the Authority and did not adequately protect the residents against the risk of infection.

The inspectors found that a number of areas of the premises were in need of maintenance. Paintwork on a number of walls was damaged and floor surfaces were in need of repair in residents' bedrooms and communal rooms. Furthermore the layout of some twin bedrooms negatively impacted on residents' privacy and daily activities. In addition, inspectors observed that storage facilities in a number of residents' bedrooms did not facilitate the residents to display and store personal items such as photographs and momentos. There were a number of designated storage rooms in the centre, however the segregation of supplies in these rooms was not effective and inspectors observed that items were not organised and stored appropriately to ensure that good standards for infection prevention and control were maintained.

While measures were in place to safeguard residents from abuse, a number of staff had not completed up-to-date mandatory safeguarding training, This finding is discussed under Regulation 16: Staff training and development.

The registered provider had ensured visiting arrangements were in place to ensure residents were supported to meet with their visitors as they wished.

Regulation 11: Visits

Visits by residents' families and friends were encouraged and practical precautions were in place to manage any associated risks. Residents access to their visitors was not restricted and facilities were available to ensure residents could meet their visitors in private if they wished.

Judgment: Compliant

Regulation 12: Personal possessions

Some residents did not have adequate space to store their personal possessions. This was evidenced by the following findings;

- Residents in two twin bedrooms could not maintain control of their clothing and other personal items due to the location of their wardrobes along a wall opposite their beds and outside their bed spaces.
- Residents in some twin bedrooms did not have a suitable surface or shelf so they could display their personal possessions in their bedrooms if they chose to do so. For example, other than the window ledges these residents did not have an alternative shelf surface to display their personal belongings on.
- One resident's bedside locker was located at the bottom of their bed and out of this resident's reach when resting in their bed.

Judgment: Substantially compliant

Regulation 17: Premises

The design and layout of areas of the designated centre did not meet the needs of the residents and a number of areas did not conform to Schedule 6 of the regulations. Some of these findings had been identified in the provider's own internal audits but no action had been taken to address the deficits. This was evidenced by the following findings;

- The layout of one twin bedroom in Lissadell Lodge was such that one resident's bed was positioned in an alcove area. The window in this room was located out of view and around a corner from this resident's bed. This limited natural light into this resident's bed space and this was reduced further when the other resident's privacy curtains were closed. This is a repeated finding from the last inspection.
- The layout of one twin bedroom on the ground floor did not ensure that there was sufficient space for one resident's locker to be placed within their easy reach when they were resting in bed. One side of this bed was placed against the wall and would have to be moved out into the room to facilitate staff access during transfer of a resident needing assistant from staff and use of assistive equipment such as a hoist.

The following findings did not conform to Schedule 6 of the regulations.

- Floor covering in a number of residents' bedrooms and in the sitting room in Hazelwood Lodge was worn, damaged and in need of repair/replacement. There was a large crack in the surface of the floor covering in the oratory. Floor covering that was continued to form skirting at the base of the walls in the communal room in Glencar Lodge was peeling away from wall surfaces. These findings did not ensure that the floor surfaces were adequately maintained or that effective cleaning procedures could be completed.
- A number of maintenance issues were identified including items of furniture that were visibly scuffed and worn. The paint on a number of residents' bed tables and some items of assistive equipment was worn, chipped and missing. This finding did not ensure that these surfaces could be effectively

cleaned and as such posed a risk of cross infection to residents.

- Paintwork on the wall surfaces in a number of residents' bedrooms, communal rooms, along some corridors and on wooden door frames and bedroom doors was scuffed, chipped and damaged and required repair and repainting to ensure these surfaces were maintained to an adequate standard and could be effectively cleaned.
- Hand rails were not in place by the sinks in two communal bathrooms. This posed a risk of fall to residents and did not promote their independence.
- The fabric on some residents chairs was damaged and foam filling was exposed. This finding did not ensure these chairs could be effectively cleaned.
- The surface of some pressure relieving chair cushions were damaged and one cushion required replacement as the internal structure was collapsed. This meant that this was no longer fit for purpose and required replacement.
- The call bell in one residents' communal bathroom in Glencar lodge was located a distance from the toilet and was not easily accessible to residents. This posed a risk that residents would be unable to get staff assistance if needed.
- One area of a ceiling surface in Lissadell lodge showed signs of water leakage damage and required repainting.
- There was inappropriate storage of equipment including residents' assistive equipment in a communal bathroom/toilet used by residents and in the residents' sitting room areas. This meant that residents' communal space was reduced and posed a risk of cross infection
- The extractor fan in the communal toilet across from the nurses station in Glencar lodge was not operational and as a result the room lacked ventilation. There was inadequate ventilation in the sluice rooms in Lissadell and Glencar lodge which resulted in malodour.
- The wall surface in the sluice room in Glencar lodge was damaged and in need of repair.

Judgment: Not compliant

Regulation 18: Food and nutrition

Although the dietician recommended that a resident with unintentional weight loss was offered rice puddings and milky drinks, the inspectors' observations and the food/fluid records available did not confirm that this recommendation was implemented by staff.

Judgment: Substantially compliant

Regulation 27: Infection control

The inspectors found that some procedures were not consistent with the standards for the prevention and control of health care associated infections and the current guidance from the Health Protection and Surveillance Centre (Health Protection Surveillance Centre Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities guidance), including:

- Hand hygiene sinks in the sluice rooms and laundry rooms did not comply with current recommended specifications for hand hygiene sinks and did not support effective hand hygiene procedures by staff.
- Hand hygiene sinks located in some corridors for staff use did not meet recommended clinical hand hygiene sink standards.
- The area around the water outlets in most sinks used by staff for hand hygiene was visibly stained.
- While residents had individual hoist slings, a large number of labelled and unlabelled slings were observed to be stored together on hoists and on a hook in a storage room in Glencar Lodge and were not returned to the resident's room or a suitable storage area. Slings were overlapping and although they appeared to be clean there was no system in place to provide assurances that they had been cleaned and decontaminated after use. This increased the risk of cross-contamination.
- A number of storage rooms were cluttered and were not segregated to ensure equipment was stored separately from incontinence wear and personal care items and posed a risk of cross contamination. Items were stored directly on the floors in some storerooms and hindered effective cleaning of floor surfaces.
- A communal bath for residents' use in Glencar Lodge was visibly stained. It was unclear if it had been cleaned after use as it was not tagged and dated. This was not in line with the cleaning procedures to be followed by staff which were displayed on the bathroom wall.
- Open top refuse bins were observed in most communal toilets and in twin bedroom en-suite facilities. Furthermore, there was no bin available in a communal toilet in Glencar Lodge. These findings did not support recommended waste management procedures and posed a risk of cross infection.
- A used urinal was stored in the window of a communal toilet in Glencar lodge and posed a risk of cross infection.
- Lockable storage for potentially hazardous cleaning solutions were not available in the house-keeping room in the Glencar Lodge.
- The area immediately around the water outlets in sinks in some communal toilets were stained. This finding did not give assurances that these areas had been thoroughly cleaned and this posed a risk of cross infection.
- The sluice room on Lissadell Lodge was being used to store linen skips, drip stands and a shower chair for use by residents.
- Two fabric towels were hanging over a grab rail next to the toilet in the en-suite off a twin bedroom and posed a risk of cross contamination.
- The wooden surface of the handrails on circulating corridors in Glencar Lodge was tarnished and sticky. This meant that this high touch surface was not

adequately cleaned and it posed a risk of cross infection.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not ensured that adequate arrangements were in place to safeguard residents from risk of fire and to ensure their safe evacuation if necessary, out of the centre premises would not be hindered or delayed.

This was evidenced by the followings findings;

- Final fire exit doors out of the sitting room where most residents spent their day in Glencar lodge dementia unit did not operate as required and the magnetic locking system failed to allow these emergency fire exit doors to open when the fire alarm system was activated. This final fire exit door was also manually locked with a key and with the centre's internal electronic door security system which was operated by a swipe card held by each staff member. The key was held in the nurse's station in addition to a duplicate key stored in a break glass unit by the door. On the day of the inspection, the designated door key held in the nurse's station and the swipe cards held by a number of staff failed to unlock this door. Furthermore, a number of staff did not carry keys or swipe cards. This finding posed a significant risk of delay in the event of an emergency evacuation being required.
- A final fire exit door in an activity room adjacent to a staff area and used by residents did not operate as required and the magnetic locking system failed to allow the emergency fire exit doors to open when the fire alarm system was activated and the fire alarm sounded. Inspectors did not see an over-ride mechanism available by this door and staff did not use one. This posed a significant risk to safe and timely evacuation of any residents using this activity room.
- The procedures for unlocking emergency final exit doors throughout the centre were not consistent and the procedures to be followed to open the individual final fire exit doors in the event of a fire emergency in the centre were not displayed at these emergency doors.
- Furthermore, Inspectors found that not all staff were aware of the location of keys or the function of the magnetic over-ride mechanism. Some staff who spoke with inspectors were not aware that a number of emergency exits doors had a break glass unit containing a key to open the key locks on the fire exit doors. Inadequate knowledge of fire safety procedures created a high risk that an emergency exit door may not be opened when required and not afford residents and staff with an adequate means of escape.

Inspectors were not assured that all staff in the centre had received suitable training on fire prevention and emergency evacuation procedures in the centre. Inspectors found that 56 staff recruited since December 2022 had not participated in a fire

evacuation drill. Records of staff attendance at mandatory fire safety training did not reference all staff and the evacuation procedures communicated to inspectors by staff did not reflect the procedure described in the centre's emergency evacuation policy.

A smoking room designated for resident use was being used as a storage area and inspectors observed that it contained combustible items such as an oil radiator and supplies of incontinence wear. This posed a risk of fire.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Poor oversight of medicine management in the centre did not provide adequate assurances that residents were protected by safe medicines management practices and procedures or that the centre's medicines management policy was adhered to. This was evidenced by the following findings;

- Medicinal products that were out of date were not always segregated from medicinal products in use.
- Some multi-dose medicine preparations were not dated on opening. This posed a risk that recommended manufacturer timescales for safe use would be exceeded.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Assessment and care planning required improvement to ensure each resident's health and social care needs were identified and the care interventions that staff must complete were clearly described. The inspectors reviewed a sample of residents' care documentation and found the following;

- Some residents' care plans were not informed by assessment of their needs. For example, meaningful activities assessments were not completed for all residents and as a consequence residents' social activity care plans lacked sufficient detail to direct staff regarding the activity programme they must facilitate to meet these residents' social activity preferences and capacities.
- Care plans were not always developed in response to assessments that identified a care need. For example, a care plan had not been developed to direct staff on the care interventions they must complete for two residents wounds, to promote wound healing and prevent further deterioration of the wound. Where care plans were developed, the inspectors found that some

residents' care plans were not being implemented by staff. For example, inspectors found gaps in the repositioning records for four residents with pressure related skin wounds, and this posed a risk to residents' skin integrity.

- Assessments completed to identify risk of pressure wound development for three residents were scored incorrectly on three occasions. This did not ensure that nursing staff had accurate information to implement appropriate measures to care for residents who were at risk of developing pressure related wounds.
- Care plans were not updated to ensure that outdated information which was no longer relevant had been removed. Additionally, some pertinent information in relation to residents had not been added to their care plan. For example, a resident's mobility care plan did not reflect current arrangements regarding their need for use of assistive equipment to enable them to transfer safely. This posed a risk that this information would not be communicated to all staff.

Judgment: Not compliant

Regulation 6: Health care

The provider and person in charge did not ensure that residents received a high standard of evidence based woundcare and medicines management to meet their needs including timely access to health-care services. This was evidenced by the following findings;

- On reviewing wound records, the inspectors found some residents' wound assessments were not completed in line with the centres own wound care policy. Furthermore, the inspectors found that there were inconsistent clinical measurements documented in some wound assessment charts which made it difficult to assess if the current wound dressing plan was successful or required further review. For example, the depth of one pressure related wound was measured just once in a three month period.
- Residents did not have timely access to occupational therapy services. Records showed that a response to a referral made in May 2022 was not addressed until April 2023.
- Medication administration in the centre did not reflect a high standard of medicine administration practices in accordance with professional guidelines issued by An Bord Altranais agus Cnaimhseachais: Medicines controlled under misuse of drugs legislation were not administered in line with professional guidelines.
- Nursing staff failed to ensure that residents were administered sufficient analgesia in a timely manner. For example, records showed that one resident with a significant pressure related wound did not receive adequate analgesia prior to repositioning and wound care procedures on a number of occasions.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

A number of staff had not attended training in the management of responsive behaviours to ensure they had the skills and knowledge they needed to provide support and care for residents with known responsive behaviours. This was an action that the provider had committed to address following the previous inspection.

Restrictions placed on residents access in the centre did not reflect national guidance and the restrictive practice register in place did not account for all residents living in the centre who had restrictive practices in place. For example;

- Access to the enclosed garden area off the sitting room in the Glencar Lodge was restricted with use of electronically locked doors. This arrangement placed restrictions on residents' freedom of movement and their choice to access the outside space without the support of staff to open the door for them.
- A number of residents' bedrooms were locked throughout the day on residents leaving their bedroom in the morning. This meant that residents were restricted from accessing their bedrooms if they wished to do so during the day without a member of staff being available to open their bedroom door for them.

Judgment: Not compliant

Regulation 8: Protection

There were systems in place to safeguard residents from abuse. Eight staff required refresher training in safeguarding, an action relation to this finding is addressed under Regulation 16, Training and development.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had not ensured that some residents could carry out personal activities in private. This was evidenced by the following findings;

- The privacy curtains were positioned closely around a bed space in one twin bedroom and did not allow for staff or residents to move freely if the bed was

pulled away from the wall. As a result the inspectors were not assured this resident's privacy would be maintained during transfer with assistive equipment into and out of bed or during personal care activities.
- A window blind was missing from a window in a twin bedroom next to a resident's bed and as such did not ensure this resident's privacy.

Residents were not supported to exercise choice in their daily routines. This was evidenced by:

- Residents in Glencar Lodge could not choose to go out into one outdoor area leading from the sitting room where the majority of residents spent their day without a member of staff being available to open the door for them.
- A number of residents in Glencar Lodge could not choose to spend time in their bedrooms without a member of staff being available to unlock the bedroom door for them.
- Residents in a twin bedroom shared one television which did not ensure that each resident had choice of television viewing and listening. Furthermore the location of the television did not ensure that both residents could view the television comfortably or that both residents could view the television if one resident had their bed screens closed.

The provider had a social activity schedule in place that included group and one-to-one social activities and some residents were seen enjoying these activities especially on the Glencar and Hazelwood lodges on the days of the inspection. However, inspectors observed that residents with higher levels of cognitive impairment on Glencar and Hazelwood lodges did not have equal access to participate in social activities to meet their interests and capacities. This observation was validated by the absence of records that referenced residents' participation in social activities that met their interests and capacities.

Records viewed by inspectors showed that a residents' meeting had not taken place since August 2022, this was confirmed by the management team. This did not assure the inspectors that residents were adequately consulted in the day to day running of the designated centre.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Laurel Lodge Nursing Home OSV-0005394

Inspection ID: MON-0038871

Date of inspection: 03/05/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • 6 Super-nummary team leaders have been appointed, 2 per unit • 6 new HCA's are in process of being recruited to replace above ensuring 6 additional WTEs added to our roster and team leaders are super-nummary. • Team leaders to work opposite each other to ensure 7/7 HCA supervisor cover • Team leaders will work directly with all new starters during their orientation period and complete their induction to improve the induction/orientation process and ensure all new staff are learning best practice • The purpose of team leaders being supernummary is to observe, assess practices, ensure staff are completing same to a high standard of safety and quality, and to educate, support and correct staff as required, recommend additional trainings and supports that they ascertain are required • Rosters are reviewed by the PIC before they are put out to ensure safe skill mix and staffing levels • Reviews are taken place before allocating new staff to units to ensure there are not too many new staff on one unit • Training has been scheduled twice per month fire, manual handling, NVPS, quality and safety (which includes human/resident rights, restrictive practices, nutrition and hydration, dysphagia, oral care, infection prevention and control, skin care and pressure ulcer prevention, falls prevention) and nursing documentation, assessment and care planning • Inhouse safeguarding is organised as required • Additional dementia care training has been sourced with three dates booked and staff rostered to attend • Same will continue to be organised as required • All staff are required to complete the following online training also prior to commencement (including but not limited to; safeguarding, manual handling, an introduction to childrens first, and numerous infection prevention and control modules) • All management and nursing vacancies are filled and have commenced their roles, other then a new rec therapy supervisor who is due to commence mid August • Recruitment is ongoing to backfill 6 positions to allow for the team leaders to become	

fully supernummary
• Risk assessments and controls are in place in the event a unit is short staffed or if skill mix were to be inadequate, with control effectiveness monitored regularly
• Audits are completed regularly to assess staff knowledge and to observe staff practices to ensure same is in line with best practice, safe and of high quality- where non compliances are evident action is taken and reviewed
• Oversight audits are also in place to ensure audits are being completed correctly
• Incidents and complaints are reviewed by the PIC to assess if staff practices/skill mix/numbers/knowledge were a contributory factor or root cause, and if so appropriate action taken
• The PIC regularly reviews resident dependencies and staffing levels inline with the RQIA safe staffing model to ensure levels are in line with guidance (same are above current recommendations)
• Meetings are regularly held with staff to enhance communication and also for staff to bring to management any concerns
• Open door policy is in place for staff to approach management and feel comfortable doing so if they have any issues, concerns and for support

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• No new starters start without a minimum of online training having been completed (this includes but not limited to an introduction to childrens first, safeguarding adults at risk of abuse, manual and people handling, national standards for IPC in community services, and IPC modules)
• Prior to their commencement on site all new starters have mandatory training scheduled in advance with same completed within the first month of employment, this includes Training has been scheduled twice per month fire, manual handling, NVPS, quality and safety (which includes human/resident rights, restrictive practices, nutrition and hydration, dysphagia, oral care, infection prevention and control, skin care and pressure ulcer prevention, falls prevention) and nursing documentation, assessment and care planning
• Safeguarding in house training also takes place regularly to add to the online training
• 6 Super-nummary team leaders have been appointed, 2 per unit
• 6 new HCA's are in process of being recruited to replace above ensuring 6 additional WTEs added to our roster and team leaders are super-nummary.
• Team leaders to work opposite each other to ensure 7/7 HCA supervisor cover
• Team leaders will work directly with all new starters during their orientation period and complete their induction to improve the induction/orientation process and ensure all new staff are learning best practice
• The purpose of team leaders being supernummary is to observe, assess practices, ensure staff are completing same to a high standard of safety and quality, and to

educate, support and correct staff as required, recommend additional trainings and supports that they ascertain are required
• Weekly review of training matrix to identify gaps, ensuring that new starters and staff who's training will be out of date in the short term are prioritised.
• New starters and starters that are out of date have been prioritised to ensure all staff are within date
• 95% of staff attended safeguarding at the time of inspection and 90% for manual handling
• Additional dementia care training has been sourced with three dates booked and staff rostered to attend
• Same will continue to be organised as required
• Two full day training sessions has been completed with an external TVN for nurses and one more sessions have been scheduled- same were scheduled prior to the inspection but the TVN had to reschedule same
• New nurses starters are required to complete the following before beginning to administer medication alone:
o Complete 3 x medication management competency assessments conducted by the DON/ADON
o Complete medication management training on HSE land
o Read and sign schedule 5 medication management policies

• As standard when an incident occurs and / or prior to completing lone medication rounds, all existing and new staff to complete
o 3 x medication management competency assessments,
o HSE land training
o Read and sign off on schedule 5 policies.
• As standard all nurses are required to complete medication management training on HSE land and a yearly medication competency assessment with the ADON/DON

• Medication competency assessment has been updated to include assessment on DDAs
• Audits have been updated to ensure adequate oversight of DDA management
• Audit results to be reviewed quarterly
• Weekly controlled Drug audit developed and implemented, being completed by ADON/DON
• Schedule 5 policies and relevant policies have been disseminated to staff to ensure knowledge of same
• Going forward schedule 5 policies shall be sent to new staff members prior to commencement to ensure all staff have read same when they come on duty
• A risk assessment with controls is in place for new staff starting/lack of staff knowledge, controls are regularly reviewed and action taken where control effectiveness is low
• Audits are completed regularly to assess staff knowledge and to observe staff practices to ensure same is in line with best practice, safe and of high quality- where non compliances are evident action is taken and reviewed
• Oversight audits are also in place to ensure audits are being completed correctly
• Incidents and complaints are reviewed by the PIC to assess if staff practices/skill mix/numbers/knowledge were a contributory factor or root cause, and if so appropriate action taken

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• Storage of resident records rectified on the day
• Roster now includes all staffs first and name and surname
• The CNM and staff nurse were referenced on another unit's roster, clearly stating on the roster they were in Glencar, it was an oversight that same was not reflected on the Glencar roster as it was the first day of same, now rectified
• The PIC/ADON review all rosters before they are put off, and on a daily basis and now ensure the rosters accurately reflect staffing on each unit and that staff members full names are on the rosters
• Part of the job role of the support services manager is to ensure appropriate storage of records, liaising with maintenance/admin as required to ensure all is kept in the appropriate place for the appropriate length of time, with feedback to the PIC where issues may arise

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• New ADON has commenced, and new CNM on Glencar (noting that the role was vacant for three days only at the time of inspection) and new CNM on Hazelwood.
• Fire drills and fire training have now been completed for all staff
• Monthly fire drill schedule in place and is being completed as per schedule, with fire drill analysis completed after each drill to determine where things went well, and areas that require improvement
• Signage on exit doors of how to open final exit door and all staff educated on same in the event of a fire
• Weekly staff knowledge audits to ascertain staff knowledge of fire procedures
• Fire audit and fire risk controls updated to ensure all risks can be identified within the audit and fire risk assessment
• Trial was completed with locks removed from doors, however many issues arouse during this trial period such as residents removing items from other residents bedrooms, residents using other residents bathroom and lying on other residents beds etc. Review of the trial was completed. Risk assessment completed and bedrooms locked where deemed necessary due to risk. Actions in place to ensure residents are able to access their rooms whenever they wish. Same are entered onto the risk register with appropriate measures in place to reduce risk of impact on residents rights, independence

and autonomy, same entered into the residents care plan, and same will be included in the quarterly notifications to HIQA
• All enclosed gardens are now accessible for residents without the need for staff assistance
• New nurses starters are required to complete the following before beginning to administer medication alone:
o Complete 3 x medication management competency assessments conducted by the DON/ADON
o Complete medication management training on HSE land
o Read and sign schedule 5 medication management policies

• As standard when an incident occurs and / or prior to completing lone medication rounds, all existing and new staff to complete
o 3 x medication management competency assessments,
o HSE land training
o Read and sign off on schedule 5 policies.
• As standard all nurses are required to complete medication management training on HSE land and a yearly medication competency assessment with the ADON/DON

• Medication competency assessment has been updated to include assessment on DDAs
• Audits have been updated to ensure adequate oversight of DDA management
• Audit results to be reviewed quarterly
• Weekly controlled Drug audit developed and implemented completed by ADON/DON
• Weekly review of medication trollies and storage areas developed

• Risk assessments and controls are in place for areas of risk, with controls regularly audited (frequency based on level of risk) and action taken for non compliances, same are regularly reviewed to ensure action taken is effective and areas of non compliance are resolved
• Audits are completed regularly to assess many areas of care, the governance and management of the centre, the environment, staff knowledge and practices etc, with all audits (and risk controls) based on policy, legislation/regulations and evidence based practice to ensure all areas are within line with best practice, safe and of high quality- where non compliances are evident action is taken and reviewed to ensure non compliances are resolved
• Oversight audits are also in place to ensure audits are being completed correctly, factually and accurately
• Incidents and complaints are reviewed by the PIC, with assessment of contributory factors and/or root cause, with appropriate action taken as required
• The PIC regularly reviews resident dependencies and staffing levels are in-line with the RQIA safe staffing model to ensure levels are in line with guidance (same are above current recommendations)
• Meetings are regularly held with staff to enhance communication
• Regular resident forum meetings are now in place with a schedule in place for the rest of the year, minutes are reviewed by the PIC and action taken where required
• Open door policy is in place for staff, residents and families to approach management and feel comfortable doing so if they have any issues, concerns and for support
• Resident and family satisfaction surveys are completed yearly with action taken where outcomes are not optimal, with additional satisfaction surveys planned for this year such

as activities satisfaction surveys and meal and meal times satisfaction surveys
• Where trends are identified in any non compliances discovered in incidents, complaints, audit results, risk controls or poor outcomes in KPIs or resident satisfaction surveys, quality improvement plans are developed with actions, persons responsible, and timeframe for completion, and same then reviewed and monitoring of effectiveness

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• Locked bedrooms doors will be reported in the HIQA quarterly notifiations
• All enclosed gardens are now accessible to residents without the assistance of staff

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• Schedule 5 policies and relevant policies have been disseminated to staff to ensure knowledge of same
• Going forward schedule 5 policies shall be sent to new staff members prior to commencement to ensure all staff have read same when they come on duty
• Risk assessments and controls (based on local policy, legislation/regulations and evidence based practice) are in place for areas of risk, with controls regularly audited (frequency based on level of risk) and action taken for non-compliances, same are regularly reviewed to ensure action taken is effective and areas of non-compliance are resolved
• Audits are completed regularly to assess many areas of care, the governance and management of the centre, the environment, staff knowledge and practices etc, with all audits based on local policy, legislation/regulations and evidence based practice to ensure all areas are within line with best practice, safe and of high quality- where non compliances are evident action is taken and reviewed to ensure non compliances are resolved
• Oversight audits are also in place to ensure audits are being completed correctly, factually and accurately
• Policies/audits and risk controls are reviewed regularly to ensure same are maintained in line with any changes in legislation, regulations and best practice
• Incidents and complaints are reviewed by the PIC, with assessment of contributory factors and/or root cause, with appropriate action taken as required where non

compliance to policy/procedure is evident
• Weekly review of wounds and all relevant document
• Wound care and assessment and care planning training for nurses
• Restrictive practice, NVPS, and Human rights training already part of the schedule, rolling schedule in place to ensure all staff attend, additional training being organized to focus specifically on dementia care
• Fire drills completed for all staff and monthly fire drill schedule in place
• Fire audit and fire risk controls to be reviewed and updated to ensure no gaps to include those identified in inspection
• face to face staff audits, same to be completed weekly by one fire warden per week (on a rotation basis) to spot check individual staff knowledge on fire procedure utilising the newly developed standarised questionnaire. Where gaps are identified staff to be referred/re-referred for training asap even if have completed yearly mandatory training already
• Wardens to ensure that all staff are spot checked at least twice yearly.
• Signage placed at the entrance to each unit and at all exit doors highlighting how to exit in an emergency.
• Mechanism on how to open fire exists doors (green push button / Key / thumblock) highlighted to all staff on each unit.
• An external company has been appointed to undertake the remedial works as soon as possible to include replacing the swipe card mechanism with key pads
• Maintenance have agreed the process and timeline with external company to fix maglocks as a priority
• Full review of fire doors has been completed and all release via green emergency exit door release
• Fire safety to be included in resident forum meetings
• Resident fire safety guidelines available for resident
• Inductions updated to include enhanced fire safety knowledge to include important locations

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• All wardrobes are located within the room-space of the resident, which ensures same are within easy access to the resident and hence does not impact on the other resident sharing the room
• Lockers, dressers, items hung on walls etc all allow the display of residents' personal belongings, where residents would like additional storage for additional items same is facilitated

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• In context of the bed positioning as per the request of the individual resident, we have installed a convex mirror to facilitate view of the window and outside area, aswell as placed a blind over the skylight window to ensure same does not impede rest. We are focused to ensure that the resident occupying this bed, prefers to spend their time in communal areas have
• Checklist has been developed for CNM's to undertake a review of environment and sluice rooms daily (ensuring cleaning schedules are completed, items are tagged, environment clean, uncluttered etc)
• All staff have received education re importance of maintenance of same
• Checklists are reviewed by the PIC/ADON and ad hoc checks are also carried out by the PIC/ADON to ensure compliance
• Housekeeping also to complete a monthly audit of the environment and action areas of non compliance
• Results are monitored by the ADON/PIC, and oversight audits also completed by the ADON/PIC to ensure audits completed are being completed correctly and reflective of the true environment
• Maintenance snag list in place and in progress to address areas of wear and tear/chipped paint/flooring/surfaces/stains/furniture wear and tear etc
• Handrails placed in communal bathrooms where they were missing
• Call bell relocated in the residents' bathroom in Glencar
• Extractor fan fixed
• Regular reviews now take place in relation to these areas by the ADON/PIC to ensure oversight and that relevant action is being taken where required

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• New experienced head chef appointed
• All staff are provided with the schedule 5 policy on food and nutrition
• All staff receive training in food, nutrition and dysphagia, and in relation to residents' choice and access to food/fluids
• Residents likes and dislikes are taken on admission and given to the kitchen and shared with staff

• Monthly nutritional screening takes place and action taken where there is evidence of risk
• Where recommendations are made by the dietician same are shared with the staff and kitchen to ensure all staff are aware of same and that resident received same
• Re-iterated to staff the importance of accurate and reflective documentation, as if same is not recorded correctly it is not clear if the resident received their meals as recommended by the dietician
• PIC/ADON review weights and MUST scores monthly
• A meal and mealtime audit is in place to observe and assess areas of the meal and mealtime experience, to assess if residents are being offered choice, are receiving nutritious and appealing meals and snacks, to observe if residents are requiring assistance the require, and the correct level of food and fluid, to ensure the mealtime is a social, unhurried and enjoyable event
• Oversight audits are completed by the PIC/ADON
• A meal and mealtime satisfaction survey is due to be completed in August
• All residents' dietary requirements are shared with kitchen staff, HCAs and nurses to ensure all staff are knowledgeable about residents requirements, fortified snacks and drinks are always available for residents- as can be seen from evidence where residents who have lost weight have gained it back, and from a significant low resident population in the nursing home having a MUST of 2 or more

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Infection prevention and control policies are provided to all staff
• IPC is regularly discussed in staff meetings
• All staff complete the HIQA IPC training and relevant online AMRIC modules, as well as regular in-house IPC meeting
• There is an IPC link nurse to educate and support on IPC practices, complete IPC audits and risk management, and implement and promote relevant IPC processes and antimicrobial stewardship
• Audits are completed regularly to assess IPC within the centre with all audits based on local policy, legislation/regulations and evidence based practice to ensure all areas are within line with best practice, safe and of high quality- where non compliances are evident action is taken and reviewed to ensure non compliances are resolved
• Oversight audits are also in place to ensure audits are being completed correctly, factually and accurately
• There is ongoing infection surveillance by the IPC nurse with low levels of HCAIs within the centre
• Hand hygiene sinks were highlighted with laurel lodges nursing home audit and action taken for new sinks to be installed
• Housekeeping staff all informed to ensure water outlets are thoroughly cleaned daily, same added to audit

• Slings were not in use, same have been washed, and stored away with clear labelling of the date items have been cleaned
• CNM's to undertake a review of environment, store rooms and sluice rooms daily (ensuring cleaning schedules are completed, items are tagged, environment clean, uncluttered etc) – Checklists for same developed and implemented
• ADON/PIC regularly review the checklists and ad hoc, unannounced spot checks to monitor compliance
• All open top refuse bins to be replaced and bin placed in communal toilet in Glencar (missing on the day)
• Lockable storage units to be installed in all housekeeping rooms (same ordered, awaiting delivery)
• Wooden surfaces of handrails became tarnished due to the frequency of cleaning undertaken on the handrails. it is also well known that some products leave a sticky residue. Handrails that are tarnished to be revarnished and review of cleaning products for an alternative that does not leave a residue

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire precautions:
Although the maglock device failed, all fire exit doors open via the green emergency exit box which overrides the magnetic lock and the swipe mechanism, so regardless of swipe and / or maglock working or not all fire exit doors can open in the event of an emergency. There is no requirement for staff to carry swipe cards or keys.

This procedure has been approved by a competent third party when our fire cert was originally issued and again in July 2022 when same was revised and re-issued. Post inspection the system was again reviewed by a competent third party (taking into account the fault in the maglock system) and they are satisfied with current procedure / process for opening final fire exit doors

Procedure for opening fire exit doors is different in Glencar for a small number of doors and includes a key lock (with the key in the break glass unit beside the fire door) due to the risk of residents absconding from this this unit. This has been risk assessed and measures in place to address risk- again this has been approved by a competent third party most recently in July 2022 and again post inspection in May 2023.

• Fire drills completed for all staff and monthly fire drill schedule in place
• Fire drills are also completed within the yearly fire training
• Fire safety is discussed at staff, management/clinical governance meetings
• Two fire wardens have been appointed and have received relevant trainings, in train the trainer, and further training provided by an external company to further educate on legislation and regulatory requirements, the maintenance manager has also attended the

latter training
• The fire wardens, having received training, and being up to date with local policy, relevant legislation and regulations, and a working knowledge of the HIQA fire handbook will be completing the in house fire checks, fire audits and staff questionnaires, with feedback to, and oversight from the PIC
• Fire audit and fire risk controls have been reviewed and updated to ensure no gaps to include those identified in inspection, this has been cross referenced with the fire handbook and relevant legislation
• face to face staff audits, same are being completed weekly by one fire warden per week (on a rotation basis) to spot check individual staff knowledge on fire procedure utilising the newly developed standarised questionnaire. Where gaps are identified staff to be referred/re-referred for refresher training asap even if have completed yearly mandatory training already
• Wardens now ensure ensure that all staff are spot checked at least twice yearly.
• Signage placed at the entrance to each unit and at all exit doors highlighting how to exit in an emergency.
• Mechanism on how to open fire exists doors (green push button / Key / thumblock) highlighted to all staff on each unit.
• A company has been sourced to repair maglock system, with order placed to complete same
• Full review of fire doors has been completed and all release via green emergency exit door release
• Fire safety is now included in resident forum meetings
• Resident fire safety guidelines available for resident
• Staff inductions updated to include enhanced fire safety knowledge and whereabouts of important locations
• Indoor smoking area to be de-commissioned

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• Schedule 5 policies including medication management policies have been disseminated to staff to ensure knowledge of same
• Going forward schedule 5 policies including medication management policies shall be sent to new staff members prior to commencement to ensure all staff have read same when they come on duty
• Risk assessments and controls relating to medication management (based on local

policy, legislation/regulations and evidence based practice) are in place with controls regularly audited (completed by the PIC) (frequency based on level of risk) and action taken for non compliances, same are regularly reviewed to ensure action taken is effective and areas of non compliance are resolved
• Audits are completed regularly to assess medication management practices, documentation and staff knowledge with audit based on local policy, legislation/regulations and evidence based practice to ensure all areas are within line with best practice, safe and of high quality- where non compliances are evident action is taken and reviewed to ensure non compliances are resolved
• Oversight audits are also in place to ensure audits are being completed correctly, factually and accurately
• Policies/audits and risk controls are reviewed regularly to ensure same are maintained in line with any changes in legislation, regulations and best practice
• Incidents and complaints are reviewed by the PIC, with assessment of contributory factors and/or root cause, with appropriate action taken as required where non compliance to policy/procedure is evident
• Where trends are identified with poor outcomes, QIPs are developed and processes amended to improve outcomes
• New nurses starters are required to complete the following before beginning to administer medication alone:
o Complete 3 x medication management competency assessments conducted by the DON/ADON
o Complete medication management training on HSE land
o Read and sign schedule 5 medication management policies

• As standard when an incident occurs and / or prior to completing lone medication rounds, all existing and new staff to complete
o 3 x medication management competency assessments,
o HSE land training
o Read and sign off on schedule 5 policies.
• As standard all nurses are required to complete medication management training on HSE land and a yearly medication competency assessment with the ADON/DON
• Nurses also receive inhouse training on medication management
• The pharmacy has also provided additional training

• Medication competency assessment has been updated to include assessment on DDAs
• Audits have been updated to ensure adequate oversight of DDA management
• Audit results to be reviewed quarterly
• Weekly controlled Drug audit developed and implemented completed by ADON/DON
• Weekly review of medication trollies and storage areas developed

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:
• Template of all care plans to be altered to allow for a more person centered, holistic and individualized care plan
• Care plan and assessment audit increased in frequency and volume of care plans audited
• Care plan and assessment care training developed and now part of the training schedule
• Admission checklist developed to ensure all care plans and assessments are completed within 48 hours of admission and reviewed thereafter by DON/ADON,
• A quarterly assessment of nurses' competencies (wound care, care planning and assessment, clinical documentation, incident management, dementia care and BPSD management etc) as part of the probation review and thereafter, yearly has been developed and for implementation

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Schedule 5 policies including medication management, have been disseminated to staff to ensure knowledge of same
• Going forward these policies shall be sent to new staff members prior to commencement to ensure all staff have read same when they come on duty
• Wound care and pain management procedures are in place and provided to all staff nurses
• Risk assessments and controls relating to these areas (based on local policy, legislation/regulations and evidence based practice) are in place with controls regularly audited (completed by the PIC) (frequency based on level of risk) and action taken for non compliances, same are regularly reviewed to ensure action taken is effective and areas of non compliance are resolved
• Audits are completed regularly to assess these areas relating to practices, documentation and staff knowledge with audit based on local policy, legislation/regulations and evidence based practice to ensure all areas are within line with best practice, safe and of high quality- where non compliances are evident action is taken and reviewed to ensure non compliances are resolved
• Oversight audits are also in place to ensure audits are being completed correctly, factually and accurately
• Policies/audits and risk controls are reviewed regularly to ensure same are maintained in line with any changes in legislation, regulations and best practice
• Incidents and complaints are reviewed by the PIC, with assessment of contributory factors and/or root cause, with appropriate action taken as required where non compliance to policy/procedure/training is evident
• Where trends are identified with poor outcomes, QIPs are developed and processes amended to improve outcomes

Laurel Lodge has no control of the HSE Occupational therapists waiting list and prioritisation of same.
Where reviewed may be prolonged and taking time to occur families / residents are offered the option of a private occupational therapist. It is the residents/families choice if they prefer to wait for same through the public system.

Wound care training for all nurses scheduled with 2 sessions already complete, this covers both wound care management, and documentation surrounding same, including accurate assessment and measurement

Weekly review of all wounds and relevant documentation/assessment/measurement/care planning and relevant referrals etc in place, completed by the PIC/ADON

Daily review of notes/incidents/complaints in place by PIC/ADON to ensure residents with significant injury/wounds are receiving adequate pain relief, and also that all relevant referrals in all areas are made in a timely manner and followed up on if correspondence not received

Nurses receive training in assessment, care-planning and documentation, which includes actioning areas that need referral in a timely manner and the importance of follow up where correspondence is not received

Care plans are reviewed by the ADON/PIC to ensure they reflect the needs of residents in relation all areas of care including medication management, wound management and pain management

Discussions have also taken place with each nurse on the importance of appropriate pain relief for residents with pain/injuries/wounds- this had already been addressed at the time of inspection and same was resolved- reference in report are prior to interventions stated here

• New nurses starters are required to complete the following before beginning to administer medication alone:
o Complete 3 x medication management competency assessments conducted by the DON/ADON
o Complete medication management training on HSE land
o Read and sign schedule 5 medication management policies

• As standard when an incident occurs and / or prior to completing lone medication rounds, all existing and new staff to complete
o 3 x medication management competency assessments,
o HSE land training
o Read and sign off on schedule 5 policies.
• As standard all nurses are required to complete medication management training on HSE land and a yearly medication competency assessment with the ADON/DON

• Medication competency assessment has been updated to include assessment on DDAs
• Audits have been updated to ensure adequate oversight of DDA management, wound

care, assessment and pain management • Audit results to be reviewed quarterly • Weekly controlled Drug audit developed and implemented completed by ADON/DON • Weekly review of medication trollies and storage areas developed • Glencar fridge has always been stored in a locked room

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

• All staff have access to training and all staff are rostered to attend same as required, gaps in the training are due to staff being unable to attend training due to personal reasons, when this occurred, these staff are prioritised for the next upcoming sessions

• Two training sessions per month for each training (including training in restrictive practices and NVPS) are scheduled with out of date staff/new starters prioritised to ensure no gaps exist. Once complete training schedule and matrix will be reviewed weekly to ensure on-going compliance.

• Dementia care training has been scheduled for three sessions over the coming two months

• All enclosed gardens are now accessible to residents without staff assistance

• Trial was completed with locks removed from doors, however many issues arouse during this trial period such as residents removing items from other residents bedrooms, residents using other residents bathroom and lying on other residents beds etc. Review of the trial was completed. Risk assessment completed and bedrooms locked where deemed necessary due to risk. Actions in place to ensure residents are able to access their rooms whenever they wish. Same are entered onto the risk register with appropriate measures in place to reduce risk of impact on residents rights, independence and autonomy, same entered into the residents care plan, and same will be included in the quarterly notifications to HIQA

• There is ongoing monitoring of restrictive practices

• Where restrictive practices are in place, these are assessed, discussed with the resident/NOK, care planned, and controls in place to reduce the impact of a restrictive practice that may be in place on a residents rights

• Policies for safeguarding of residents and management of residents with responsive behaviours are in place and disseminated to staff, a copy of same are available on each unit, Management ensure this occurs and staff have read same

• Risk assessments which are regularly reviewed, with controls that are audited in line with the risk review are in place to ensure appropriate risk management and ensure controls are being implemented. These are reviewed regularly by the DON and discussed at the clinical governance meetings

• Incident reviews and behaviour charts reviewed daily by the DON/ADON, with action taken to reduce risk and learning shared, same are reviewed at the clinical governance meetings, with potential trends and action taken/required discussed

• Auditing (based on evidenced based practice) of dementia care and residents with challenging behaviours are regularly completed to ensure care given, and prevention and management of residents with responsive behaviours are in line with best practice, audit results are now reviewed by the DON/ADON regularly, and additional "oversight" audits in place to ensure audits are being completed correctly and factually
• Mandatory online safeguarding training is required prior to commencing work in Laurel Lodge, and same is completed in house also within the induction period of new staff, management provide oversight to ensure same is completed
• Mandatory in-house training is also provided in restrictive practices, human and resident rights, and NVPS, management provide oversight to ensure same is completed
• The DON/ADON complete a pre admission assessment of all long term admissions, before accepting any admissions, to assess the residents in all areas of care, including responsive behaviours, and how a resident with responsive behaviours may impact the other residents on the unit. The ADON/DON will only make the decision to admit a resident where it is assessed the resident, based on the current and past presentation, would be able to be cared for safely within the nursing home, without negatively impacting other residents
• All residents are then assessed on admission and re-assessed on a minimum of three monthly basis, and on an as required basis as needs changes etc for all areas of care including relating to responsive behaviours, assessments inform the care plan, as well as discussions with the resident and NOK/Nominated representative, areas including triggers, behaviours and effective non pharmacological interventions are identified and shared with staff to aid in the prevention and management of responsive behaviours, as well as assessments including a key to me and meaningful activities assessments (all currently being updated) to ensure we have an overall view of the resident's background, likes, dislikes, how to like to engage socially etc to inform social and recreational activities to enhance engagement and reduce risk factors of responsive behaviours
• ABCs and 'PINCH Me's' are used to assess and identify potential causes of responsive behaviours and action taken based on outcome, management review documentation and receive a daily handover from the units and ensure this occurs
• Management ensure restraints are never used for the management of responsive behaviours
• As required, residents are referred to G.P/Psychiatry of later life and other allied health care professionals, management have an overview of resident care and ensure this occurs when needed
•

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Blind re-placed on window
• Privacy curtains altered to allow more space where resident requested re-positioning of bed
• All enclosed gardens are now accessible to residents without staff assistance

• Trial was completed with locks removed from doors', however many issues arouse during this trial period such as residents removing items from other residents bedrooms, residents using other residents bathroom and lying on other residents beds etc. Review of the trial was completed. Risk assessment completed and bedrooms locked where deemed necessary due to risk. Actions in place to ensure residents are able to access their rooms whenever they wish. Same are entered onto the risk register with appropriate measures in place to reduce risk of impact on residents' rights, independence and autonomy, same entered into the residents care plan, and same will be included in the quarterly notifications to HIQA
• Residents are asked re their choices in relation to items such as TV's, radios etc
• Bi monthly resident forum meeting schedule in place for the remainder of 2023
• Discussions held with rec therapy staff re the importance of documenting all therapies and activities, same are available for all residents with all degrees of cognitive functioning- however documentation did not reflect same, spot checks being completed on same
• Mandatory online safeguarding training is required prior to commencing work in Laurel Lodge, and same is completed in house also within the induction period of new staff, management provide oversight to ensure same is completed
• Mandatory in-house training is also provided in restrictive practices, safeguarding, human and resident rights, and NVPS, management provide oversight to ensure same is completed
• Audits are completed to assess staff practices and knowledge in relation to residents' rights, as well as residents perspectives on same, resident satisfaction surveys also encompass resident rights to ensure Laurel Lodge can be assured residents feels their rights are met and respected, action is taken where poor outcomes are evident

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	21/06/2023
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes	Substantially Compliant	Yellow	21/06/2023

	and other personal possessions.			
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/08/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/08/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/08/2023
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	21/06/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Not Compliant	Orange	31/01/2024

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Substantially Compliant	Yellow	31/08/2023
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	21/06/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	21/06/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	21/06/2023

	effective delivery of care in accordance with the statement of purpose.			
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	21/06/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	21/06/2023
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	30/11/2023
Regulation 28(1)(a)	The registered provider shall take adequate	Not Compliant	Orange	30/09/2023

	precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/09/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/09/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	21/06/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire	Not Compliant	Orange	21/06/2023

	alarm call points, first aid, fire fighting equipment, fire 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	21/06/2023
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	30/09/2023
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated	Not Compliant	Orange	21/06/2023

	centre.			
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Not Compliant	Orange	21/06/2023
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	21/06/2023
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out	Substantially Compliant	Yellow	21/06/2023

	in Schedule 5.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	21/06/2023
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.	Not Compliant	Orange	21/06/2023
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus	Not Compliant	Orange	21/06/2023

	Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	21/06/2023
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	21/06/2023
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	21/06/2023
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance	Not Compliant	Orange	21/06/2023

	with national policy as published on the website of the Department of Health from time to time.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	21/06/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	21/06/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	21/06/2023
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	21/06/2023