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:	Lucan Lodge Nursing Home
Name of provider:	Passage Healthcare International (Ireland) Limited
Address of centre:	Ardeevin Drive, Lucan, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	21 September 2023
Centre ID:	OSV-0000061
Fieldwork ID:	MON-0041532

About the designated centre

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

Lucan Lodge Home is situated in a residential area in Lucan. The provider is registered as a designated centre under the Health Act 2007 to provide for the care of 74 residents over 18 years of age male and female with 24-hour nursing care available. Accommodation is provided over 3 floors. The registered provider states they can accommodate residents with Short, Medium and Long Term Care needs including Palliative Care. A specific smaller environment located on Level 1, that is specifically designed to meet the needs of residents living with Dementia. The aim of Lucan Lodge Nursing Home is to provide individualised care and attention for all of the residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	73

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
Thursday 21 September 2023	15:55hrs to 22:00hrs	Frank Barrett	Lead
Thursday 21 September 2023	15:55hrs to 22:00hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Residents gave mixed feedback with regard to their experience of living in the centre. Residents told inspectors that they received a good quality of care from a team of staff who knew their individual likes and preferences. While residents were complimentary of staff, they told inspectors that staff were busy. In particular those residing on the third floor reported having to wait for long periods of time to receive assistance as staff were busy providing care to other residents.

Inspectors arrived unannounced at the centre during the evening time and were met by a nurse in charge. Following a brief introductory meeting, inspectors walked through the centre and spent time talking to residents, visitors and staff, and observing the care provided to residents, and the care environment.

Inspectors observed that the supervision and allocation of staff was inadequate. Inspectors observed that there was inconsistent provision of calls bells for residents to seek assistance, with some residents not having any call bell. Staff told inspectors that some residents were unable to use a call bell due to poor cognition and therefore one, was not provided. One of the inspectors spoke with a resident who did not have access to a call bell and who communicated via hand pressure that they were thirsty. Assistance was requested on behalf of the resident and provided. The person in charge was requested to ensure that residents had a call bell within their reach while in bed, or when sitting out on a chair in their bedroom. Inspectors observed that staff were busy attending to residents and that a number of resident seating areas were unsupervised.

Lucan Lodge Nursing Home is registered for 74 beds and there was one vacancy on the day of inspection. The building has four levels:

Level one, basement level - has 15 single bedrooms with two assisted shower rooms, day spaces, kitchenette and dining room. This level also accommodates the main kitchen and Laundry, as well as staff areas. There is access to an enclosed garden space from this level for residents.

Level two, Ground floor level provides accommodation to 22 residents in 20 single and one twin bedroom. There are four assisted showers as well as large dining and sitting rooms, a visitors room, a large dayroom and the hair salon. Residents have access to the enclosed patio area and garden with water feature to the back.

37 residents can be accommodated on the third level (first floor level) with accommodation provided in 29 single, two twin rooms and one four-bedded room. There are four assisted bath/shower rooms and there is a small day space area at this level.

Level four- Second floor level. This area is used for staff only, and includes a

meeting room, staff offices and a store room.

While walking through the centre the inspectors observed that there was limited communal space and inadequate provision of storage throughout. This will be further detailed under regulation 17 and 28.

A number of rooms were found to be locked, and accessible only through obtaining a key from reception or the human resource manager. This impacted on the timely access to the room in the event of a fire emergency.

Overall bedrooms were clean and personalised, however the kitchen, laundry and floor in the dementia unit were observed to be unclean.

Inspectors found that a central emergency staircase at the centre had been removed, and the stairwell space was now used as storage space on level two and three. This posed a significant risk to te safety of the residents in the event of evacuation and is discussed further under Regulation 17: Premises and Regulation 28: Fire Precautions

The following two sections of this report details the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

Overall this inspection found that the registered provider did not ensure a safe and appropriate premises was provided in line with its conditions of the registration and did not ensure that the centre was appropriately resourced to ensure appropriate care delivery in line with residents' assessed needs.

This unannounced risk inspection was carried out over one day by inspectors of social services to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).
- review the changes made to the premises on foot of information provided by the provider at a meeting on 09 August 2023. At this meeting the provider confirmed that two additional showers on level 2 and 3 had been installed. The provider advised that a stairwell had been removed and altered to become a storage facility.
- examine if improvements committed to in previous inspection compliance plans had been implemented.

On this inspection, the inspectors found a number of changes to the premises that had not been notified and not approved by the Chief Inspector of Social Services,

including;

- At level 2,
    - the existing central stairs was changed into a store room
    - A Nurses station had been converted to a bedroom which was not occupied.
- At level 3
    - an existing wheel-chair bay and store room were combined and changed to a bedroom; this room was not occupied.
    - the existing stair area was closed and changed into a hoist and wheelchair store.

Inspectors found that the registered provider had allowed the removal of an escape stairs in the centre of the building, which had significantly increased the travel distances in the event of an emergency or a fire to the next nearest emergency exit.

The designated centre is a residential care setting operated by Passage Healthcare International (Ireland) Limited. The management team was made up of the provider representative, the person in charge and four clinical nurse managers (1) (CNM). An assistant director of nursing had been recruited since the previous inspection. The clinical nurse managers were part of the nursing complement delivering direct care to residents and did not have any supernumerary time allocated to fulfill managerial duties. This impacted on their ability to supervise staff and to review resident assessments and care plans.

Inspectors found that some of the personal emergency evacuation plans (PEEPs) viewed had not been updated since 2020 and in some cases, did not reflect the needs of the resident in an evacuation scenario. This included the use of evacuation aids for residents who needed them such as evacuation mats. Inspectors reviewed checks and audits of fire safety procedures at the centre. It was found that while daily, weekly monthly and annual checks were in place at the centre, not all fire safety checks were completed up-to-date, and those checks were not identifying issues outlined at inspection; for example, daily ski-sheet checks did not pick up issues with the fitting of some ski-sheets, which were found to be incorrectly fitted as observed by inspectors.

There were two activity personnel who provided activities over six days, with limited activity provision on Sundays.

There was a poorly defined management structure. Inspectors were informed that household, catering and laundry staff report to the human resource manager (HR). Catering staff reported to both the person in change and the human resource manager. On the day of inspection, the HR manager was not available, and the DON did not have access to the HR office area. The DON was not aware that the staff who usually report to the HR manager, would now, report to him.

Inspectors found that the provider had failed to organise and manage the staffing resource effectively within the centre. Consequently, the provider had failed to ensure that the designated centre had sufficient resources to ensure that safe care and services were provided, in accordance with the centre's statement of purpose. A

review of the staffing rosters evidenced that staffing resources were not available to cover planned leave, particularly in respect of nursing staff. For example, a review of the rosters found three occasions where two nurses, rather than the three required, were on duty at night time to monitor and provide nursing care for up to 74 residents. Inspectors found that deficits in the nursing rosters were supplemented with health care staff. Inspectors were not assured that there were sufficient staff to safely evacuate residents to a place of safety taking account the dependencies of residents, the use of evacuation aids, and the removal of the stairs in the centre of the building.

The management systems failed to ensure that the service provided was safe, consistent and effectively monitored. The system in place to manage risk was not effective. There were ineffective systems in place to assess, respond and manage risks associated with fire safety. Significant risks were identified which required an urgent compliance letter to be issued in respect of:

- Safe evacuation of residents
- Removal of obstructions from escape route, and stairwells
- Safe storage of Oxygen
- Staff training in respect of evacuation aids, and the fire evacuation procedure at the centre
- Completion of fire drills to ensure staff knowledge was tested.
- Service records for bedpan washers and lifts at the centre

The provider responded to the letter on all the points outlined, however, the response **did not** provide adequate assurances that all issues identified in the urgent compliance plan would be addressed satisfactorily.

Regulation 23: Governance and management

The registered provider failed to ensure there was an effective management structure, with clear lines of accountability and responsibility in place as outlined in the statement of purpose. This was evidenced by:

- Poor oversight of maintenance with findings outlined under Regulation 17: Premises.
- Poor oversight of fire precautions in particular fire safety checks and audits. Further fire safety issues are detailed under regulation 28: Fire Precautions.

The registered provider did not ensure that the designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. A review of the duty rosters found that staffing resources and structures were not in line with those outlined in the centre's statement of purpose. There were four clinical nurse managers in post as opposed to five committed to in the statement of purpose. There were inadequate numbers of staff to supervise and

meet the needs of residents on the third floor where the level of need and residents' dependencies were assessed as mostly maximum, with the majority of residents requiring the assistance of two staff to attend to their hygiene needs and one-to-one supervision while eating and drinking. The clinical nurse managers did not have any dedicated time to oversee staff practices and ensure that safe and effective care was provided at all times. Inspectors observed residents unsupervised in sitting areas and waiting for assistance by staff who were busy providing care to other residents. In addition, alternative arrangements for maintenance requirements were not in place in the event of extended unplanned absence. This resulted in maintenance issues being left unresolved as the staff member responsible had been on unplanned leave for two weeks. These are detailed further under Regulation 17 Premesis.

The inadequate resources and the poorly defined organisational structure impacted on the quality of the management systems in place to ensure that the service was safe and appropriately monitored. Examples included;

- The registered provider was found to operate in breech of its conditions of registration. Changes were made to layout of the centre. These changes were not appropriate and had a negative imapct on the safety of residents accomodated at the centre.
- Poor risk management systems which did not ensure effective oversight of the risk of fire. The removal of a main central staircase was completed without assessing the risk of the staircase removal to residents' evacuation in the event of a fire. Other risks are detailed under Regulation 28; Fire Precautions.
- Poor supervision and oversight of cleaning procedures.The catering, laundry and dementia areas were not clean.
- There was no defined system to handover resident information from management team at change of shift.
- Poor safeguarding systems as evidence could not be provided that all volunteers were vetted in accordance with the National Vetting bureau (Children and vulnerable persons) Act 2012.
- Poor oversight of care as evidenced by delayed provision of care to a number of residents who reported and were observed waiting prolonged periods of time to have their care needs met. Furthermore, one resident who was in receipt of funding for one- to one care did not have this level of care consistently provided.
- Repeated non-compliance in Regulation 23; Governance and Management and Regulation 17; Premises.

An urgent action was issued to the provider, however, the response **did not** provide adequate assurances for all the issues raised.

Judgment: Not compliant

Quality and safety

Overall, the premises at Lucan Lodge home was bright and homely. This centre was previously inspected on 28 June 2023. That inspection found significant non-compliance's with regulation in relation to Premises, Governance and Management among other regulations. Fire safety arrangements in the centre were not assessed at that time. Since the time of that inspection, the provider had taken measures to address a number of the premises issues, however, the conversion of the stairs to storage had impacted on other areas of the centre, and was not discussed with inspectors in advance of works beginning. Significant findings in relation to fire precautions were identified. These issues are discussed further under Regulation 28; Fire precautions.

Improvement was required to ensure that the centre was appropriate to the number and needs of the residents, and in accordance with the statement of purpose and floor plans under which the centre was registered. Changes made to some areas meant that the centre was not operating in accordance with the registered plans and statement of purpose. Improvement was also required to ensure that the centre conformed to the matters set out in Schedule 6 of the regulations. These failings included services which were out of order, storage issues and maintenance at the centre. These issues are detailed further under regulation 17; Premises.

Significant improvements were required in relation to fire precautions. Inspectors were not assured of the systems in place to provide adequate evacuation aids to assist staff in the event of a fire. Inspectors found that while some evacuation mats were available, there were not enough mats available for all residents who required them. Staff spoken with had not received adequate training on the use of mats, and were unsure of the procedure to use them in the event of a fire. Ski-sheets were also found to be incorrectly fitted to some beds at the centre. This was the subject of an urgent compliance letter issued to the provider following the inspection, however, the response to this letter **did not** provide the assurances required that appropriate numbers of evacuation aids were in place.

The provider had removed a central staircase which linked the ground floor (Level 2) to the first floor (level 3). The provider had outlined the reasons for this and explained to inspectors in advance of the inspection, that this central staircase was not, in fact, an emergency escape route. Inspectors reviewed this on inspection and found that the staircase, as it had been installed, was an emergency escape route. The stairwell was identified on emergency evacuation plans displayed on the first floor, and was a primary escape route in the event of a fire from several areas within the centre. Furthermore, the design of the centre around this central stairwell, allowed for evacuation of residents, staff and visitors from some areas of the first floor with appropriate travel distances to the relative safety of the protected stairwell. This would be crucial in the context of horizontal evacuation of residents in the event of a fire. The removal of the stairwell, meant that travel distances for residents in areas of the first floor were greatly increased, which would significantly add to the action required for staff in the event of a fire on the first floor.

Inspectors found issues relating to storage which were impacting on fire safety at

the centre. Oxygen cylinders were found stored inappropriately and unsecured in a lower ground floor inner store room. Large items of furniture were found obstructing escape routes both internally and externally. This issue formed part of the urgent compliance plan request issued to the provider after the inspection. The provider's response to this issue, **did** provide assurance that the evacuation routes had been cleared.

Signage throughout the centre relating to fire evacuation was found to be contradictory and inconsistent. Signage directing evacuees to a now blocked off stairway was found on the first floor. Information displayed at the centre regarding staff responsibility in the event of a fire, identified the first staff member who arrives at the fire alarm panel, as the person who takes charge of the fire event. This was not staff's understanding of the method of selecting the person to take charge in the event of a fire. In one policy document, this was also written into the procedure, however, a document in the "Fire folder" stated that the senior nurse in charge, trained as a fire marshall would take charge of the situation in the event of a fire. This scenario was found to be staff's understanding also. Inspectors were told that fire drills were being performed weekly at the centre, however, when reviewing the record of these drills, inspectors found that while the fire alarm was sounded, all staff were informed on each occasion when reporting to the fire alarm panel, that this was a false alarm, and there was no simulated fire. This meant that there was no record of regular trialling of evacuation scenarios. No trial of evacuation of residents with the use of evacuation aids and using the remaining evacuation routes from the first floor was recorded. No record of evacuation of the largest compartment or of evacuation using low staffing number (for example night time staffing numbers) was available to inspectors on the day.

Containment issues were identified on a Fire Safety Risk Assessment dated September 2022 which raised concerns relating to containment at the centre, these issues were confirmed on inspection with additional concerns which were not in the FSRA. Inspectors found extensive service penetrations in a boiler room wall, which were not sealed, and which provided an access route for potential fire and smoke from the boiler room to the residents' areas of the centre. Service penetrations were also identified through compartment walls in the stairwell which was blocked off. This room was now a store room, and an unsecured oxygen cylinder was inappropriately stored in the first floor of this area. Inspectors noted that bedroom doors were not fitted with fire door closers. This would result in the doors remaining open in the event of a fire, and may impact on the containment of fire and smoke. Staff spoken with did not indicate that closing doors was a step that would be taken in an evacuation scenario. These, and other issues are discussed further under Regulation 28; Fire Precautions.

Regulation 17: Premises

The registered provider did not ensure that the premises of the designated centre was in accordance with the statement of purpose prepared under Regulation 3. For example:

- Changes had been made to the footprint of the centre including;
    - The removal of a central staircase changing this area to a store room on the ground (level 2) and first floor (level 3)
    - A Nurses station converted to a bedroom (Unoccupied) on level 2
    - A Wheelchair bay and store room converted to a bedroom (unoccupied) on level 3
    - A store room on level one had an inner store room which was not identified on the floor plans.
    - A large store room on level one was converted to a plant room with communications equipment, water tanks, electrical distribution boards, pipework and pumps fitted following an upgrade of the hot water system. This room also had inappropriately stored items such as toiletries and clothing.

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:

- Some areas of the premises required maintenance attention internally:
    - Flooring was in need of repair on level three.
    - A communal shower room and toilet on level three was out of order for more than a week.
    - A sluice was out of order on level three.
    - Rubbish was not being removed and was obstructing escape routes externally
    - Required checks were not being carried out on fire doors, escape routes, or fire safety systems. These chacks had been completed by the maintenance staff at the centre, and were not being continued while those staff members were on leave.
- Inappropriate storage was found throughout the centre for example, overfilled store rooms with boxes piled on the floor, and items stored in stairwells. This would cause difficulty in cleaning these areas, and presented a fire safety risk due to obstruction of escape routes. The issue of storage has been a recurring finding over the last three inspections, and remained unaddressed.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider did not take adequate precautions against the risk of fire,

and did not provide suitable fire fighting equipment for example:

- There were oxygen cylinders (five in total) stored in the inner store room on level one. These oxygen cylinders were not protected from collision. A damaged oxygen cylinder could increase the risk of fire in the room
- Excessive storage of flammable items alongside other combustible materials was found in storage areas throughout the centre. The policy at the centre is to keep flammable storage separate to other storage.

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

- The removal of a central stairwell increased the travel distance for evacuees from the first floor level to a place of relative safety in the event of a fire.
- Emergency lighting was modified following the removal of the central stairwell. There was no record available to indicate that this work had been assessed and completed in line with the fire safety design of the centre and certified by a competent person
- Each stairwell in the centre was found to have items stored within the stairwell. This could cause an obstruction in the event of a fire.
- Excessive amounts of furniture, wheelchairs, bins etc were obstructing the route externally to the fire assembly point. This could cause delays in safe evacuation in the event of a fire.
- Inspectors could not be assured that emergency lighting was available outside each emergency exit externally.
- Cabinets were fitted on some escape routes with items stored inside raging from linen to toiletries. These cabinets were not fire rated, which impacted on the protected nature of the evacuation corridors at the centre.

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 drill records at the centre were recording each fire drill as a false alarm. This meant that staff were not trialling fire evacuation scenarios, and were attending the fire alarm panel when the alarm sounded however were being told that there was no (simulated) fire.
- There were no fire drills reflecting 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.
- A gas shut off valve in the laundry room was obstructed by clothes. A bag was also hung on the lever making it difficult to find. This was removed immediately on the day of inspection by the person in charge at inspectors' request.
- Signage displayed on level 3 identified the removed stairwell as a primary escape route in some areas and as a secondary escape route in other areas. This could cause confusion in the event of a fire as this escape route was no

longer in place
- Staff were unsure of the procedure to take in the event of a fire, to identify the person who would take charge of the management of the situation. This was further compounded by conflicting information displayed on signage on the walls, and in policy at the centre.
- Some members of staff at the centre had not received mandatory fire safety training in the previous year. Some newer members of staff had not received any training despite being on the roster for a number of months.

The registered provider did not make adequate arrangements for containing fires. For example:

- Extensive service penetrations were found in the walls of the boiler room. These services were not fire sealed, and there were large gaps around their perimeter. This would impact on the containment of fire and smoke from the boiler room in the event of a fire.
- Bedroom doors throughout the centre did not have automatic door closer devices fitted to them. This would mean that a fire in a room with an open door, could spread to other areas of the centre, and smoke and fumes would not be contained for a period on the protected corridoors. The closing of doors in the event of a fire did not form part of the procedure outlined by staff to inspectors.
- Service risers on protected corridors did not have evidence of fire sealing around the frames. This would impact on the fire rating of the door-set, and could result in fire smoke and fumes spreading to the escape routes from the risers in the event of a fire. These risers extend through the floors of the centre, which could provide a route for fire, smoke and fumes to travel throughout the centre in the event of a fire.

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:

- Inspectors could not be assured that staff could evacuate residents to a place of safety externally in the event of a fire. There was no record of "vertical evacuation'' being trialled at the centre. This could impact on residents on level three who would need to be evacuated down the stairs in the event of a fire.
- Policy at the centre indicated that residents who required ski-mat evacuation would have the mats available in the event of a fire. Inspectors found that there were not enough ski-mats available on level 1 or level 3 to evacuate residents who required the assistance of these aids in the event of a fire. Furthermore, ski-sheets fitted to beds were not fitted correctly.
- There was no procedure in place at the centre to identify the additional requirements of evacuating bariatric residents in the event of a fire. There was also no plan in place for the vertical evacuation of bariatric residents who lived on level three or level one.

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
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Lucan Lodge Nursing Home OSV-0000061

Inspection ID: MON-0041532

Date of inspection: 21/09/2023

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: There is a clear management structure in place and to ensure that everyone knows and understands this structure it will be placed in each nurses station. In the statement of purpose it is detailed that there are 4 Clinical Nurse Managers which is what is in place. At Night there will be three nurses which is always our intention – unfortunately on top of planned leave one of our nurses had to go home unexpectedly due to a family bereavement. We have done a review of staffing on Level 3, and with the current mix of residents will increase the staffing – this will mean that there will be nine staff on this floor till 9pm. We are in the process of applying for a fire regularisation cert – which will establish the safe evacuation. The fire consultant is preparing the last few things on this and it will be submitted to DFB for review. When the Maintenance man has planned leave cover is put in place, at the time of the inspection the Maintenance Man was on sick leave. The registered provider is working to get all aspects in place to allow to apply for an application to vary, this will be completed when the fire regularistion cert is issued. The cleaning regime is tight and has since been tightened, there was an issue with water supply on the day of inspection with the water board turning off the water for a large portion of the day. This really affected the washing machines but nothing else as the water tanks were able to manage the rest of the supply of water and drinking water had been purchased in advance. There seems to be a misunderstanding about an incident that a family member relayed to you, however they have since said to us that they have never been in our lift as they have a fear of lifts from previously. The ADON/DON have put in place a more structured process for handover. The group of ladies that come in from the local church to give eucharist and sing hymns are not Garda Vetted, but neither are they classed as volunteers, we have made a request to them that if any of them do still want to visit that we will apply for a Garda	

Vetting for them.
As above there will be an additional staff member put in place as soon as possible (interviews commenced) on Level 3.
There is no longer a requirement for 1-1 care (this was short term and will assist with us filling the additional hours on level 3.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
As above the provider is working on the application to vary – to complete this process a fire regularistaion cert must be obtained which is in process. The nurses station will be converted to a physio room and this will also be on the application to vary. The store room on level one was always a plant/store room this will be idenbtified on the plans as this. The inner store room on level 2, which was always there will be identified on the plans. The architect has been requested to complete same. There are some areas on level 3 where the flooring is in need of repair, this is in the plans and will be completed.
The communal bathroom on level 3 was repaired the following day – this had been seen by the plumber and a part was required for the toilet and had to be ordered, hence the delay.
A new sluice has been ordered and fitted.
All escape routes are kept clear and going forward when a skip is being ordered it will be placed further away from the building.
There is now a process for all checks to be maintained even in the event of unplanned absence.
Storage is now fully functioning and items are stored correctly – from the previous inspection there was a compliance plan submitted that stated that storage would be correct at the 30 September, this visit occurred on the 21 September, whilst we were mid way through sorting same which was the reason for the skip. Storage is now addressed and staff are reminded to keep storage areas tidy and safe.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
There is a new dedicated store for oxygen cylinders which is outside, the only oxygen cylinders stored in the Nursing Home are located in the First Aid Bag in each Nurse Station.
As above, the removal of the link stairwell is in process of fire regularisation. Emergency lighting has been reviewed and some more emergency lights will be added to the system and commissioned as per fire standards.

As above all stairwells are cleared. There were some items that were waiting on the delivery of a new skip and removal of full skip, these have been removed. One cupboard is awaiting a fire rated door and the other cabinet has been emptied. Fire drills going forward will include some evacuation practice so staff are confident in same. We are in the process of evacuating each compartment and timing same using night time staffing. All staff have been shown in small groups (max 4) how to evacuate a resident. Nothing will obstruct any gas shut off in the Nursing Home. Signage (maps) have been removed for updating on L3, running man signage has been revised.
All of the Fire procedures have been updated in the Nursing Home, any older documents discarded. Staff have been given a copy of the procedure and the procedure has been explained to them in small groups, further fire training is booked and all staff will attend one of the sessions.
As per the Fire Risk Assessment service penetrations and service risers were noted to require some fire stopping, Masterfire have been employed and are mid way through their survey of same, when the survey is complete they will carry out the works. Door closers are in the plan for Q4 of 2024, in the meantime staff have been reminded about keeping bedroom doors closed and this was reiterated in the fire procedure and will be reiterated in the Fire training. Vertical evacuation drills will take place as part of the fire drills with staff. There are eight ski evacuation mats in the centre and a further fifteen will be purchased. All staff have been shown correctly how to fit a ski sheet and how to check a ski sheet. There is currently one bariatric resident in the centre and this person is located beside a fire exit. The Peeps for this person indicates the level of assistance required which is dependent upon the weight of the staff evacuating the resident.

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 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	24/12/2023
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	24/12/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to	Not Compliant	Orange	24/12/2023

	ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	14/11/2023
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	28/09/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	28/09/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape,	Not Compliant	Red	28/09/2023

	including emergency lighting.			
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Red	28/11/2023
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 procedure to be followed in the case of fire.	Not Compliant	Red	28/11/2023
Regulation 28(2)(i)	The registered	Not Compliant		28/02/2024

	provider shall make adequate arrangements for detecting, containing and extinguishing fires.		Orange	
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	28/11/2023