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:	Sally Park Nursing Home
Name of provider:	Passage Healthcare International (Ireland) Limited
Address of centre:	Sally Park Close, Firhouse, Dublin 24
Type of inspection:	Unannounced
Date of inspection:	13 September 2023
Centre ID:	OSV-0005565
Fieldwork ID:	MON-0041488

About the designated centre

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

Sally Park is a Georgian building with two modern extensions, with views over the local area. There is parking at the front of the premises, and the centre is close to public transport routes and local shops and facilities in the area.

The designated centre is provided over three floors. There are 21 single en-suite bedrooms, 5 single rooms, four double rooms and three multi-occupancy rooms. There are a range of communal rooms and seating areas in the centre, and a large dining area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	39

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
Monday 18 September 2023	08:00hrs to 16:40hrs	Helen Lindsey	Lead
Wednesday 13 September 2023	10:00hrs to 18:30hrs	Kathryn Hanly	Lead
Wednesday 13 September 2023	10:00hrs to 18:30hrs	Karen McMahon	Support
Monday 18 September 2023	08:00hrs to 16:40hrs	Frank Barrett	Support

What residents told us and what inspectors observed

At the time of the inspection a large renovation project was in progress in the designated centre. Inspectors found the registered provider had reduced the size of the centre by demolishing part of the building, including the removal of an emergency escape stairs serving the first and second floors where residents were accommodated. Three other emergency exits on the ground floor were put beyond use due to the construction activity outside these doors which included the escape routes. These changes presented significant risks for the safety of the resident living in the home which will be described throughout this report.

In addition to this the demolition works also removed three storage rooms, the laundry, an office, a shower, and an accessible toilet. The removal of these rooms impacted the operation of the designated centre and the lived experience of residents.

An accessible toilet on the ground floor had been removed in the demolition. Renovations of a second bathroom on the ground floor had led to a toilet been moved and fitted in to an existing shower. This toilet was placed directly in the shower area, and partially over the shower drain. On both days of inspection, this toilet was blocked and there was a strong odour from the room. The risk of cross contamination with this arrangement was high.

Storage space was extremely limited throughout the centre, which resulted in the inappropriate storage of equipment and supplies throughout the centre and in storage containers externally. For example, one resident's bedroom was used to store two hoists, wheel chairs were stored down the side of the stairs, and food trolleys where placed on corridors which were also fire escape routes. The provider was asked to remove oxygen cylinders which were not stored securely in the kitchenette area.

The premises was found to be in a poor state of repair, and was not laid out to meet the needs of residents. For example, paint was worn off down to the wood on doors and skirting, meaning it could not be readily cleaned. There were signs of water damage on the ceiling, and above one bedroom door pieces of the plaster were coming away.

Appropriate facilities for the storage and preparation of medications and facilities for the preparation and storage of cleaning chemicals and equipment were not available. There was no dedicated clean utility or treatment room for the storage and preparation of medications, clean and sterile supplies such as needles, syringes and intravenous fluids. These items were stored and prepared in the kitchenette where staff were observed to eat lunch and where potatoes were prepared for resident's meals. The specimen fridge was also stored within this room which posed a risk of cross contamination. There was no dedicated housekeeping room for storage and preparation of cleaning trolleys and equipment. Inspectors were

informed that trolleys were stored and prepared externally.This also increased the risk of environmental contamination and cross infection. Details of issues identified are set out under regulation 17 and 27.

The laundry service had been outsourced to an external company. However, there was no assessment of the risks associated with the new arrangements such as as the risk of cross contamination associated with the external storage of a trolley containing clean linen in an external area adjacent to the waste compound.

On the ground floor, residents had access to a range of communal areas including three sitting rooms and a spacious dining area. However, as a consequence of the ongoing construction works there was no garden and limited safe external spaces that residents could freely enter. The front of the designated centre, which had previously been lawned gardens were now used for storage containers, and for the construction site. Inspectors were not assured that access to the building site was restricted. A door leading directly onto the building site was unlocked at the beginning of the first day of the inspection, and remained open on the second day.

On entering the building site, inspectors noted the boiler house building had been demolished and a temporary shelter had been erected around it. The pipe that carried exhaust gases produced by the boiler was venting into the shelter. There were gaps through the wall and this potentially provided a route through for the toxic gases, posing a hazard to anyone in close proximity to the shelter.

Inspectors also observed that a temporary gas line had been set up between the two boilers for the centre. The provider could not provide assurance that this alteration had been carried out by a registered gas installer.

Residents were observed to receive visitors throughout both days of inspection. However, there was no space provided to meet visitors in private. This would significantly impact residents who lived in shared bedrooms.

The residents and visitors who spoke with inspectors during the inspection expressed their satisfaction at the quality of care and support they received. However, inspectors were not assured that residents were protected from the risk of fire or that their living conditions were acceptable given the deterioration in the fabric of the building and the removal of significant parts of the building.

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

Capacity and capability

Overall the registered provider had failed to provide a safe and effective service, failed to comply with their conditions of registration and failed to conduct risk

assessments to prepare and manage for construction works which were in progress on the days of the inspection. The failure to take appropriate responsibility negatively impacted on the safety of the residents living in the centre. Significantly the registered provider had :

- Failed to ensure effective management systems were in place to ensure that the service provided was safe. This is detailed under regulation 23: governance and management.
- Failed to ensure residents were protected from the risk of fire and that residents could be safely evacuated to a place of safety. This is detailed under regulation 28: fire precautions.
- Failed to ensure the premises is adequately maintained for the number and needs of people using the service and in accordance with the Statement of Purpose. This is detailed under regulation 17: premises.
- Failed to ensure residents were protected from the risk of infection. This is detailed under regulation 27: infection control.
- Failure to submit notification in line with regulatory requirements. This is detailed under regulation 31: notification of incidents.

In addition the findings of this inspection are that the registered provider is not compliant with other key regulations which underpin the care and welfare of residents including regulation 5: individualised assessment and care planning, regulation 9: resident rights, and regulation 11: visits.

The registered provider was not operating the designated centre in line with their statement of purpose and function. The provider had decommissioned the use of the laundry facilities, store rooms, office space, a toilet, and a shower in the designated centre without consulting with the office of the chief inspector or submitting an application to vary condition 1 of the registration of the designated centre. Findings in this regard are presented under regulation 17.

When the registration was renewed in March 2023 a restrictive condition was applied to the providers registration requiring that they take action to address serious fire safety risks in the centre. In particular, by the 31st October 2023 the registered provider was required to:

- Ensure that there were adequate alternative means of escape available for all parts of the designated centre at all times
- Ensure that all the fire rated door sets in the designated centre were fit for purpose and provide adequate containment of fire and smoke
- Install additional fire rated double door set at the bottom of the stairway
- Ensure that there was effective fire compartments that achieved the required fire rating of 60 minutes and which were suitable for progressive evacuation.

At the time of the inspection, there was no evidence that this work had commenced to address these significant fire risks, and to meet the deadline. In addition, inspectors identified that the works that were in progress had significantly increased the risk relating to fire safety in the centre.

The provider had failed to implement effective strategies to mitigate the risk to residents. Temporary measures had been put in place to retain power and heat to the centre during the construction work, however, inspectors were not assured of the adequacy of the temporary measures which were put in place. For example, inspectors noted a temporary gas line supplying fuel to a temporary boiler. This gas line was tied to pipes along the back wall of the centre beneath residents bedroom windows. There were inadequate arrangements in place for the safe evacuation of residents in the event of a fire. Adaptations had been made to the fire alarm and emergency lighting system. The effect of these changes was that evacuees would not have any escape signage to direct them to any exit door, or to a place of safety. There were no systems in place to review this situation, nor was there any documentation to support the modification made to the emergency lighting system or escape routes from the existing centre.

The registered provider failed to ensure that adequate precautions were in place against the risk of fire and the person in charge had not ensured that all relevant adverse incidents are notified to the Chief Inspector in the recommended format and within the specified time frames. For example a review of management meetings found that a 'fire event' had been recorded in the kitchen in January 2023. Findings in this regard are presented under regulation 31.

Inspectors found that there were insufficient local assurance mechanisms in place to ensure that the environment and equipment was maintained in accordance with the National Standards for Infection Prevention and Control in Community Services. For example, the general environment in the original part of the building was in a state of disrepair. Environmental hygiene audits had not been completed in 18 months and cleaning records were not available to view on the first day of the inspection. These issues identified were compounded by the demolition of parts of the building during the ongoing building works. Findings in this regard are presented under regulation 17, 23 and 27.

Regulation 23: Governance and management

The registered provider had failed to put effective management systems in place to ensure that the service provided was safe. Significant risks were identified by inspectors that had not been identified by managers, and therefore appropriate steps to mitigate those risks were not implemented. This included risks in relation to fire safety, infection prevention and control, and the premises.

A review of staffing resources was required to provide assurance that there were enough staff to safely evacuate residents in the event of a fire in light of the changes in the building and construction works in operation.

Inspectors identified that management systems were not sufficiently robust to ensure the service provided was safe, appropriate consistent and effectively monitored. For example:

- There were ineffective risk management arrangements in place, for example the registered provider had removed a fire escape stairs without recognising the risk that created for the eight residents on the second floor and five residents in the older part of the first floor.
- The registered provider did not have oversight or insight into the inadequacies of the the fire safety arrangements in the designated centre and as a result inspectors could not be assured that residents would be safe in the event of a fire.
- Management systems for the oversight for the maintenance of the premises was found to be ineffective. For example, infection prevention and control audits were not routinely undertaken. Inspectors identified several areas of significant risk and wear and tear throughout the building which required addressing. This is further detailed under Regulation 17, Premises.
- There was poor oversight of infection and prevention and control. Inspectors were informed that specialist infection prevention and control personnel were not consulted at the outset of the demolition and building works.
- The registered provider was not operating within the conditions of registration. Significant changes had been made to the footprint of the building, but no application had been made to vary condition 1, relating to the statement of purpose, or the floor plan against which the provider was registered. For example laundry, store rooms and a toilet and shower room had been removed. Other items had been added, for example a number of temporary structures were now on the premises storing items related to the designated centre.
- The provider failed to protect the rights and dignity of the residents. For example, residents did not have access to safe external spaces during the ongoing building works. This is further detailed under Regulation 17, Premises.

Judgment: Not compliant

Regulation 31: Notification of incidents

All incidents and reports as set out in schedule 4 of the regulations were not notified to the Chief Inspector within the required time frames. A three-day notification of the operation of fire alarm equipment where there was a fire event in the centre was not submitted.

Judgment: Not compliant

Quality and safety

Inspectors found that the quality and safety of services provided to residents in the centre was significantly compromised. There were significant risks relating to fire safety, residents care plans did not reflect their needs sufficiently, parts of the premises were in a poor state of repair, and infection prevention and control measures were not in line with the national standards in all area. Residents did not have a space to meet visitors in private, and there was no external gardens available, due to the construction work taking over the front lawns.

Paper based care plans were available for all residents. A nursing assessment was completed on admission and care plans were updated every four months, or sooner if required. However, on review of care plans, inspectors were not assured that residents were receiving the highest standard of evidence based nursing care. Details of issues identified are set out under Regulation 5, Individual assessment and care plan.

Action was required to ensure that all residents' rights were protected and upheld. For example, inspectors observed that an accessible toilet in the vicinity of the communal and day rooms had been demolished and the arrangements to reconfigure a second toilet created significant malodours and were unsafe. These arrangements also had the effect of reducing the number of accessible showers on the ground floor to one.

There were no visiting restrictions in place. Visits and outings were encouraged and facilitated. Visitors were seen coming and going over the course of both days of the inspection. However there was lack of communal space for people to receive visitors in private if they so wished.

The physical environment in the centre had not been managed and maintained to effectively reduce the risk of infection. Damage from wear and tear in the original part of the building meant that surfaces and finishes were difficult to clean. Maintenance requests were not being actioned in a timely manner. Damage was noted to doors throughout the centre. Wall and ceilings were also found in a poor condition. This was a repeat finding from previous inspections, and was not actioned.

Major external construction including major soil excavation and demolition of parts of the designated centre had commenced. An *aspergillosis* risk assessment had not been undertaken and documented. Inspectors observed that the majority of bedroom windows overlooking the construction area were open. Inspectors also observed an open vent leading to the construction site in the room used to store and prepare medications and dressing trolleys. Details of issues identified are set out under Regulation 27.

A mobile high efficiency particulate air (HEPA) filter air cleaners had been installed in each of the three day rooms to improve the air quality and reduce the risk of airborne transmission including COVID-19. However inspectors found that further training on their operation and purpose was required as there was some ambiguity among staff around their use. For example, one staff member told inspectors that

the machine were only turned on in the morning while another staff member told inspectors that these units had the ability to detect infection in the air.

Significant fire safety issues were identified during this inspection. There were issues identified to the provider at the previous inspection, which were not actioned. Inspectors identified issues relating to prevention of fire, containment of fire, means of escape, fire safety management, fire safety training and fire drills. These issues are dealt with further under regulation 28 Fire Precautions.

Regulation 11: Visits

Residents did not have access to a private space, other than their bedroom, to receive their visitors. The impact on residents would be they could not have private conversations.

Judgment: Substantially compliant

Regulation 17: Premises

The registered provider did not, having regard to the needs of the residents at the centre, provide premises which conform to the matters set out in schedule 6 of the regulations. For example:

- The premises was found to be in a poor state of repair, and was not laid out to meet the needs of residents.
- There was a lack of appropriate storage space in the centre resulting in the inappropriate storage of equipment. Equipment and supplies was stored in sitting rooms, residents bedrooms, an external yard and in storage containers that were overfilled and cluttered.
- The only available sluice room located on the first floor did not support effective infection prevention and control. The sluice room contained a bed pan washer and a hand washing sink which did not comply with the recommended specifications for clinical hand wash sinks. There was no sluice sink for the disposal of body fluids or contaminated water.
- The physical environment was not kept in good structural and decorative repair, internally and externally. Extensive wear and tear was observed on surfaces in the original part of the building including worn and damaged doors, walls, ceilings, flooring, radiators and door and window frames. This impacted on effective cleaning.
- Due to the ongoing construction works, residents were not supported and facilitated to access safe, secure and appropriate outside spaces.

- Maintenance issues were not actioned in a timely manner. This was evidenced by damage to doors, floors, walls and ceilings in the centre. Several bedroom doors did not close fully, and were not lockable.
- The lift at the centre was operational on the days of inspection, however, the lift mechanism/motor room had been removed, and the lift motors moved to a temporary structure at the back of the lift shaft. Inspectors were not assured that this was commissioned, and serviced according to the manufacturers instructions as no documentation to this effect was available.
- Inspectors noted that dust from the adjacent construction works was entering rooms through the windows. On day two, inspectors noted that all bedroom windows were closed with a sign on the windows to keep them closed. Inspectors found that this situation was impacting on the ventilation of the bedrooms.
- The laundry and storage rooms in the west wing area of the centre had been demolished. This resulted in excessive amounts of storage elsewhere in the centre. Storage was also impacting fire safety which is discussed under regulation 28 Fire Precautions.

Judgment: Not compliant

Regulation 27: Infection control

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

- Inspectors observed a failure to segregate function areas within the centre. For example staff dining, food preparation and storage and preparation of medications, clean and sterile supplies was observed within the kitchenette on the ground floor.
- Inspectors were informed that cleaning trolleys were prepared and stored in the external courtyard. However on the day of the inspection these were observed to be stored within the sluice room and a shower room rendering both rooms inaccessible and posed a risk of cross-contamination.
- The environment had not been cleaned to an acceptable standard. For example dust was visible on the floor and skirting boards of several rooms and a press containing personal protective equipment in the kitchenette was visibly unclean. The carpet on the main stairwell was damaged and was not included on a steam cleaning schedule.
- Hand hygiene facilities were not in line with best practice and national guidelines. There was a limited number of dedicated hand wash sinks in the centre.

Equipment and supplies were not consistently decontaminated and maintained to minimise the risk of transmitting a healthcare-associated infection. For example;

- Inspectors observed that a commode and a bedpan in the sluice room were found to be visibly dirty. Inspectors were informed that all utensils in this room were manually washed weekly as the bedpan washer sometimes failed to remove staining. Ineffective decontamination posed a risk of cross-contamination.
- Furniture in several bedrooms was seen to be worn, with damaged surfaces, impacting on the effective cleaning.
- Sinks in multi-occupancy bedrooms were not kept clear of extraneous items including toothbrushes, washbasins and personal hygiene products. This increased the risk of cross contamination.

The registered provider had not ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. For example;

- The overall antimicrobial stewardship programme (antibiotic use) needed to be further developed, strengthened and supported in order to progress this programme. For example antibiotic use was monitored, however, this data was not used to inform or target quality improvement initiatives by the provider.
- Management and staff were unaware of which residents were colonised with multi-drug resistant organisms (MDROs). Lack of awareness meant that appropriate precautions may not have been in place to prevent the spread of the MDROs within the centre.
- Assurances were not provided that effective oversight and controls were in place to manage the risk of resident exposure to Aspergillus during the ongoing demolition, excavation, construction and refurbishment activities.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider did not have effective oversight or systems in place is respect of fire safety and fire safety management systems to protect residents from the risk of fire. Fire safety management, systems and procedure at the centre did not reflect the nature of the building as it was on the day of inspection. Significant construction works to the building were impacting fire safety at the centre.

The registered provider did not take adequate precautions against the risk of fire, and did not provide suitable fire fighting equipment for example:

- Flammable and combustible items were stored in linen store three on the first floor, and in the staff cloakroom on the ground floor. Flammable Items such as hand sanitser were stored alongside linen, incontinence wear, and were stacked to the ceiling of the cupboard.

- Inappropriate storage of Oxygen cylinders was found on the ground floor in a cupboard on the route to the staff kitchenette. The oxygen cylinder was not protected from collision with other items in the cupboard, nor was it secured. There was no signage on the cupboard to indicate the presence of oxygen, and there was no fire detection in the cupboard. Staff removed this immediately when this was brought to their attention.
- A temporary gas line was tied to the outside of the centre at the back of the building. This gas line supplied fuel to a temporary boiler. Inspectors were not assured that the line was adequately secured or protected from construction activity. The existing gas line had been modified, and a shut-off device connected to the fire alarm had been deactivated and removed.
- A temporary boiler shelter housing a gas boiler was fitted to the west side of the centre. The flue gases from this boiler were discharging directly into the temporary shelter. Flue gases are toxic, and would pose a significant threat to residents living in this area of the centre. There were no fire fighting equipment available at this boiler.
- While there was an LI type fire alarm system in place, not all areas of the centre had coverage.

The registered provider did not provide adequate means of escape including emergency lighting for example:

- Escape routes on the ground floor had been put out of use due to construction activity. Three emergency exits to the external had been blocked off on the ground floor. An external escape stairs which provided an alternative means of escape from the first and second floor was removed. This resulted in the emergency exit door on the first and second floors being shuttered closed with plywood. The effect of these changes would have a catastrophic impact on the evacuation of residents staff and visitors to the centre in the event of a fire.
- An exit door from the resident bedroom corridor on the ground floor was found to be locked. Inspectors asked where the key for the door was, and if this was available at all times. A member of staff was called by the person in charge, who identified that the key was on a keyring of another key which was in the intruder alarm lock at the top of the door. This location was not readily accessible, and was not known to all staff.
- The emergency lighting directional signage throughout the centre had been modified, removed, or obstructed. Some of the directional escape signs had been removed for example in the ground floor dining room. Others had been covered with cardboard as the exits which they had been directing to had been removed. The impact of this would cause confusion and delays in an evacuation scenario.

The registered provider did not ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of a fire. For example;

- Fire drills completed at the centre did not provide detail of the scenarios which had been trialled. No evidence was available that staff had trialled evacuation under differing scenarios using evacuation aids available at the centre.
- There were no fire drills reflecting the current arrangement at the centre for evacuation of the largest compartment under times of low staff numbers. This meant that inspectors could not be assured that staff would be able to evacuate those residents safely and in a reasonable time in the case of a fire.
- Fire safety training was completed annually by in-house staff. No certification of the trainer was available on the day of inspection. Inspectors could not be assured that staff were fully familiar with the procedure in the event of a fire.

The registered provider did not make adequate arrangements for containing fires. Inspectors could not be assured of effective compartmentation within the building, for example:

- There was no evidence that containment measures were in place. Containment lines are compartments within the building which contain fire and smoke for a specified period. These containment lines need to be effective above and below ceiling level to ensure containment of fire so that evacuation of residents to the relative safety of the next compartment can be competed.
- Fire doors throughout the building had large gaps underneath and around the perimeter. Many doors were found to remain open on release of the door holding device. The ironmongery fitted to the doors in most cases did not appear to be fire rated. Inspectors found non fire-rated hinges, door handles, and glazing which did not have a fire rating. Many doors were missing fire and smoke seals, and most bedroom doors did not have door closer devices fitted. This was a repeat finding from previous inspections. The totality of this finding raised concerns of the fire-protected nature of bedroom corridors.
- Compartment doors at the bottom of the main stairs were not in place. Doors entering stairs are vital to ensure a protected stairs is in place. This stairs was the only escape route from the second floor in the event of a fire, and was the primary escape route for a significant proportion of residents on the first floor. Furthermore, The under stairs storage area did not have containment measures in place. There was no fire sealing evident on the underside of the stairs. The door did not appear to be a fire door.

The registered provider did not make adequate arrangements for evacuating where necessary in the event of a fire, of all persons in the designated centre. For example:

- No evidence was available on the day of inspection to indicate that vertical evacuation had been practiced at the centre. This would impact the evacuation of residents on the first and second floor in the case of evacuation to the outside.
- The external assembly point was spray painted onto loose road surfacing in the remaining section of car park. This position was not adequately removed from the building, and there was no directional signage in place to direct

evacuees to the assembly point location. The impact of the adjoining construction works also impacted the assembly point as the removal of garden space and parking space meant that in the event of a fire, this area would be used by emergency vehicles to access the building. The location required review.

The person in charge did not ensure that the procedure to be followed in the event of a fire was displayed in a prominent place in the designated centre. There was no procedure available at the main entrance, or at the fire alarm panel. Layout maps throughout the centre were modified with exits crossed out to reflect the closure of fire exits. The layout maps retained the primary and secondary evacuation routes, which were now, in some cases, not accessible. This would cause significant delays and confusion in the event of a fire for residents staff or visitors to the centre using these maps to exit the building.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- Inspectors found that Activity of Daily Living (ADL) care plans lacked detail regarding residents' preferred frequency of bathing and washing.
- Care plans for several residents colonised with drug resistant organisms were not in place to guide staff with regard to infection prevention and control practices needed to prevent infection.
- All residents had between one and three COVID-19 care plans in place. These were not person centred and were not proportionate to the current risks posed by COVID-19 infection.

Judgment: Not compliant

Regulation 9: Residents' rights

Action was required to ensure that residents' right to choice, privacy and dignity was supported and upheld in all aspects of their care and daily life. For example, residents did not have access to safe external spaces during the ongoing building works.

The layout and configuration of a multi-occupancy bedroom required attention to ensure that these rooms supported residents' right to privacy and dignity. Inspectors

observed that in the current configuration of one bedroom all residents could not get dressed or access their personal possessions in private as one wardrobe was located outside their private curtain space.

A shower room had been reconfigured and the toilet was now positioned in the shower tray meaning that residents would have to sit on the toilet while having a shower. This reconfiguration did not support residents right to dignity while attending to their personal care needs.

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 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Sally Park Nursing Home OSV-0005565

Inspection ID: MON-0041488

Date of inspection: 18/09/2023

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

- There is a Fire Risk assessment in place that was completed in September 23 and passed to DFB in early October 2023, actions required from same will be actioned in a timely manner. Compartmentalisation is the priority and architects and engineers are working on same with us and with DFB. There is a new environmental audit that has been sourced and adapted to fit the environment of Sally Park. This will be completed every six weeks and an action plan to remedy issues outstanding will be formulated. There will be some areas that will be dependent upon fire actions (compartmentalisaton) but these will be noted within the action plan. The building is being maintained but some areas will be uprooted with the compartmentailsation and this will be completed upon completion of same. The Landlord is going to rebuild removed spaces including a shower room, toilet and office along with a new three story internal stairwell. This will bring the footprint of the building to be almost what it was but with the benefit of a new internal fire escape that will service all floors. At this point an application to vary will be submitted as per the guidance that was available at the start of 2023. Staffing levels have been reviewed in conjunction with Dublin Fire Brigade, Our Fire Consultant and our Fire trainer, staffing has been increased to 7 staff from 8pm to 10pm, 5 staff from 10pm to 7am and 6 staff from 7am to 8am. The fire safety arrangements are reviewed regularly, last time being June 2023, they have since been updated in September 2023. Residents in Sally Park have always enjoyed sitting out the front of the house looking at all of the comings and goings, there are two courtyard areas that are rarely used but available to residents and generally used if residents have very young children visiting in the summer as one of these courtyards feature some fairy paraphernalia. Resident's have enjoyed the interaction with the builders, the hanging baskets and flower boxes have been maintained throughout.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
At the time of the incident, the notification categories were checked and the incident was a minor incident, it was not a fire, it was a tray in the oven that created smoke and activated the fire alarm. There was no need for any evacuation, nor interventions from the fire brigade. As a precaution the gas pipe was checked. This will be completed and sent in, however this was a genuine omission as this was perceived to be an incident like toast burning. The records of same were not hidden away and were available for inspection.

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
There are three sitting rooms within the centre, when families visit, they chose to either go to the persons bedroom or to remain beside the resident in the lounge, some families like to sit in the dining room and some families like to be outside, (obviously in good weather). This has not changed and whenever residents need a private space, this is always facilitated sensitively and appropriately.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

The older part of the building is having extensive compartmentalisation works done to it, when the fire proofing has been done the aesthetics of the building will be up to standard. Storage is continually being addressed, the storage containers have been reorganized and PPE coming up to expiry date will be removed. This will be ongoing as expiry dates are reached. No equipment will be in resident's bedroom's unless it is being

used at that time. The sluice room has a bed pan washer, we have since had additional training for all staff for the bed pan washer, this has solved the problem with staining and decontaminates same with very high temperature cycle. All of the older part of the building is being brought up to standard as part of the fire proofing. There are two courtyard areas that are rarely used but available to residents that feature some fairy paraphernalia. Some resident's enjoy sitting out at the front of the Nursing Home. The lift motor room was moved and the lift had been tested thoroughly by the lift engineers that moved the motor room. The certificate for same was requested and when received will be available for inspection (Attached)Daily in handover, the building works are discussed, on days where there is no construction works the windows will be opened for a few hours by the housekeeping staff as usual. On days when there is construction work, the windows adjacent to the work will be closed and the housekeeping staff will ensure that a mobile air purification unit is left in each of these rooms for a number of hours (dependent upon the room). The laundry has been outsourced and dirty linen only is stored at the back of the house near the bin area.

Regulation 27: Infection control	Not Compliant

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

The kitchenette area has been repurposed to be utilized as a clinical area only. The premises are undergoing some work that is beyond aesthetic, with the need to uplift flooring to fit fire safety materials – this will comprise fire stopping that is sealed and skirting boards etc. replaced. The architect and engineers have commenced the surveys pre starting and this will commence imminently. The storage has increased with the use of additional portacabins, there is also some PPE that is coming near its expiry date and this will be removed and will make way for additional storage. The cleaning trolleys are now stored in the container across from the main entrance. There has been a full deep clean of the premises and the cleaning schedules have been enhanced, and additional cleaning hours have been maintained. New handwash sinks are being sourced to replace current handwash sinks, there has been 40 alcohol gel dispensers fitted in all pertinent areas of the home and the older ones removed. The bed pan washer is capable of removing stains, training has been done to ensure all staff understand and know how to use the bed pan washer safely and well. Any furniture that had a damaged surface has been removed. All staff have been reminded to ensure that all of a residents personal care items are stored withing their storage area, Senior HCA's and Nurses have been requested to check on same. The PIC/ADON also walks the house as part of their checks. Immediate action was taken to manage anti microbial stewardship, a comprehensive review of residents was undertaken and all resident's with MDRO's have been identified and care planned, with appropriate precautionary measures in place. All staff have been educated with regards same and understand how to support individuals and the measures that need to be taken should there be any indications of possible infection. This includes the housekeeping staff. Antibiotic usage is monitored and from this the Nurse identifies areas that the staff need to assist with to prevent further usage e.g

increasing fluid intakes. Nurses are aware of alternative remedies and understand that antibiotics is a last resort. An aspergillosis risk assessment was conducted and measures are being taken to protect residents and staff.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Each store has been reorganized and there are no flammable items stored with linen etc. All oxygen is stored in the oxygen store outside which has appropriate signage. The gas works have been assessed by a mechanical engineer and a gas specialist and will be made right with correct certification and commissioning of the boiler. In addition to this, there will be gas shut off's in situ and fire detection. The work will commence on Monday 13 November and will be completed at the outside by Friday 24 November. The boiler house will be completed at the same date. The Fire Alarm provider has been out to check all areas of the NH and confirmed all areas have coverage, there will be a need for additional coverage in the boiler house which the alarm company are aware of and will be part of the schedule of works. There has since been a temporary escape stair put in place which has been signed off by the Fire Consultant. This stairwell has been tested for evacuation purposes by staff. One of the three exit routes has been brought back into use, there are two exits not in use (one which is beside the lift and the alternative route for this is the main hall door, the other is out past the now clinical room and the alternative route is the main hall door. The only people in the now clinical area would be staff. All final exit doors now have a thumb turn lock in situ. The emergency lighting has been added to and the electrician is working to ensure the right signage is in situ. Fire drills have been occurring more than once per week to date and going forward a weekly drill will be carried out. A whole house evacuation has also occurred with timings included. Fire training has been carried out by an external Fire Trainer for all staff, this included both practical and theory. A specialist architect for Fire containment has been employed and has commenced surveying work for compartmentation, there is also a Fire Consultant working with this architect. A bill of works will be drawn up and a schedule of same. This should be completed by the 23 November 2023, at this point the contractor's will review same and be in a position to produce a schedule of works. This will be completed as timely as possible but a definitive date on this is not yet possible. Forty three doors out of sixty eight have been refitted with fire proof ironmongery, locks and handles, the further 25 doors require some additional work that will be an addition to the compartmentation works in the Nursing Home. The compartment at the bottom of the stairs has been designed in conjunction with the Fire Consultant to the specification of the Fire Risk Assessment – work on this is due to start imminently. We are awaiting the actual schedule so will follow with the date of completion. Vertical evacuation has occurred in fire drills with night staffing numbers. The external assembly point has been officially cordoned off and correct signage and emergency lighting fitted. The fire procedure and floor plans of the centre are displayed beside the fire panela nd in the reception area. All care plans have been updated to include more detail on ADL's..

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:
All care plans have been updated to include more detail on ADL's. Care plans have been updated for any residents with MDRO's and all nurses have been remined to ensure that they check carefully all discharge notes from hospital. Covid 19 care plans have been updated to reflect the current risk of Covid 19.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Residents have access to two courtyards however resident's often request to sit outside at the front of the house, staff have been directed to encourage residents to the courtyard. The layout of the multi occupancy room will be reconfigured to ensure dignity of all residents. The reconfiguration of the shower room has proven to be difficult due to plumbing, this is being looked at by a second mechanical engineer to propose and develop a solution. There is a quandry about this now as the engineers have said that it would not extremely difficult to locate the drain at the side of the room, and it could still cause an issue with the position of the toilet and shower, at the moment resident's do not use that shower room to have a shower but use the alternative shower on the ground floor. A new shower room will be built to bring the Nursing home back to what it was pre building works (awaiting plans on same to submit) but until this is built it would mean that the current shower is used by 10 residents. The suggestion is to turn that shower room into a toilet with wash hand basin for now until the new shower and toilet is complete and then this room returned to be a shower room as per the previous layout.

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 11(2)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	10/11/2023
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	Not Compliant	Red	29/09/2023

	the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	10/11/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Red	19/09/2023
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	Red	19/09/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated	Not Compliant	Red	19/09/2023

	infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	19/09/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	29/09/2023
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	Red	19/09/2023
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	Not Compliant	Orange	28/10/2023

	procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	29/09/2023
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	Red	19/09/2023
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 centre.	Not Compliant	Orange	29/09/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	10/11/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment	Not Compliant	Orange	29/09/2023

	referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	10/11/2023
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	10/11/2023