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:	Lake House Nursing Home
Name of provider:	Sheephaven Properties Limited
Address of centre:	Portnablagh, Dunfanghy, Donegal
Type of inspection:	Unannounced
Date of inspection:	04 January 2023
Centre ID:	OSV-0000353
Fieldwork ID:	MON-0036043

About the designated centre

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

The designated centre provides care and support to meet the needs of 48 male and female older persons who require long-term and short-term care. Residents assessed as having dementia can be accommodated.

The philosophy of care is to provide a residential setting where residents are cared for, supported and valued within a care environment that promotes their health and well-being. This includes providing a person centred service, taking into account the wishes and suggestions of the residents and providing a living environment that takes account of residents' previous lifestyles.

The centre is a two storey building located in a coastal area. Resident bedroom accommodation is located on both floors and consists of single, twin and one triple room. The ground floor contains a number of communal spaces, dining areas, household facilities including kitchen, sluice room, clinical room and offices. There are suitable sanitary facilities on each floor. The laundry is located nearby in a separate building.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	44

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 4 January 2023	08:55hrs to 16:55hrs	Nikhil Sureshkumar	Lead

What residents told us and what inspectors observed

Overall, the feedback from the residents was positive, and the residents were found to be happy with the care they received in the centre. Many residents told the inspector that the centre was a nice place to live and they were well cared for by the staff. However, improvements were required to ensure that the quality and safety of the service provided to the residents in the centre were of a high standard.

The inspector spoke with some residents in the centre, and their positive comments ranged across a number of areas. Residents said that "the food is great and we could get what we want from here", I get plenty of visitors, and I am able to see my general practitioner (GP)".

The centre is located near the main road in Portnablagh and is close to local amenities. The centre is in a two-storey building with five wings, namely Glenveagh, Rooskey, Sessiagh, Gartan and Glen wing. Resident accommodation is located on both floors.

This was an unannounced inspection, and on arrival, the inspector was met by a member of staff who went through the infection prevention and control practices in the centre. This included a check for wearing facemask and hand hygiene. The inspector then completed an introductory meeting with the person in charge. Following the introductory meeting the inspector went for a walk around the centre.

The centre's front door opened to the day room of the Rooskey wing, and a small corridor from the day room led to the visitors' room, office area, reception and residents' accommodation.There was sufficient seating available for residents in the day rooms, and the residents were found to be relaxing in the day room areas. Some residents who were in the front day room told the inspectors that they enjoyed the views of the main road while they were seated in this area.

The residents who spoke with the inspectors said that they enjoyed the activities in the centre, and a schedule of activities was displayed in the day rooms of the centre. Newspapers and magazines were available in day rooms, and some residents spent time in day rooms reading newspapers and watching their favourite television programs.

Staff interactions with residents were found to be respectful, and staff attended to the care needs of the residents with kindness and compassion. The day rooms of the centre have a relaxing ambiance, and residents were sufficiently supervised on the ground floor. However, there were no day rooms available on the first floor, and a small number of residents with higher dependencies stayed on the first floor of the building. Although staff were allocated to be available on the first floor, the inspector found that there was insufficient staff presence on the first floor of the building during the afternoon hours of the day to meet the needs of residents, and staff were found spending time with the residents in the day rooms of the ground

floor. Furthermore, the records related to the nursing care of some residents who stayed on the first floor of the centre were not completed on some days. As a result, the records were not a contemporaneous record of the care provided for those residents on the first floor.

The corridors of the ground floor of the centre were wide, and handrails were available on both sides of the corridors. The ground floor corridors were bright and had natural and artificial lights, and were well-ventilated. The centre's first floors were interconnected with the ground floor by a staircase and a lift. However, one section of the corridor on the first floor was found to be narrow, with residents' bedrooms located at either end of this narrow corridor. This narrow section of the corridor did not facilitate those residents who used assistive devices to mobilize safely in this area. Furthermore, the narrow corridor poses a risk for residents and staff who might need to evacuate in the event of a fire emergency.

There were sufficient communal bathrooms and toilets for the number of residents in each unit, and they were found to be well maintained. However, the height of some communal toilets was not sufficient and was not suitable adapted to meet the needs of the residents in the centre.

The inspector reviewed the residents' rooms and noted that most of the rooms were appropriately decorated, and residents had access to a wardrobe to store their clothes and sufficient space to store their personal belongings. However, the layout of some bedrooms was found to be insufficient to support the needs of residents, and as a result, some residents did not have full access to their storage space in order to reach their clothes and personal possessions. In addition the layout of these rooms did not provide enough room for the resident to have a bedside cabinet and a comfort chair beside their bed.

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

Capacity and capability

Overall, the inspector found that the residents were made central in the organisation of the centre. The provider, together with staff and the clinical management team, were found to be working hard together to drive quality improvements in the centre and to improve compliance with the regulations. However, repeated non-compliances were found in relation to Regulation 17 on this inspection. The provider had made on this inspection changes to the layout of some of the multi-occupancy rooms, however, the layout of a number of multi-occupancy bedrooms were found not to meet the needs of those residents accommodated in these bedrooms. This is addressed under Regulations 17 and 9. The provider had recently been granted planning permission to extend the premises, which would create a number of

additional single and twin en-suite bedrooms.

This risk-based unannounced inspection was carried out to monitor compliance with the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulation 2013 (as amended). The inspector reviewed the actions from the compliance plans of the last inspection, and the information submitted by the provider and the person in charge.

The provider of the designated centre is Sheephaven Properties Limited. There is a clearly defined management structure in the centre, and the management team was observed to have good communication channels. The person in charge was supported by clinical nurse managers, a team of nurses, carers and support staff. There were deputising arrangements in place for when the person in charge was absent. The person in charge facilitated this inspection.

There was a quality assurance programme in place in the centre, which included a range of audits. A schedule of audits was available for the inspector to review, and the results of the audits were found to be communicated with staff during staff meetings. However, some audits, such as the fire safety audits, failed to identify the fire safety issues identified on this inspection. The person in charge informed the inspector that a fire safety risk assessment was conducted in the centre recently, and that the provider was awaiting the report.

While regular management meetings and staff meetings were held in the centre, the review of the meeting minutes indicated that a number of safeguarding risks arising from incidents had not been brought to the management meetings for discussion and the inspector was not assured that the provider had sufficient oversight of this type of risk.

While the provider's arrangement to record accidents and incidents was satisfactory, incidents related to a resident's responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment), which had negatively impacted other residents, were not notified to the Chief Inspector.

Regulation 15: Staffing

The provider had kept the number and skill mix of staff in the centre under review, and the rosters reviewed on the day of inspection evidenced that there was a sufficient number of nurses and care staff on duty at all times in the centre. The inspector reviewed a sample of staff files and noted that Garda vetting records were made available before staff commenced employment in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Arrangements in place to ensure staff were appropriately supervised required improvement. For example, although staff allocations were available for staff to be available in the first floor of the building, staff choose to be on the ground floor during the afternoon hours, and the inspector found insufficient staff presence on the first floor of the building to assist residents in meeting their needs.

Furthermore, supervision of staff to ensure they completed daily resident care records was insufficient.

Judgment: Substantially compliant

Regulation 21: Records

Arrangements in place to ensure the care records such as fluid balance and repositioning records of residents were always completed on a daily basis were insufficient. For example, the care records of some residents who required assistance for their personal care were found to be incomplete for several days.

Judgment: Substantially compliant

Regulation 23: Governance and management

Actions were required to ensure that the provider's quality assurance systems effectively monitored the quality and safety of care and services provided for the residents. For example:

- The safeguarding policy was not being implemented when safeguarding incidents may have occurred in the designated centre. As a result the inspector was not assured that the provider had sufficient oversight of these incidents and the management actions required to protect the residents.
- The falls analysis that was scheduled for the last quarter of 2022 had not been completed which meant that falls had not been reviewed by the management team so that strategies and improvement actions to reduce the risk of falls happening were discussed and implemented.
- The oversight arrangements of fire precautions in the centre was insufficient. As a result, the issues regarding fire doors, detailed under Regulation 28, were not identified during the provider's regular fire safety checks.
- Housekeeping audits carried out at six monthly intervals did not identify the issues found on this inspection in relation to carpet cleaning and

arrangements to ensure effective cleaning of hoist slings.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A number of potential safeguarding incidents in relation to a resident's responsive behaviour that may have impacted on the safety and well-being of other residents were not notified to the Chief Inspector.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A centre-specific complaints policy was in place and available to staff. The complaints policy identified the nominated complaints officer and included an appeals process.

Judgment: Compliant

Regulation 4: Written policies and procedures

The centre's policies and procedures as outlined in Schedule 5 of the regulations were reviewed and updated within the previous three years.

Judgment: Compliant

Quality and safety

Overall, this was a good service where the care and well-being of the residents was promoted. Regular residents' meetings were held in the centre, and the records indicated that the residents were consulted about and participated in the organisation of the centre. However a number of actions were required to ensure that the service was compliant with the regulations.

Overall the provider had taken precautions to protect the residents in the event of a fire emergency however the centre's fire door safety checks were not robust and did

not ensure that all fire doors were well maintained and would protect the resident in the event of a fire. This is addressed under Regulation 28.

Furthermore, the flooring of the centre was found to be not well maintained, and there were gaps between the wall and floor linings. As a result, the poorly maintained floor surfaces of the building made it difficult to ensure effective surface cleaning. In addition, the floor lining of the staircase was lined with carpet, and the carpets had a dull appearance and were found to be dusty on the day of inspection. Although the staff informed the inspector that the dust was due to some minor building works carried out on the day of inspection, the staff were unsure about the appropriate cleaning procedure for the carpets. There were no cleaning records available about when the carpets were last steam cleaned in the centre.

The inspectors reviewed a sample of assessments and care plans and noted that all residents had a comprehensive assessment and a care plan in place. However, the care plans were found to be not sufficiently detailed and did not provide clear and up to date information for staff who were caring for the residents. Care plan reviews were not carried out every four months in line with the regulations and the centre's own policies. In addition, the review of residents' files indicated that the residents were not consulted during the review of their care plans.

Residents had access to general practitioners (GPs) from local practices. However, some improvements were required to ensure that follow-up reviews with specialist mental health services were arranged in a timely manner following changes in the number and type of episodes of responsive behaviours that one resident was exhibiting. In addition the referral arrangements for those residents who required specialist services such as mental health services and palliative care services were not clearly recorded in the resident's care plans. This had resulted in a delay for some residents who needed to access specialist services.

While the centre had a safeguarding policy in place, the inspector found that this policy had not been implemented in full. As a result, incidents related to a resident's responsive behaviours, which reported clear safeguarding concerns to other residents, were not adequately investigated, and a safeguarding care plan was not put into place to protect residents who might be impacted.

Regulation 17: Premises

The layout of the centre's premises did not support the needs of the residents. For example:

- Some bedrooms on the ground floor were poorly laid out, and the residents' bedside cabinets were placed inside the resident's wardrobe and were not accessible from the resident's bed.
- Some bedrooms did not have space for a comfortable chair next to the residents' bed.
- Some bedrooms on the first floor were found to be unsuitable to meet the

needs of residents with higher levels of dependencies as the layout of these rooms and the lack of space between beds made it difficult for staff to use assistive equipment such as a hoist safely in the rooms.
- A twin room on the first floor only had one window, and the layout of this twin room meant that when a resident in the bed space near the window pulled their privacy curtain, other residents in the bedroom could not see out of the window and did not have access to sufficient natural light in order to read or use their personal equipment such as a mobile phone.
- The layout of the section of a corridor on the first floor did not allow residents who use assistive devices and higher dependencies to mobilize safely in this area.

The premises did not conform to the matters set out in Schedule 6 of the regulation. For example:

- Several bed frames were damaged and did not support effective surface cleaning.
- The flooring of the centre was found to be not well maintained, and there were significant gaps between the wall and floor linings in several areas of the centre. As a result, the poorly maintained flooring did not support effective surface cleaning in the centre.
- The height of some communal toilets was too low and was not suitably adapted to meet the needs of the residents.

Judgment: Not compliant

Regulation 27: Infection control

The infection prevention and control processes in the centre required improvement to ensure compliance with the national standards for infection prevention and control in community health services and other national guidance. This was evidenced by:

- The clinical hand wash sinks in the designated centre did not comply with the current recommended specifications.
- Some areas of the centre required enhanced cleaning to support effective infection prevention and control within the centre.
- The arrangements to clean carpets in the centre were insufficient and did not support effective infection prevention and control within the centre.
- The systems that were in place to ensure equipment was cleaned after use were not robust and did not prevent cross-contamination and cross-infection. For example, a hoist sling, which was left hanging on the hoist was not identified either with a resident's name which meant that it was not used by more than one resident. Neither was it tagged or labelled as having been laundered and ready for re-use if it was to be used by more than one

resident.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Actions were required to ensure that the provider's arrangements to maintain all fire equipment were adequate. For example:

- The cross corridor fire doors in the centre were found to be misaligned. As a result, some fire doors were not closing properly, and some had significant gaps between the floor and the fire door.
- In addition, a number of automatic door closure devices on the sub-compartment fire doors were ineffective as they did not allow the fire doors to close fully and create an effective seal.

Actions were required to ensure the provider's arrangements to review fire precautions in the centre were effective. For example:

- The issues related to the fire doors identified above were not identified during the provider's regular fire door checks.
- Furthermore, the fire drill records kept in the centre were not sufficiently detailed to support review of fire precautions, and the fire drill records did not specify the fire scenario simulated.
- The corridors leading to the bedrooms on the first floor were found to be narrow, and this posed an injury risk for staff and residents when evacuating residents with higher dependencies. This risk was not identified on the centre's risk register and as a result there was no plan in place to reduce the risk to residents who may need to use this escape route in the event of a fire emergency.

The provider had not carried out a simulated compartment evacuation on the second floor of the building at suitable intervals to ensure that the staff and residents were made aware of the procedures to be followed in the event of a fire emergency.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed a sample of residents' files and found that the residents' care plans were not appropriately reviewed. For example:

- A mobility care plan was not sufficiently developed following a review with a

physiotherapist, and the physiotherapist's prescribed treatment plan was not included in the resident's care plan.
- End-of-life care plans were not sufficiently reviewed following changes in a resident's care needs. As a result, the care plan created ambiguity about the resident's end of life preferences for care and support including medical interventions.
- The behavioural care plans of a resident with responsive behaviours were not sufficiently developed following their admission. As a result, the resident's care plans were not informative in directing staff to respond to and manage the occurrence of responsive behaviours.

Residents and where appropriate their representative were not consulted in the care plan reviews.

Judgment: Substantially compliant

Regulation 6: Health care

Residents did not always have timely access to specialist medical and nursing services. For example:

- Follow-up reviews with specialist mental health services were not arranged for a resident following a deterioration in their mental health and an increase in episodes of responsive behaviours.
- Palliative care referrals were not made for a resident in line with the centre's end-of-life policy for prescribing anticipatory medication and to manage end of life symptoms.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The provider's measures to ensure that staff have up-to-date knowledge to respond to and manage behaviour that is challenging were found to be insufficient. For example:

- Staff who spoke with the inspectors did not demonstrate their awareness to respond to and manage a resident's behaviour that is challenging.

Judgment: Substantially compliant

Regulation 8: Protection

The provider's measures to protect residents from abuse in the centre were found to be insufficient. For example, records of four incidents of a resident's responsive behaviours, which reported clear safeguarding risks, were not investigated and managed in line with the centre's own safeguarding policy.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The layout of some twin-bedded rooms on the ground floor meant that residents had to go through the bed space of another resident to reach their own bed space. This arrangement did not support the privacy of a resident in the room and did not ensure that they could carry out personal activities in private.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Lake House Nursing Home OSV-0000353

Inspection ID: MON-0036043

Date of inspection: 04/01/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff are allocated daily in the allocation book to specific corridors. "Glenveagh" corridor on the first floor has now got one member of staff highlighted to be responsible for any resident while they are on the first floor, but usually when all residents have had their personal hygiene and dressing attended to in the morning, they come downstairs to the ground floor for the day. A member of staff will now be allocated, that is highlighted in the allocation book which is read out at handover every morning. This staff member will supervise and assist residents in meeting their needs on the first floor throughout the day and night.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Staff nurses have been informed by the Person in charge that they now must check and sign off all completed daily residents care records that are being filled out for residents throughout the day and night. The Person in charge will carry out an audit monthly to ensure record charts are being completed appropriately.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The safeguarding policy is to be reviewed. The Person in charge will supply refresher training for all staff in safeguarding, this is scheduled for the 4/4/23 and the 11/4/23. An audit will be compiled and carried out by the provider to oversee any incidents and the management actions required to protect the residents.
.
A falls analysis will be scheduled monthly, and falls will be recorded on the EpicCare system as the take place by the nurse, a falls incident form is also filled in and signed by the doctor. This falls incident form then is compiled by the Person in Charge for auditing. A staff nurse will be nominated to do a monthly falls analysis and the person in charge will audit this on a 3 monthly basis. Falls management is also included in management, nurses, and care staff meetings so that strategies and improvement actions can be implemented to reduce falls.
.
The oversight and management of fire precautions under regulation 28 especially fire door checks are now to be carried out by Master Fire an outside fire protection company that have been commissioned to carry out a fire door survey within the Lakehouse Nursing Home. This survey is scheduled to take place on the 17/02/2023. This will identify any deficiencies in the fire doors, it will also suggest an approved repair technique relevant to bring the doors to an acceptable level of compliance. This will be carried out on a 6 monthly basis.
.
There is a carpet cleaning schedule of the stairs in place. The carpet will be steam cleaned now instead of manually scrubbed. The stairs is hoovered daily and will be steam cleaned on a weekly basis, this is overseen by the domestic supervisor.
.
There is also a cleaning schedule in place for the laundry of hoist slings on a regular basis. Once they are laundered, they will have a cleaning label on them to prove they are clean and ready for re-use. Each resident who requires a full sling hoist has their own sling which is named. Slings that are used for sit to stand hoists and hand belts are cleaned with sani wipes between use. Staff have been educated to follow the policy on cleaning and storage of slings within the nursing home. This will be checked and documented on management walkarounds and audited on a three-month basis.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Any potential safeguarding incident in relation to residents' responsive behavior will be

notified to both the safeguarding team and HIQA as per the safeguarding policy.

Any such incidents will be addressed in management meetings with the provider.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Bedrooms on the ground floor have been rearranged to ensure each resident has a bedside locker and a comfortable chair beside their bed.

Any residents that need any assistive equipment such as hoists are now only to be accommodated on the ground floor and this will be changed in the admission policy to adhere to this. If any residents' dependencies change, and need assistive equipment then they will be transferred to the ground floor at the earliest time possible. Residents' families of residents on the first floor will be made aware of this on admission.

In Room 2 on the first floor the privacy curtain will be adjusted to ensure that more light will be accessed by the resident on the right side of the room.

The footboards of some beds that are damaged are to be refurbished, this was in the risk register and is being dealt with.

The whole building's floor covering is being reviewed by maintenance any gaps between the skirting board and the floor covering will have quadrant fitted.

Some of the communal toilets are high and some are low to suit the needs of individual residents, this will be reviewed to ensure there are enough of each for all residents.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The clinical hand wash sinks in the designated centre did not comply with the current recommended specifications.
The person in charge will meet with the IPC lead in this area and will discuss which sinks to install to comply with the HBN 00-10 standards. The sinks that are advised will be plumbed and installed before the 30/07/2023.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A fire door survey is now to be carried out by Master Fire an outside fire protection company that have been commissioned to carry out a fire door survey within the Lakehouse Nursing Home. This survey is scheduled to take place on the 17/02/2023. This will identify any deficiencies in the fire doors, it will also suggest an approved repair technique relevant to bring the doors to an acceptable level of compliance. This will be carried out on a 6 monthly basis by this company from now on.

A new detailed fire drill report has been compiled by the Person in charge specifying the fire scenario simulated. These drills are being carried out on both first floor and ground floor by staff night and day.

These drills are then being reviewed by management at management meetings.

There is a risk now identified on the risk register concerning the narrow corridor on the first floor that could pose a risk in the event of evacuation of residents who have higher dependencies and need assistive equipment to mobilize. Any residents that need any assistive equipment such as hoists are now only to be accommodated on the ground floor and this will be changed in the admission policy to adhere to this. If any residents' dependencies change, and need assistive equipment then they will be transferred to the ground floor at the earliest time possible. Residents' families of residents on the first floor will be made aware of this on admission.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
There is a review of all residents care plans being carried out by nurses.
The physiotherapist will include his prescribed treatment plan for each resident that he is working with in their care plans.

A nurses meeting about care plan took place to discuss the importance of care plans being updated with changes daily, as residents care needs change. We have developed a care plan diary that nurses record changes in and then use this over the 24-hour period that follows to have the care plan updated.

The person in charge has scheduled a nurses meeting to discuss with all nurses the

importance of care plans being up to date, informative and person centered for each resident.

The person in charge will continue to audit care plans on a 6-month basis.

Care plan meetings were not held with residents' families during the pandemic but now are being held again with residents and their families.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
A review of responsive behaviors policy will be carried out that will clearly indicate when to refer a resident to the mental health team. A meeting with The Gp is arranged to discuss the prompt referral of residents who need follow up reviews by the mental health team.

A review of the End of Life policy will be carried out and this will also include the GP and the Palliative care nurse as to when referrals will be made to the Palliative care team as the GP does not always require a referral made to the palliative care team for each resident who may be palliative.

Nurses will then be updated on the policy and procedures for residents who are palliative.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The safeguarding policy is to be reviewed. The Person in charge will supply refresher training for all staff in safeguarding, this is scheduled for the 4/4/23 and the 11/4/23. During this training we as staff will discuss any resident's management plan for behavior's that challenge.

All staff will be informed of any potential behaviors that challenge that residents might display; this will take place at handovers and huddles to include domestic staff also as they do not be in attendance at handovers.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The safeguarding policy is to be reviewed. The Person in charge will supply refresher training for all staff in safeguarding, this is scheduled for the 4/4/23 and the 11/4/23. An audit will be compiled and carried out by the provider to oversee any incidents and the management actions required to protect the residents. Any potential safeguarding incident in relation to residents' responsive behavior will be notified to both the safeguarding team and HIQA as per the safeguarding policy.

Any such incidents will be addressed in management meetings with the provider.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
In order to ensure that residents do not have to go through other resident's bed space the provider is to re-configure the privacy curtains around residents bed space to ensure that another resident in a twin room can access their bedspace without invading someone else's personal privacy. S and E care Trade will be commissioned to carry out this task in the bedrooms in question.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	14/02/2023
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.	Not Compliant	Orange	22/04/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/07/2023
Regulation 21(1)	The registered	Substantially	Yellow	27/03/2023

	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.	Compliant		
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.	Substantially Compliant	Yellow	01/05/2023
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.	Substantially Compliant	Yellow	30/07/2023
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.	Substantially Compliant	Yellow	01/07/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate	Substantially Compliant	Yellow	14/02/2023

	arrangements for reviewing fire precautions.			
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.	Substantially Compliant	Yellow	20/03/2023
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.	Substantially Compliant	Yellow	14/02/2023
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's	Substantially Compliant	Yellow	23/03/2023

	admission to a designated centre.			
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.	Substantially Compliant	Yellow	14/02/2023
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.	Substantially Compliant	Yellow	30/05/2023
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.	Substantially Compliant	Yellow	16/03/2023
Regulation 7(1)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	01/05/2023

	have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	14/02/2023
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	01/09/2023