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:	Woodlands House Nursing Home
Name of provider:	Sandcreek Limited
Address of centre:	Trim Road, Navan, Meath
Type of inspection:	Unannounced
Date of inspection:	03 January 2024
Centre ID:	OSV-0000186
Fieldwork ID:	MON-0042413

About the designated centre

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

The designated centre provides 24- hour nursing care to 36 residents, male and female who require long-term and short-term care (assessment, rehabilitation, convalescence and respite).

The centre is a two storey building. Communal facilities and residents' bedroom accommodation consists of a mixture of 26 single and five twin bedrooms with en-suite facilities. A passenger and platform lift was available between the ground and upper floors where six residents resided. The centre is well laid out around centrally located communal facilities that include a range of day and dining rooms, and a spacious oratory for prayer, reflection and repose. Enclosed outdoor courtyards are accessible from parts of the centre.

The philosophy of care is to provide a good quality service where residents are happy, content, comfortable and safe, and for residents to be treated as unique individuals to experience inner peace.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	35

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 3 January 2024	09:20hrs to 17:35hrs	Aislinn Kenny	Lead
Wednesday 3 January 2024	09:20hrs to 17:35hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

From what residents told us and what inspectors observed Woodlands House Nursing Home was a nice place to live. On the morning of inspection the inspectors were met by a staff nurse, who guided them through the sign-in procedure. After an introductory meeting with the person in charge who arrived at the centre shortly after, the person in charge accompanied inspectors on a walk about of the premises. During this walk about inspectors observed immediate risks in relation to Regulation 28: Fire Precautions and that a number of areas were not used in line with their designated purpose, as per centre's certificate of registration. These are outlined further in the report and under the relevant regulations.

The centre is divided into an original house and a modern extension part of the building. The original house is laid out over three floors. On the ground floor there was a welcoming entrance hall where visitors signed in. A lounge room with seating arranged for residents and visitors was off the hallway and inspectors observed that this lounge also contained an area which was used as a reception office. There was a desk, computer, phone and filing cabinets near the entrance of the lounge. This room had been registered as a communal space for residents' use and was not an appropriate space for a reception office as it provided no privacy for either the residents or the reception staff receiving or making confidential phone calls. In addition, carrying out administrative duties would disturb residents partaking in activities in that area.

Further down the hall there was a quiet room, a sitting area which was a relaxing and pleasant space containing comfortable furniture and this room had a nice relaxing atmosphere. Access to the first floor was by stair lift or by lift.There were four bedrooms on the first floor, two twin rooms and two single rooms, these were bright and spacious with original features and were nicely decorated and warm. Residents had personalised their rooms with photographs and personal possessions. Residents spoken with said they enjoyed living in this part of the house and were happy with their rooms. All rooms had a spacious en-suite with toilet and shower facilities. There was a small nurses station including a small desk and computer located on this floor also. Unprotected staircases were observed to continue onto a second floor containing an office, which was locked and not in use at the time of inspection.

There was a lift from the ground floor which stopped at the landing of the first floor. This lift did not have a lobby to prevent the travel of smoke in the event of fire. When residents disembarked from the lift, there were five steps up to the landing where the bedrooms were located. This was supplemented by an automated wheelchair ramp that was utilised through a remote control on the wall beside it. This was installed to help residents to exit the area and access the external fire escape located on the landing beside the lift.

Inspectors observed that on the day of inspection an oratory that had been located

on the ground floor of the original house had been changed into an office. This had not been notified to the Office of the Chief Inspector of Social Services and was not in line with the centre's registered statement of purpose. The change in use of the room reduced the communal space available to residents and there was no other oratory made available to them.

The newer extension of the original building had wide corridors with hand rails for residents to mobilise freely around the centre. Residents' rooms were nicely decorated and there were modern prints on the walls around the centre. Inspectors observed a Sun room at the end of the corridor that was a nicely decorated space overlooking the village. There were also large print wall signs directing residents around the centre.

The inspectors spoke with seven residents who all reported high level of satisfaction with the food, staff, premises and the care they received in the centre. Interactions between staff and residents were observed to be courteous and person-centred. Staff who spoke with the inspectors were confident and it was clear that they knew the residents and their needs well. Inspectors spoke with four different staff who described what they would do in the event of fire. While staff displayed good knowledge, significant action was required to ensure that policies were implemented in practice and that appropriate fire safety precautions were in place to safeguard the residents.

The inspectors met with two visitors on the day who also reported that they had no concerns and were satisfied with the care and services their loved one was receiving in Woodlands House Nursing Home and said that they could visit freely and were always welcomed. Residents were observed to be well-groomed and appropriately dressed. On the day of inspection residents were gathered listening to a local entertainer and joining in the singing and dancing, this took place in the large lounge area located in the new extension.

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 provider aimed to provide a good service and to support residents living there to receive a good standard of quality care. Residents' health care needs were met, however, this inspection found that the registered provider had not ensured that the governance systems were effective in overseeing that a safe service was continuously provided for residents living in the designated centre. Significant action was now required to bring the centre into regulatory compliance and to strengthen governance and management systems relating to the oversight of premises and fire

safety. This unannounced risk inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centres for older people) Regulation 2013 (as amended) to inform the renewal of the registration of the designated centre.

The registered provider is Sandcreek Limited which is part of the Beechfield Care Group. From a governance perspective, the person in charge was supported by a senior management team comprising of a Group Operations and Procurement Manager with responsibility for premises and fire safety and the Group Quality and Clinical Practice Lead, who were both present on inspection and the registered provider representative who arrived for the feedback meeting. The person in charge led a team consisting of a Clinical Nurse Manager (CNM) and nurses, health care assistants, catering, housekeeping, activity and maintenance staff. There were clear lines of accountability and responsibility in line with the statement of purpose.

The centre had a good history of compliance with the regulations. However, this inspection identified that significant improvements were required in some areas. While there was evidence of audits taking place and management systems were in place, there was a clear lack of oversight on the fire safety risks, some of which had already been identified in provider's own fire safety risk assessment dated February 2022, for example that only residents who are ambulatory and with low dependency needs should be accommodated on the first floor. Inspectors found that one resident was located on the first floor and their dependency levels had recently changed and were no longer mobile. Inspectors were not assured that they could be evacuated safely from the first floor bedroom in the original building and an urgent compliance request was issued to the provider to address this risk. The provider's response gave assurances that appropriate action has been taken to address this risk.

Other immediate risks were identified, including inappropriate storage of chemicals under stairs, inappropriate storage of oxygen, faulty self-closing devices to the door of the laundry which is a high risk area and means of escape which were obstructed by clutter or locks. The inspectors were satisfied that prompt remedial action was taken by the provider to address all these risks before the end of inspection. Inspectors reviewed records of fire drills that had been carried out in the centre and found there was only one recorded fire drill that had taken place in the designated centre in 2023, which was not in line with local policy that stated that monthly fire drills should be carried out. There was also a lack of available evidence that regular environmental audits took place. There was an annual review available however inspectors found it was not a comprehensive review of the service and did not have recorded actions or time frames for improvement detailed. There was also no evidence of resident involvement in the annual review.

A sample of contracts of care were reviewed and were found to contain all the required regulatory information.

The statement of purpose required review as it did not fully describe the premises as they were registered, and changes made to premises without agreement in advance with the Chief Inspector as further detailed under Regulation 17: Premises,

were not acceptable.

The complaints procedure was reviewed and inspectors found there were inconsistencies in the versions of the procedure in different records and areas of the centre. A synopsis of the procedure was displayed in corridors throughout the centre and was also referred to in the statement of purpose and residents guide. Inspectors also reviewed the complaints policy document. Documents reviewed were different and while most of the required information was contained in the procedure there was an inconsistent message about who the nominated review officer was and different persons were named in these areas. There were no open complaints at the time of inspection. The complaints log was reviewed with the person in charge and there was evidence of complaints being dealt with promptly and fairly. Advocacy services were referred to within the policy.

Regulation 23: Governance and management

The registered provider did not ensure that effective management systems were in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- The registered provider did not operate the centre in line with its conditions of registration as a number of communal areas dedicated for residents' use had been re purposed without agreement with the Chief Inspector in advance. This is further detailed under Regulation 17: Premises.
- Immediate and urgent fire safety risks were found on the day which had not been identified by provider's own systems of fire safety oversight.
- There were inconsistencies and a lack of clarity in respect of the fire evacuation strategy, between the local policy, evacuation plans displayed on the wall, staff training and knowledge, and completed evacuation drills.
- Appropriate management systems were not in place with respect to premises and fire safety to ensure the service provided was safe, appropriate, consistent and effectively monitored by the provider
- Information governance systems required review to ensure records were maintained in a safe manner at all times. Inspectors observed that the office created in the lounge of the main building was unattended and had open drawers where records containing personal information were maintained.
- The registered provider did not ensure that local policies were effectively implemented in practice, for example fire safety policy.
- The registered provider had a complaints procedure in place, however, there were different versions of the procedure available on the day of inspection and it required updating to ensure it accurately described who the nominated review officer was. While there was no evidence found on the day that complaints had not been appropriately managed, this lack of clarity in respect of nominated people managing the complaints process could adversely

impact the integrity of the complaints process and required review.

While the registered provider had an annual review in place there was no evidence of its preparation in consultation with residents.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of residents' contracts of care were reviewed. These were agreed in writing with the resident, and where appropriate, their representative. Contracts contained all of the required information, including the fees to be charged, and the terms related to the bedroom to be provided.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose did not contain all the information required under Schedule 1 and required review in respect of:

- There were gaps in the description of some facilities which are to be provided
- There were inconsistencies in measurements of some facilities between the floor plan and the statement of purpose
- A review was required of the arrangements made for dealing with complaints
- A further review was required of the services to be provided by the designated centre to include access to community services such as physiotherapy and occupational therapy.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had a complaints procedure in place which met the regulatory requirements and there was evidence to show that all complaints had been appropriately managed and investigated. However, there were different versions of the procedure available on the day of inspection as described under

Regulation 23: Governance and management, and this required review.

Judgment: Compliant

Quality and safety

Overall, residents appeared happy living in the centre and their health, social care and spiritual needs were well catered for. Residents were well supported by staff and were able to choose how they spent their day.

The inspectors reviewed a sample of residents' care records and saw that a variety of validated tools were used to appropriately assess the residents. Inspectors saw that the care plans were completed within 48-hours post residents' admission and were updated within the four-month time frame and that there was a system in place to audit care plans also.

Residents at end-of-life stage had access to appropriate care and comfort. The centre had arrangements in place to support the provision of compassionate end-of-life care to residents, in line with their assessed needs and wishes.

Information for residents was available through the residents guide. This document was reviewed on inspection and did not contain all the required information as outlined further under the Regulation 20.

Residents were seen enjoying spending time in the large lounge area and sun room on the day of inspection and these spaces were nicely decorated and welcoming. However, there were areas of the premises that were not maintained in a satisfactory state of repair. For example, the dry goods store and staff changing areas showed signs of damp and there was inappropriate storage throughout the centre. Further findings are described under Regulation 17: Premises.

Inspectors reviewed fire safety precautions and found that the registered provider had failed to identify significant fire safety risks in the centre, which required immediate and urgent action. Specifically, significant concerns were found in respect of fire and smoke containment, maintaining of escape routes, evacuation plans and completion of regular fire drills to ensure that all residents could be safely evacuated to a place of safety in the event of fire. There was a lack of clarity in respect of compartmentalisation. Inspectors were informed that the largest compartment was of nine residents. Information received as part of the urgent assurance request following the inspection show that the largest compartment has 12 residents. No full compartment fire drill had been completed to demonstrate that staff had the capacity and ability to evacuate all residents in the event of fire.

The fire safety risk assessment identified that a minimum of four staff were required on night duty to maintain residents' safety, with one staff located on the first floor at all time. While staffing levels were sufficient, supervision practices and staff

deployment were not in line with the risk assessment. There was a fully addressable fire alarm system and all the required checks, inspections and service of the fire equipment had been completed in line with regulatory requirements.

Overall, full review of the fire precautions was immediately required by the provider. These are discussed further under Regulation 28: Fire Precautions.

Regulation 13: End of life

There were care practices and facilities in place so that residents received end-of-life care in a way that met their individual needs and wishes. Residents had been afforded the opportunity to outline their wishes in relation to their care at the end of their lives

Judgment: Compliant

Regulation 17: Premises

The registered provider did not ensure that the premises of the 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. Changes made to premises had not been communicated to the Chief Inspector and resulted in a reduction to communal space available to residents which was not appropriate. These included:

- No arrangements had been made to relocate a resident from the first floor to an alternative bedroom on the ground floor as a result of changing in their dependency level.
- The Oratory had been converted to an office, which included two desks, a computer and office chairs;
- Parts of the residents' Lounge had been re purposed to facilitate the creation of a reception desk area.
- Visitors room was not available to residents or visitors as it was used for storage purpose

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:

- There were inappropriate storage arrangements and poor oversight of how inadequate storage practices impacted on fire safety. For example; there was excessive clutter and materials blocking a fire escape route near the activities

store room; cleaning chemicals were stored under the stairs; oxygen concentrators stored in linen rooms and storage rooms; dry good stores had inappropriate storage arrangements with some food stored on the floor;
- The treatment room was unclean, cluttered and had a bed and various other items stored in it including pieces of luggage and required cleaning
- Areas of the premises were not well-maintained and deep cleaning and maintenance was also required in areas such as dry goods store, corridors and staff changing areas. For example, in the service areas there was damp in the staff corridor area and staff changing facilities required cleaning and maintenance; a sluice room required cleaning and replacement of equipment.
- The clinical room did not have a clinical hand wash sink of correct specifications to support appropriate hand hygiene.

Judgment: Not compliant

Regulation 20: Information for residents

There was a residents' guide available for residents. This did not contain all of the required information for residents and required updating with an accurate complaints procedure details and details of advocacy services.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Significant risks were identified in respect of fire safety which required immediate action by the registered provider on the day of inspection. Further written assurances were requested in an urgent compliance plan request to the provider following inspection.

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

- Oversight of oxygen required review. There were excessive amounts of O2 cylinders (16 small bottles) and a large Flo-gas cylinder found in an external storage area; In addition two oxygen concentrators were found in a main storage area filled with supplies and another two oxygen concentrators were found in a linen cupboard. There was no hazard signage in these rooms.
- Poor housekeeping practices impacted the overall fire safety, and this issue had been highlighted in a previous fire safety risk assessment of the centre. Excessive clutter near the activities storage area and in the GP treatment room, was blocking the means of escape and posed a fire safety risk.

- The outdoor smoking area was not fitted with all the required equipment to ensure residents' safety such as access to a call bell facility, fire extinguisher and fire blanket in the immediate vicinity
- Fire safety policy was poor and was not being implemented in practice; there was no consideration in the policy for the vertical evacuation of the residents located on the first floor; monthly fire drills were not being completed. While the policy stated that one staff must be at all times present on the first floor in the old building, this was not the practice in the centre as confirmed in discussion with several staff members. Urgent assurances were requested in this respect and provider's response did assure that effective arrangements were put in place following the inspection.
- There were unrecognised risks associated with excessive amounts of electrical equipment used in a high risk area (the old building) which was one compartment. For example there was a mini-desk station with computer on the landing on the first floor, and a fully equipped reception desk in the lounge where inspectors observed an overloaded five plug extension lead.

The registered provider did not provide adequate means of escape:

- A small courtyard area which was a designated means of escape had a padlock on the gate. This was in direct contradiction with the fire safety certificate which stated that it should be unobstructed and free from fastenings.
- Means of escape were found blocked or obstructed; in the GP treatment room the external evacuation route was blocked with a Yale door lock that prevented the door from releasing in the event of a fire. This may delay access to an escape route and was removed before the inspection was completed.
- In the old part of the building the means of escape route for residents' accommodated on the first floor was severely compromised by the lack of compartmentalisation and lack of fire stopping at the lift. Assurances received following the inspection that fire stopping measures have been put in place in that area however the risk of smoke had not been mitigated.

The registered provider did not ensure by means of fire safety management and fire drills at suitable intervals that staff working in the designated centre were aware of the procedure to be followed in the event of fire and had the skills and capability to evacuate all residents from one compartment to another should it be required.

- There was a lack of clarity in respect of the size of the compartments. The largest compartment included 12 residents and no fire drills had been completed at the time of inspection, to demonstrate the evacuation of a full compartment with night time staffing levels. Instead, drills were considered a training exercise demonstrating how to evacuate one bed.
- The Main House building which was spread over two floors was one large compartment where vertical evacuation was the only method of evacuation appropriate. No full evacuation of the whole compartment had been trialled
- Records showed that one fire drill have been completed in 2023. This was against provider's own local policy which stated that monthly fire drills should

be carried out.

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

- There was a lack of smoke containment at the lift in the Main House Building. While the provider gave assurances of fire stopping works completed following the inspection to protect against the risk of fire, in the absence of a lift lobby the risk of smoke could not be mitigated. This was a finding of provider's own fire safety risk assessment, and this action remained outstanding.
- The Main House Building was one large compartment. While a sub-compartment door had been installed at the first floor level, there was no containment between the first and second floor and no enclosed stairwell.

The person in charge did not ensure that the procedures to be followed in the event of fire were appropriately displayed

- The procedures were not clear and appropriately displayed in a prominent place at key locations in the designated centre.
- The fire evacuation procedure did not include guidance on the vertical evacuation requirements for this building.
- Evacuation plans displayed at the entrance of the centre were outdated and did not reflect the current use of the building.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans were reviewed in line with regulatory requirements and individual assessments and care plans were in place for all residents

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant

Compliance Plan for Woodlands House Nursing Home OSV-0000186

Inspection ID: MON-0042413

Date of inspection: 03/01/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The registered provider did not operate the centre in line with its conditions of registration as a number of communal areas dedicated for residents' use had been re purposed without agreement with the Chief Inspector in advance. This is further detailed under Regulation 17: Premises.
o The Oratory was converted back to its original use the following day. All desks, chairs and computers were removed.
o The reception was relocated beside the Nurses Station. The 'Resident's Lounge' was reinstated to its original room and purpose. Floor plans and SOP updated to identify reinstated rooms / areas.
• Immediate and urgent fire safety risks were found on the day which had not been identified by provider's own systems of fire safety oversight.
o Immediate action was undertaken on the day of inspection, the chemicals stored under the stairs was removed. There is now a lock placed on the door to prevent futher usage of this area.The Fire Exit was cleared and the oxygen cylinders removed to their appropiate loaction. The padlock was removed from the gate. The lock was removed from the fire door. The fire systems were reviewed post inspection by a Competent Fire Risk Assessor and the Group Operations and Procurement Manager.
• There were inconsistencies and a lack of clarity in respect of the fire evacuation strategy, between the local policy, evacuation plans displayed on the wall, staff training and knowledge, and completed evacuation drills.
o A new strategy was implemented post inspection. This was in line with our new Fire Policy. Fire evacuation plans were updated to highlight the Compartmentation within the home. Posters were placed around the home stating what compartment staff are in at any time.
o The evacuation plans on display have been updated to reflect the 7 Compartments within the home. In addition to this we have displayed 'you are here in compartment' so staff / visitors / residents are aware of what compartment they are in at any given time. Fire drills have been ongoing to reflect the Compartments and within these drills we have

carried out nighttime scenarios (4 members of staff evacuating the largest Compartment with 12 beds). After each Fire Drill there is a debrief carried out. Learnings are identified and discussed and an action plan is drawn up. Going forward there will be weekly fire drill completed until we are satisfied that all staff are aware of the fire policies and procedures. Then monthly drills will be carried out as per policy. Fire drill reports are to be sent to the Ops Team and discussed as part of the monthly Ops meetings and quarterly Health and Safety reports. Fire evacuation strategy has been updated to reflect the compartments within the home. All staff have completed a Fire Drill in the home. Fire Drills from the first floor where vertical evacuation is the only method of evacuation have been completed and they demonstrated the ability to safely evacuate all residents in the event of fire to the nearest point of safety.
o Within the first week post inspection all staff within the home had completed a fire drill in line with the new evacuation procedure. Fire drills are completed weekly until further notice.
• Appropriate management systems were not in place with respect to premises and fire safety to ensure the service provided was safe, appropriate, consistent and effectively monitored by the provider.
o A new Fire register is now in place which documents the required Fire checks carried out internally and verified weekly by the Director of Nursing and the Operations Team.
o There is also a new property management folder which details all appropiate checks that maintenance need to fulfill on a weekly basis.
o A new weekly audit has been implemented in the home which is undertaken by the Director of Nursing / PIC to ensure all of the above is documented , verified and all actions completed.
o A new Health and Safety audit of the building has been completed and will be done every quarter by the Operations Team.
• Information governance systems required review to ensure records were maintained in a safe manner at all times. Inspectors observed that the office created in the lounge of the main building was unattended and had open drawers where records containing personal information were maintained.
o The following day the reception area was relocated beside the Nurses Station. All documentation was removed and is now secured safely and stored in the DON office.
• The registered provider did not ensure that local policies were effectively implemented in practice, for example fire safety policy.
o The Policies have been reintroduced to all members of staff and signed off for verification. A new Fire policy was developed, all staff have signed to say they have read and understood same.
• The registered provider had a complaints procedure in place, however, there were different versions of the procedure available on the day of inspection and it required updating to ensure it accurately described who the nominated review officer was. While there was no evidence found on the day that complaints had not been appropriately managed, this lack of clarity in respect of nominated people managing the complaints process could adversely impact the integrity of the complaints process and required review.
o The Complaints Procedure has been updated to reflect the required changes in legislation. This is also reflected in the SOP.
While the registered provider had an annual review in place there was no evidence of its preparation in consultation with residents.
• A new Annual Review template is being rolled out in the home for this year. It will

include the residents survey and all consultation with the residents and their advocates.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • There were gaps in the description of some facilities which are to be provided o A description of communal sanitary facilities has been updated in the SOP • There were inconsistencies in measurements of some facilities between the floor plan and the statement of purpose o A full review of the floor plan and SOP was carried out. Both documents updated to reflect the required changes. • A review was required of the arrangements made for dealing with complaints. o The Complaints Procedure has been updated to reflect the required changes in legislation. This is also reflected in the SOP. • A further review was required of the services to be provided by the designated centre to include access to community services such as physiotherapy and occupational therapy. o The SOP now highlights that HSE community services (OT, physio, SALT) will be offered in first instance to all residents who qualify. Private services can also be offered but in addition to not as a replacement.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • No arrangements had been made to relocate a resident from the first floor to an alternative bedroom on the ground floor as a result of changing in their dependency level. o Appropriate arrangements have been put in place to relocate the resident whose mobility and dependency levels changed as a result of recent changes in their condition. The Director of Nursing has communicated to the other 5 residents on the first floor that they will need to be relocated should their dependency levels change. Going forward it will be documented in the contract of care that any resident occupying these rooms may have to relocate rooms if their dependency levels change. • The Oratory had been converted to an office, which included two desks, a computer and office chairs. o The Oratory was converted back to its original use the following day. All desks, chairs and computers were removed. • Parts of the residents' Lounge had been re purposed to facilitate the creation of a reception desk area.	

o The reception was relocated beside the Nurses Station. The 'Resident's Lounge' was reinstated to its original room and purpose.
• Visitors room was not available to residents or visitors as it was used for storage purpose.
o This room was cleared of all storage. It is now used as a Library for residents / relatives to use.
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:
• There were inappropriate storage arrangements and poor oversight of how inadequate storage practices impacted on fire safety. For example; there was excessive clutter and materials blocking a fire escape route near the activities store room; cleaning chemicals were stored under the stairs; oxygen concentrators stored in linen rooms and storage rooms; dry good stores had inappropriate storage arrangements with some food stored on the floor.
o Excessive clutter and materials were removed on the day of inspection. All cleaning chemicals and oxygen concentrators were also removed to appropiate storage on the day of inspection. The day following the inspection the catering department conducted a deep clean and declutter of the dry goods store. The Director of Nursing / PIC completes a weekly formal inspection of these areas to ensure compliance.
• The treatment room was unclean, cluttered and had a bed and various other items stored in it including pieces of luggage and required cleaning.
o The day after inspection the room was decluttered and deep cleaned.
• Areas of the premises were not well-maintained and deep cleaning and maintenance was also required in areas such as dry goods store, corridors and staff changing areas. For example, in the service areas there was damp in the staff corridor area and staff changing facilities required cleaning and maintenance; a sluice room required cleaning and replacement of equipment.
o A deep clean of all areas was carried out. An external contractor has been engaged to carry out required works on the areas identified.
• The clinical room did not have a clinical hand wash sink of correct specifications to support appropriate hand hygiene.
o A review of clinical hand wash sinks is being undertaken.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
• There was a residents' guide available for residents. This did not contain all of the required information for residents and required updating with an accurate complaints procedure details and details of advocacy services.
o The residents guide has been updated to include an accurate Complaints procedure and updated advocacy services.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Oversight of oxygen required review. There were excessive amounts of O2 cylinders (16 small bottles) and a large Flo-gas cylinder found in an external storage area; In addition two oxygen concentrators were found in a main storage area filled with supplies and another two oxygen concentrators were found in a linen cupboard. There was no hazard signage in these rooms.
o The excessive amount of O2 cylinders have been removed. All remaining o2 cylinders and oxygen concentrators are being stored appropriately.
o The Flo gas cylinder has been removed from the premises.
o There is hazard signage now in the appropriate rooms.
• Poor housekeeping practices impacted the overall fire safety, and this issue had been highlighted in a previous fire safety risk assessment of the centre. Excessive clutter near the activities storage area and in the GP treatment room, was blocking the means of escape and posed a fire safety risk.
o A full declutter of all storage rooms and the GP treatment room was completed. The Yale lock was removed from the door on the day of the inspection. These areas are now checked on a daily basis and form part of the fire register checks.
• The outdoor smoking area was not fitted with all the required equipment to ensure residents' safety such as access to a call bell facility, fire extinguisher and fire blanket in the immediate vicinity.
o The outdoor smoking has now been fitted with all the required equipment to ensure residents' safety such as access to a call bell, fire extinguisher and a fire blanket in the immediate vicinity.
• Fire safety policy was poor and was not being implemented in practice; there was no consideration in the policy for the vertical evacuation of the residents located on the first floor; monthly fire drills were not being completed. While the policy stated that one staff must be at all times present on the first floor in the old building, this was not the practice in the centre as confirmed in discussion with several staff members. Urgent assurances were requested in this respect and provider's response did assure that effective arrangements were put in place following the inspection.
o The Fire safety policy was reviewed and now clearly identifies the different methods of evacuation required and confirmation that all staff are aware of this policy.
o Fire drills are now carried out in line with our policy, until further notice these will be conducted weekly and verified by the Ops team.
o These Fire drills will form part of the discussion at the homes monthly Operations meeting and Quarterly Health and Safety Meetings.

• There were unrecognised risks associated with excessive amounts of electrical equipment used in a high risk area (the old building) which was one compartment. For example there was a mini-desk station with computer on the landing on the first floor, and a fully equipped reception desk in the lounge where inspectors observed an

overloaded five plug extension lead.
o We have reviewed all electrical equiptment in the old building. As a result the mini desk station and the reception desk have been removed from this area. Night nurses are to ensure all plugs are switched off in this area during their duty.
• A small courtyard area which was a designated means of escape had a padlock on the gate. This was in direct contradiction with the fire safety certificate which stated that it should be unobstructed and free from fastenings.
o The padlock was removed and the area is now free from obstruction.

• Means of escape were found blocked or obstructed; in the GP treatment room the external evacuation route was blocked with a Yale door lock that prevented the door from releasing in the event of a fire. This may delay access to an escape route and was removed before the inspection was completed.
o The Yale lock was removed on the day of inspection.

• In the old part of the building the means of escape route for residents' accommodated on the first floor was severely compromised by the lack of compartmentalisation and lack of fire stopping at the lift. Assurances received following the inspection that fire stopping measures have been put in place in that area however the risk of smoke had not been mitigated.
o A Fire Engineer attended the home and reviewed the Fire stopping at the lift shaft. Work has been completed and certified. In addition to this the home is installing 'Fire Curtains' at the lift on each floor. We are awaiting the contractor to install same.
o There is one WTE night HCA's is permanently based on the first floor of the old building. Staff are assigned 4 houly shifts, rotating to cover the 12 hours.
The registered provider did not ensure by means of fire safety management and fire drills at suitable intervals that staff working in the designated centre were aware of the procedure to be followed in the event of fire and had the skills and capability to evacuate all residents from one compartment to another should it be required.
o The fire drills are now conducted on a weekly basis. An action plan is developed following each drill to ensure any gaps in the procedure / knowledge is idenified and actioned. This covers night time scenarios, evacuation of the largest compartment and vertical evacuation of the 'old house'. All staff in the home have now completed a fire drill.
o The home has engaged with the local Fire Station to organise a familiarisation visit.
• There was a lack of clarity in respect of the size of the compartments. The largest compartment included 12 residents and no fire drills had been completed at the time of inspection, to demonstrate the evacuation of a full compartment with night time staffing levels. Instead, drills were considered a training exercise demonstrating how to evacuate one bed.
o Clarification has been sought and we now have a clear understanding of all compartments in the home. We have updated our maps and added additional posters around the home detailing the compartments.
o Fire drills within the largest compartment have now been undertaken on numerous occasions.
o There is a copy of the floor plans of the designated centre outlining the compartment boundaries in place. These new plans are displayed throughout the centre. All staff are aware of the Compartments and same is discussed during Fire Drills.

• The Main House building which was spread over two floors was one large compartment where vertical evacuation was the only method of evacuation appropriate. No full evacuation of the whole compartment had been trialled.
o Vertical evacuations have been included in our recent fire drills.
o A full evacuation of the whole compartment has been conducted and will continue.
• Records showed that one fire drill have been completed in 2023. This was against provider's own local policy which stated that monthly fire drills should be carried out.
o We have now conducted 9 drills in 2024. These drills included night time scenarios, evacuation of the largest compartment, vertical evacuation of the old building. These drills will continue on a weekly basis until further notice.
The registered provider did not make adequate arrangements for containing fires.
• There was a lack of smoke containment at the lift in the Main House Building. While the provider gave assurances of fire stopping works completed following the inspection to protect against the risk of fire, in the absence of a lift lobby the risk of smoke could not be mitigated. This was a finding of provider's own fire safety risk assessment, and this action remained outstanding.
o A Fire Engineer attended the home and reviewed the Fire stopping at the lift shaft. Work has been completed and certified. In addition to this the home is installing 'Fire Curtains' at the lift on each floor. We are awaiting the contractor to install same.

• The Main House Building was one large compartment. While a sub-compartment door had been installed at the first floor level, there was no containment between the first and second floor and no enclosed stairwell.
o We have engaged with a Fire Engineer to install fire curtains and FD60 fire doors on the stairwell.
The person in charge did not ensure that the procedures to be followed in the event of fire were appropriately displayed
• The procedures were not clear and appropriately displayed in a prominent place at key locations in the designated centre.
o All procedures have been updated and are now displayed around the home. All staff have been made aware of same.

• The fire evacuation procedure did not include guidance on the vertical evacuation requirements for this building.
o The Fire evacuation procedure now includes the vertical evacuation requirements.
Evacuation plans displayed at the entrance of the centre were outdated and did not reflect the current use of the building.
• A review of the evacuation plans around the home have been carried out. All old plans have been removed. New plans detailing compartments have been installed throughout.

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	13/02/2024
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	04/01/2024
Regulation 20(2)(e)	A guide prepared under paragraph (a) shall include information regarding independent	Not Compliant	Orange	04/01/2024

	advocacy services.			
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure respecting complaints, including external complaints processes such as the Ombudsman.	Not Compliant	Orange	04/01/2024
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	17/01/2024
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Orange	29/02/2024
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	17/01/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape,	Not Compliant	Red	17/01/2024

	including emergency lighting.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	30/06/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	30/06/2024
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	10/01/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety	Not Compliant	Red	29/02/2024

	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.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	30/06/2024
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	10/01/2024
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Red	10/01/2024
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated	Substantially Compliant	Orange	13/02/2024

	centre concerned and containing the information set out in Schedule 1.			