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:	28 June 2023
Centre ID:	OSV-0000061
Fieldwork ID:	MON-0040485

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:	74

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 28 June 2023	08:40hrs to 18:30hrs	Sinead Lynch	Lead
Wednesday 28 June 2023	08:40hrs to 18:30hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

From what residents told us and from what inspectors observed, it was evident that most residents were happy living in the centre. Residents who spoke with inspectors expressed satisfaction with the staff and the service that was provided to them. Staff were observed to treat residents with kindness and respect. Staff appeared to know the residents well and what their likes and dislikes were.

On the day of the inspection there were many activities for residents to choose from. The inspectors observed an exercise class for residents that showed positive participation from the residents. They appeared to enjoy the class and a resident later told the inspectors that 'this is my favourite activity as we have such a laugh'.

The universal requirement for staff and visitors to wear surgical masks in designated centres had been removed on the 19 April 2023. Staff and management expressed their delight at improved communication with residents since the masks had been removed. Staff felt the removal of the mask mandate signaled a return to normalcy which in turn led to improved socialisation for residents.

The layout of the building over three separately staffed floors lent itself to effective outbreak management. This meant that each area could operate as distinct cohort areas with minimal movement of staff between zones to minimise the spread of infection should an outbreak develop in one area of the centre.

A dedicated housekeeping room for storage and preparation of cleaning trolleys and equipment was located on level one. Overall the general environment and residents' bedrooms, communal areas and toilets, bathrooms inspected appeared appeared clean. However inspectors observed that the small sitting room on level two was cluttered with four bags of library books, two bags of clothing belonging to recently deceased residents and activities equipment.

The provider was endeavouring to improve existing facilities and physical infrastructure at the centre through ongoing painting and maintenance. Painting was ongoing on the day of the inspection. The inspectors observed that changes were being made to the existing premises and the provider informed the inspectors that a store room and a nurse's station were in the process of being converted into two additional bedrooms on levels two and three. However, inappropriate storage of supplies was observed in several areas throughout the centre. For example clean linen was stored within a room storing clinical equipment, clean and sterile supplies on level two.

Other ancillary facilities such as the laundry and the sluice rooms did not support effective infection prevention and control. For example, unlabelled clean laundry was observed on shelving beside the dirty laundry skips in the main laundry. The sluice rooms on level two and three did not have slop-hoppers for disposal of body fluids

and separate sinks for decontaminating equipment.

Barriers to effective hand hygiene practice were also observed during the course of this inspection. Clinical hand washing sinks were not available within easy walking distance from all residents rooms. Dedicated hand wash sinks were available in the sluice rooms and nursing office on each floor for clinical staff use. Alcohol-based hand-rub was available in wall mounted dispensers along corridors. However additional dispensers or individual bottles of alcohol hand gel were required to ensure alcohol hand gel was readily available at point of care in the rooms accommodating residents that were colonised with multi-drug resistant organisms (MDROs).

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

While there were management systems in the centre to ensure oversight of care and service provided was delivered to the residents, improvements were required to ensure regulatory compliance with the regulations. Specifically the governance and management arrangements in the centre had failed to ensure that a directory of residents was in place, that the Chief Inspector of Social Services was timely notified of all reportable incidents and the failures identified on this inspection in respect of premises, infection prevention and control and care planning arrangements for the residents. Further detail is available under each regulation. In addition the registered provider had failed to inform the Chief Inspector of changes made to the premises, and therefore was in breach of Condition 1 of their registration certificate.

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 three clinical nurse managers (CNM). It is registered to accommodate 74 residents. The centre contained many communal areas where residents could spend time with family and friends.

The registered provider had made improvements in relation to the review of policies and procedures as set out in Schedule 5.

Staff files had been audited since the last inspection and all files viewed on the day of the inspection were found to have all the required documents required.

On the day of the inspection there was no active directory of residents available. The registered provider has, since the inspection provided assurances that this has been uploaded electronically and now available.

There was a statement of purpose available in the centre. However, this did not

reflect the premises and service as observed by inspector on the day. The physiotherapy room that was listed in the statement of purpose was no longer available for residents use. The registered provider had made changes to the function of this room without applying to vary the conditions of their certificate of registration. A nurse's station that was also in the statement of purpose was no longer in use. The organisational structure of the centre had also changed. There was no longer an assistant director of nursing in place but the provider assured the inspectors that the delay in An Garda Siochana vetting (police clearance) had delayed the start date for the newly appointed assistant director of nursing. The registered provider amended and updated the organisational structure in the statement of purpose on the day of the inspection.

The person in charge had not notified the Chief Inspector of incidents that had occurred in the centre. Notifications in relation to peer to peer abuse had not been submitted. In relation to the deaths of residents and wounds in the centre the person in charge had not submitted these on the quarterly notifications as required.

Inspectors found that the provider did not comply with Regulation 27 and the National Standards for infection prevention and control in community services (2018). Weaknesses were identified in infection prevention and control governance, antimicrobial stewardship, environment and equipment management. Details of issues identified are set out under Regulations 23 and 27.

Overall responsibility for infection prevention and control and antimicrobial stewardship within the centre rested with the Director of Nursing.

Although the provider had previously nominated an IPC (Infection prevention and control) lead, at the time of inspection this person was no longer working in the centre. This meant that an IPC lead with the required training and protected hours allocated to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre was not in place. Inspectors were informed that a clinical nurse manager is to be nominated to take up this role.

Progress in relation to actions from the previous inspection were evident on this inspection. For example inspectors found that there were sufficient local assurance mechanisms in place to ensure that the environment and equipment was cleaned in accordance with best practice. Four housekeeping staff were rostered on duty daily and all areas were cleaned each day. The provider had a number of effective assurance processes in place in relation to the standard of environmental hygiene. These included oversight from a housekeeping supervisor, cleaning specifications and checklists and disposable cloths to reduce the chance of cross infection. Regular environmental hygiene audits were carried out. However, inspectors observed several unclean flat mop heads during the course of the inspection.

The volume of antibiotic use was also monitored each month. However, the overall antimicrobial stewardship programme, to improve the quality of antibiotic use, needed to be further developed, strengthened and supported in order to progress. Findings in this regard are further discussed under the individual Regulation 27.

A dedicated specimen fridge was available for the storage of laboratory samples awaiting collection. Staff had electronic access to relevant laboratory results required to support timely decision-making for optimal use of antibiotics. However surveillance of healthcare-associated infection (HCAI) and multi-drug resistant bacteria colonisation was not routinely undertaken and recorded. A review of acute hospital discharge letters and laboratory reports found that staff had failed to identify several residents colonised with multi-drug resistant bacteria. Findings in this regard are presented under regulation 27.

Efforts to integrate infection prevention and control guidelines into practice were underpinned by mandatory infection prevention and control education and training. A review of training records indicated that the majority of staff were up to date with mandatory infection prevention and control training. However inspectors identified, through talking with staff, that further training was required to ensure staff are knowlegable and competent in the management of residents colonised with multi-drug resistant organisms (MDROs) including Carbapenemase-Producing *Enterobacterales* (CPE).

Regulation 16: Training and staff development

Staff had access to appropriate training. Staff were appropriately supervised in their role.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had not established and maintained a Directory of Residents for the designated centre. This was not available when requested.

Judgment: Not compliant

Regulation 21: Records

The records set out under Schedule 2 of the regulations were well maintained and found to have all the required documents in place.

Judgment: Compliant

Regulation 23: Governance and management

Notwithstanding the improvements made to the quality of the lived environment, the registered provider had failed to ensure the designated centre was operated at all times in line with its statement of purpose and its conditions of the registration. Specifically, the registered provider had failed to inform the Chief Inspector of proposed changes to the premises which had resulted in the removal of facilities registered for residents' use, such as the physiotherapy room, and further removal of storage areas. The inadequate storage facilities have been a recurrent finding over the last two inspection reports.

Management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by:

- Disparities between the findings of local infection prevention and control audits and the observations on the day of the inspection indicated that there were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services.
- There was no evidence of targeted antimicrobial stewardship quality improvement initiatives, training or guidelines.
- The process for the review and management of residents' individual care plans required further oversight.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose relating to the designated centre. However, this did not match with the findings on the day of inspection. For example;

- The description of the rooms and their primary function were not correct
- The organisational structure stated in the statement of purpose was not what was found on the day of inspection
- The arrangements for the management of the designated centre where the person in charge is absent was not defined

Judgment: Substantially compliant

Regulation 30: Volunteers

There were no volunteers involved in the centre on the day of inspection. However, the registered provider was aware of the requirements under the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had not notified the Chief Inspector of Social Services at the end of each quarter in relation to the occurrence of any incidents set out in Schedule 4 (2).

An allegation of abuse was not notified to the Chief Inspector of Social Services within the required time-frame.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing, adopted and implemented policies and procedures on the matters set out in Schedule 5.

Judgment: Compliant

Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre

Inspectors were assured on the day of the inspection that the provider was aware of the notice to be given to the Office of the Chief Inspector in the absence of the person in charge from the centre.

Judgment: Compliant

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The registered provider failed to inform the Office of the Chief Inspector of the intended changes in respect of the footprint of the centre and submit the application for variation of the Condition 1 of the registration and the relevant reasons for the

variation of this condition.

Judgment: Not compliant

Quality and safety

While there were clear efforts to provide good quality care to the residents and improve their quality of life and lived environment, further action was required in respect of individual assessment and care plan, premises and infection prevention and control.

Care plans were available for all residents. However, these care plans did not guide practice. Restrictive care plans were generic and did not specify the actual restraint in use. A resident that was observed to have responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) did not have a care plan to guide staff on the triggers or the management of such behaviour. Further work was also required to ensure that all residents' files contained current health-care associated infection status and history. Details of issues identified in care plans and transfer documentation are set out under Regulation 27.

There was a residents guide made available for residents. This provided information for residents and visitors about the services and facilities available in the centre. This also explained the process for making a complaint and the procedures for visiting.

There were no visiting restrictions in place and public health guidelines on visiting were being followed. Visits were encouraged and practical precautions were in place to manage any associated risks.

The provider had identified that ventilation is an important line of defence for infection prevention and control in the environment. Eight high efficiency particulate air (HEPA) filter air cleaners had been installed to improve the air quality and reduce the risk of airborne transmission including COVID-19. These floor standing devices were located in communal areas on each floor.

A lack of appropriate storage space was also observed which resulted in the inappropriate storage equipment in some areas. For example equipment was stored within a communal bathroom and medications were stored within a fridge in a kitchenette on level one. Details of further issues identified are set out under Regulation 17.

There was a hydrotherapy (jacuzzi) bath available on level three. While the external surfaces of the baths were cleaned after use, the pipes/ air jets did not receive routine disinfection. These baths are potentially a high-risk source of fungi and bacteria, including Legionella if not effectively decontaminated after use. Inspectors

were informed that this bath had not been used in several years.

Inspectors identified some examples of good practice in the prevention and control of infection. Staff spoken with were knowledgeable of the signs and symptoms of gastrointestinal and respiratory infections and knew how and when to report any concerns regarding a resident. Ample supplies of personal protective equipment (PPE) were available. Appropriate use of PPE was observed during the course of the inspection. The provider had also substituted traditional unprotected sharps/ needles with safer sharps devices. This practice decreased the risk of a needle stick injury.

Regulation 11: Visits

There were no visiting restrictions in place and public health guidelines on visiting were being followed. Visits were encouraged and practical precautions were in place to manage any associated risks.

Judgment: Compliant

Regulation 17: Premises

The premises were not in accordance with the statement of purpose. For example;

- The physiotherapy room was converted to a nurse's office
- A wheelchair bay and storage room was now one large store room with a changed entrance from the floor plans
- A sitting room dedicated to the residents was used for storage of activities items and two bags of clothes

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

- Emergency call bells were not accessible from each resident's bed. For example, the inspectors observed that several residents did not have access to a call bell to request assistance if needed. These residents were in bed at time observed by inspectors.
- Suitable storage was not available for equipment. For example, two hoists were stored under a stairwell partially blocking a fire exit, clean linen was stored within a room containing clinical equipment, clean and sterile supplies and used linen trolleys were stored within a bathroom. Failure to appropriately segregate functional areas posed a risk of cross-contamination.
- A medication fridge was stored within a kitchenette on level one. The door to this room was observed to be open on two occasions during the course of the inspection.

Judgment: Not compliant

Regulation 20: Information for residents

There was a resident guide available in the centre. This guide had the most up-to-date visiting arrangement in the centre.

Judgment: Compliant

Regulation 27: Infection control

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;

- Staff and management were unaware of which residents were colonised with MDROs. Accurate information was not recorded in resident care plans to effectively guide and direct the care of residents colonised with MDROs. This meant that appropriate precautions may not have been in place when caring for these residents and posed a risk of further transmission.
- Inspectors identified through speaking with staff that they did not know which infection prevention and control measures were required to be used if caring for a resident that was colonised with Carbapenemase-Producing *Enterobacter* (CPE). Lack of awareness meant that appropriate precautions may not have been in place to prevent the spread of the bacteria if caring for these residents.

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

- The sluice rooms did not support effective infection prevention and control. For example there was no slop-hopper for disposal of body fluids and a separate sink for decontaminating equipment on levels two or three. The detergent in the bedpan washers on level one and two was expired. This impacted the efficacy of decontamination. Both bedpan washers were out of order on level 3. Inspectors were informed that bedpans and urinals were manually emptied in a toilet adjacent to the sluice room and washed in the hand washing sink within the sluice room. This practice posed a risk of environmental cross contamination.
- The infrastructure of the onsite laundry did not support the functional separation of the clean and dirty phases of the laundering process. Clean laundry was observed on shelving beside the dirty linen skips.
- Open and partially used wound dressings were observed in all treatment

rooms. This may have impacted the sterility and efficacy of these products. A trolley containing stocks of various wound dressing was observed to be brought into a bedroom accommodating a resident that was colonised with MDROs. This could lead to cross contamination.
- Portable fans within several bedrooms accommodating residents with MDRO were found to be visibly unclean. This posed a risk of cross-contamination.
- Three flat mops holders were heavily soiled. Effective cleaning and decontamination is compromised if cleaning equipment is unclean.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Improvements were required in relation to individual assessment and care plans. For example;

- The assessment completed prior to the admission of a resident was not comprehensive and did not include all relevant details required to plan and deliver safe care, such as the infection status of that resident
- There was no behavioural support care plan for a resident that was documented and observed as having responsive behaviour. This meant that staff did not have clear guidance on how to meaningfully respond to any such incidents
- Some care plans were generic in nature and as a result did not inform the care. For example a restraint care plan for one resident did not indicate what the actual restraint was
- Further work was required to ensure that all resident nursing assessments and care plans contained residents' current MDRO colonisation status.

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 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Compliant
Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre	Compliant
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant

Compliance Plan for Lucan Lodge Nursing Home OSV-0000061

Inspection ID: MON-0040485

Date of inspection: 28/06/2023

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 19: Directory of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Nursing Home has had all of the information required to comply with Regulation 19 for the last eight years, however to ensure a full directory all on one page assistance had to be sought from the software company. This was received on the 29 June 2023. The DON, ADON and RP now know how to pull this information together on one page.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider will ensure that the Statement of Purpose is reflective of the footprint of the Nursing Home. The physio room will now be located in what was the Nurse station on Level 2, two storage areas on Level 3 (5.9 and 5.8sqm) were made into a prospective bedroom and a store room (8.4sqm) was created on Level 3. There are other areas where storge is being created within the Nursing Home to ensure adequate storage areas. The current storage is being re-jigged with all staff involved to maximise storage and to encourage ownership from all staff. This will ensure that staff understand the need to ensure everything is stored where it should be. There are a few additional things to sort prior to formal application to vary goes to HIQA. A Submission needs to be made to South Dublin County Council, (the original fire cert insures the building for 76 inhabitants but the configuration is slightly different with this extra bed being on Level 3 (previous 2 rooms were on Level 2). New floor plans are in the process of being drawn up. Since the inspection a new IPC lead has been appointed (previous one had left the Nursing Home for an external promotion). The new IPC has been given a clear focus,	

dedicated time and has been booked for the next available training. In the meantime, on the 20 July, 4 August and 24 August an external IPC consultant has come/and is booked to provide training to the staff team. The New IPC Lead is targeting antimicrobial stewardship and has commenced some initiatives to assist all staff to care appropriately for residents, which will safeguard processes. Since the inspection a new ADON has commenced and she is focussing on the review and management of Care Plans. She has commenced Care Planning workshops with Nurses. Compliance in these areas are ongoing and will be formally complete by the 30 September 2023 with ongoing checks in place by the ADON and DON and communicated to the RP.

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

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The description of the rooms and their primary function are now correct in the statement of Purpose, however an application to vary is required and as there are some further housekeeping arrangents to be done eg. Having SDCC Fire department approve same, new floor plans are being prepared and upon completion an application to vary will be submitted to the Chief Inspector, by 30 September 2023.
The organisational structure has been updated in the statement of purpose as has the complaints procedure
The arrangements for the management of the designated centre where the person in charge is absent is now defined. The Complaints procedure has been modified to ensure that it is correct with current guidance.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Director of Nursing will ensure to send NF39- quarterly returns going forward and will ensure to backdate any missing notifications by 01.08.2023. The DON and the RP has gone through the Notification process and all notifications will be sent timely.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not Compliant

Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration:
An application to vary will be sent into the Chief Inspector when the changes are ready to be inspected (as per guidance on applications to vary), a Fire Risk Assessment has been completed and additional elements are being pulled together to send to SDCC Fire Department and we expect to have this back to us by mid September 2023, at which point we will then have everything ready for inspection and a decision from the Chief Inspector.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The physio room will now be located where the Nurse Station was and the Nurse Station will be located in the old physio room, this change is reflected in the SOP and will be submitted as part of the application to vary.
Two storage areas have been merged and converted to what will be requested to be a new bedroom for one resident, another storage area has been made on the other side of the building for wheelchairs and hoists, this will be requested of the Chief Inspector in an application to vary by the 30th September 23.
The small sitting room is a sitting room for residents, where there are some games etc stored. Families will be requested to remove their loved ones belongings as soon as is possible and if needs be, the NH will arrange for these to be delivered.
Since the inspection took place all the rooms are now fitted with emergency call bells.
The medication fridge was moved to the designated storage room. The room is fitted with a digital lock and it is maintained closed at all time.
Storage was not fully re-organised at the time of the visit (this was work in progress) and additional space has been identified and we will be continuously looking at how storage can be improved.
Clinical equipment will not be placed in the bathroom and linen trolleys will be stored in the sluice room or the storage facility adjacent to the side entrance.

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

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Following the inspection, any residents with any query mark on MDRO's have been retested via appropriate swabs. All Staff and Management know what residents were colonized and the residents care plans have been updated to effectively guide and direct the care for these residents.
A discreet system has been put in place so that all staff can easily identify affected residents nad understand the care needs and housekeeping needs of these residents.
Two trainings are booked to take place on the 04 and 24 August 2023 from an IPC specialist and covered the following MDROs, HCAIs, Hand Hygiene, Standard and Transmission based Precautions and Antimicrobial Stewardship to ensure that all the staff are educated and made aware of the appropriate precautions. One has taken place in July.

The Director of Nursing will ensure that the sluice rooms will support effective infection prevention and control. The detergent in the bedpan washers on level one and two was changed on the day of the inspection. A schedule was created for the domestic staff to ensure the detergent is changed regulary. Both bedpan washers are now fully functioning on level 3. One of these has been replaced and the other will be replaced by 30 September. In consultation with the Sluice Machine specialist, they have suggested that slop hoppers pose arisk to the environment with some spores escaping and have suggested that in the event of a sluice machine not operating effeciently that disposable bed pans are used and disposed of approritely via a yellow bin collection. One of the sluice machines on Level 2 will be replaced by the 24 August (as this has been giving trouble on and off).
The infrastructure of the onsite laundry was changed on the evening of the inspection to ensure dirty and clean areas segregated.
Staff Nurse's have been remined that once adressing pack is opened it is no longer sterile and therefore needs to be disposed of – CNM's will ensure this happens.
There os a weekly cleaning schedule in place for the maintenance man to clean residents fans.
The Mop heads that were unclean have been replaced.

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:
The Director of Nursing will ensure that the pre- admission assessment completed prior to the admission of a resident is comprehensive and will include all relevant details required to plan and deliver safe care, such as the infection status of that resident.
The Director of Nursing will ensure that a behavioural support care plan for any resident that experiences responsive behaviour will be in place and that there is clear strategy for staff to follow.
The Director of Nursing will ensure that all of the care plans will be personalised in order to meet the persons care needs. This has commenced and the new ADON has commenced workshops on Care planning and will be working with Nurses to ensure this is carried out and also communicated to staff. This work will be ongoing but all care plans will be corrected and added to by the end of September 2023

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
Registration Regulation 7 (1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition or conditions of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Not Compliant	Orange	30/09/2023
Registration Regulation 7 (2)	An application under section 52 of the Act must specify the following: (a) the condition to which the application refers and whether the application is for the variation or the removal of the condition or conditions; (b) where the	Not Compliant	Orange	30/09/2023

	application is for the variation of a condition or conditions, the variation sought and the reason or reasons for the proposed variation; (c) where the application is for the removal of a condition or conditions, the reason or reasons for the proposed removal; (d) changes proposed in relation to the designated centre as a consequence of the variation or removal of a condition or conditions, including: (i) structural changes to the premises that are used as a designated centre; (ii) additional staff, facilities or equipment; and (iii) changes to the management of the centre that the registered provider believes are required to carry the proposed changes into effect.			
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the	Not Compliant	Orange	30/09/2023

	residents of that centre and in accordance with 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	30/09/2023
Regulation 19(1)	The registered provider shall establish and maintain a Directory of Residents in a designated centre.	Not Compliant	Orange	29/06/2023
Regulation 19(2)	The directory established under paragraph (1) shall be available, when requested, to the Chief Inspector.	Not Compliant	Orange	29/06/2023
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Orange	29/06/2023
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	Orange	30/09/2023

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	Orange	30/09/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/09/2023
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/08/2023
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	01/08/2023

Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Not Compliant	Orange	01/08/2023
Regulation 31(4)	Where no report is required under paragraphs (1) or (3), the registered provider concerned shall report that to the Chief Inspector at the end of each 6 month period.	Not Compliant	Orange	01/08/2023
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 admission to a designated centre.	Substantially Compliant	Yellow	01/07/2023
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	Not Compliant	Orange	01/07/2023

	admission to the designated centre concerned.			