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:	The Marlay Nursing Home
Name of provider:	Brehon Care
Address of centre:	Kellystown Road, Rathfarnham, Dublin 16
Type of inspection:	Unannounced
Date of inspection:	14 September 2022
Centre ID:	OSV-0000108
Fieldwork ID:	MON-0037861

About the designated centre

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

The Marlay Nursing Home is located in Rathfarnham in South Dublin close to the M50 motorway. It is a purpose built centre containing 124 single bedrooms with full en suites over three floors. The centre opened in 2006. It is well serviced with amenities including a local park, restaurants, pubs, shops and churches. It provides long term 24-hour general care, convalescence and respite care to males and females over the age of 18 years. The centre has a team of medical, nursing, direct care and ancillary staff and access to other allied health professionals to deliver care to residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	116

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 14 September 2022	08:40hrs to 17:20hrs	Jennifer Smyth	Lead
Thursday 15 September 2022	08:20hrs to 18:20hrs	Jennifer Smyth	Lead
Wednesday 14 September 2022	08:40hrs to 17:20hrs	Niall Whelton	Support
Thursday 15 September 2022	08:20hrs to 18:20hrs	Niall Whelton	Support
Wednesday 14 September 2022	08:40hrs to 17:00hrs	Siobhan Nunn	Support
Thursday 15 September 2022	08:20hrs to 18:20hrs	Siobhan Nunn	Support

What residents told us and what inspectors observed

From what residents told us and from what inspectors observed, residents were mostly happy with the care they received within the centre. Inspectors observed many positive interactions between staff and residents. The Marlay Nursing Home has a total of three floors with internal courtyards. On walking through the designated centre inspectors observed that a number of rooms were being used which had not been registered and were not contained within the existing floor plan.

When inspectors and visitors arrived at the centre they were guided through infection prevention and control measures necessary on entering the designated centre. These processes were comprehensive and included a signing-in process, hand hygiene, the wearing of face masks, and temperature check.

The inspectors spoke directly with residents, they stated staff who delivered their care were kind and caring. Inspectors observed that staff greeted residents by name and residents were seen to enjoy the company of staff. Staff spoken with were knowledgeable of their role and reported that they were well supervised and supported. Interactions between staff and residents were seen to be courteous and respectful.

Inspectors saw that a number of bedrooms were personalised with residents' family photographs, ornaments and other personal memorabilia. However, for residents with sensory impairments there was limited directional signage to help them to navigate the centre. Over the two days of the inspection inspectors observed inappropriate storage of equipment in various locations throughout the centre, including items being stored on the floor in sluice rooms posing an infection prevention and control risk and equipment being stored in corridors on the ground floor which could pose a risk hazard.

Many residents were seen partaking in activities in the large reception area. A dedicated activities coordinator led a number of lively, fun filled activities during the inspection, such as a music and exercise sessions. Residents who spoke with the inspectors said that they were aware of who to speak to if they had a complaint and one person said that they "always received a good response" when they raised issues.

Inspectors saw that residents had unrestricted access to the garden either alone or accompanied by staff. The garden contained raised flowerbeds and outdoor seating. Residents were observed walking outside in the garden with their family members. Visitors indicated that they felt welcomed by the staff to visit mainly in resident bedrooms. They said that they were kept updated regarding their loved ones condition and that they were well cared for.

Residents were very complimentary about the food and the inspectors saw that residents were offered choice. In the dining room on the ground floor, a setting for

24 residents was set up for lunch, 15 residents attended. Menus were displayed and staff also informed residents regarding the choices on offer. Residents reported that they found the new dining area 'tight for space'. Inspectors observed residents' mobility aids had to be left outside the dining room as there was not enough space inside. This had a restrictive impact on residents, as they were unable to independently leave the area. Another resident stated that they preferred the old dining room, as the new room was "too dark". There was no external window to allow for natural light.

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

An established management structure was in place to oversee the safe provision of care to residents. However the registered provider was found in breach of their condition of registration using areas that had not been registered or inspected by the Chief Inspector of Social Services as part of the designated centre. The governance systems failed to identify this requirement and a number of risks associated with building works within the designated centre. Following the inspection a warning meeting was held in relation to the breach of conditions. Furthermore significant fire safety risks were identified which resulted in an immediate action plan being issued on the day, which is detailed under Regulation 27

This inspection was prompted by an application by the registered provider to vary conditions 1 and 3 of their registration in order to increase the registered beds by 62. At the time of the inspection a decision had not been made regarding the application.

Brehon care is the registered provider for The Marlay nursing home. The person in charge is supported in their role by two assistant directors of nursing (ADON's) and one part time ADON, clinical nurse managers (CNM's), nursing staff, care assistants, activity, catering and laundry staff. At operational level the management team had systems in place to monitor the quality and safety of the care provided to residents.

Audits were available on the clinical care delivered to residents and on the facilities available to them and their living environment. Audit results were discussed with the person in charge, who in turn reported them to the senior management team. However, inspectors observed that the auditing system, required improvement. For example, inspectors reviewed a sample of audits completed and observed that a responsible person or completion date for actions had not been identified following the audit. Inspectors also noted that some findings remained logged as open, in audits completed, although they had been addressed, for example a leak reported in

a dayroom ceiling.

Regular management meetings were held to review the effectiveness of the services provided including catering, maintenance, falls prevention and infection prevention and control. The management team facilitated monthly unit meetings, three monthly falls review meetings, carers and nurses meetings.

The centre's day and night staff rosters were reviewed by inspectors. From observations during the day and the review of rosters, sufficient staff were available to meet the assessed needs of residents. Inspectors observed nursing and care staff working together to provide person-centred care to residents.

Staff received training in a number of areas including dementia care, working with people with responsive behaviours (how people with dementia or other conditions, communicate or express their physical discomfort, or discomfort with their social or physical environment) and food safety. The person in charge had a system in place to monitor training and make sure that all staff were up to date. Staff were supervised by senior nurses throughout the day and during the night. An appraisal system was in place for senior nurses and inspectors were informed that this was going to be introduced for all staff in the coming months. On joining the organisation staff completed a nine month probation period which included regular reviews.

The complaints procedure was on display in reception, and on notice boards within the designated centre. Inspectors viewed a complaints leaflet which was available to residents and their families and clearly outlined the steps to be taken if they wished to make a complaint. The person in charge was nominated to investigate complaints, and an appeals procedure was clearly outlined in an up to date complaints policy.

Inspectors reviewed the safety statement and emergency plan for the designated centre which detailed the procedures to follow in the event of an electrical or gas shut down. A generator on site was available to provide power in the event of an electrical power outage.

Staff records were made available for inspectors to review. All of the required information was contained in the files including, An Garda Siochana vetting, staff references and up-to -date identification documentation.

Inspectors reviewed two resident contracts of care and found that the room number and occupancy of the room was documented in the contract, as well as details of the services provided by the registered provider and the fees to be paid.

An annual report was completed for 2021 which was prepared in consultation with residents and their families.

Regulation 15: Staffing

The registered provider had ensured that the number and skill-mix of staff was appropriate for the needs of the residents, taking into account the size and layout of the designated centre. There was a registered nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge ensured that staff received appropriate training. This included safeguarding, infection control and manual handling training. Staff were appropriately supervised and a coaching system was in place to guide supervisors and support staff.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that a number of unregistered rooms were in use on the ground floor of the designated centre which resulted in the registered provider being in breach of condition 1 of their registration. The provider had failed to consult with the Chief Inspector of Social services regarding the changed footprint of the building including a new kitchen, laundry, staff canteen, store rooms, staff changing rooms and a resident dining room.

Management systems did not identify a number of risks related to the reconfiguration of existing rooms and building new areas of the designated centre. For example the risk of Aspergillosis and fire safety had not been managed; these risks had not been identified and assessed. There were fire risks related to poor storage arrangements in the plant room and an external store containing the electrical distribution boards had not been recognised.

Immediate action was required to ensure the safety of residents in relation to fire risks identified during the inspection, details of which are set out in Regulation 28

The Registered Provider had applied to vary condition one and three, to increase the occupancy by 62 residents, however all works had not been completed. The inspection identified a number of areas that had not been completed including, inadequate storage arrangements, deficits with fire doors, inadequate arrangements and protocols for evacuation and smoke detectors in two bedrooms were covered. There were lithium ion batteries were left on charge on the floor in a store room of the extension and there was no risk assessment available; the store room was cluttered and contained combustible storage.

Robust oversight of audits was required to ensure that all required actions were completed and fully documented.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed two contracts, detailing different financial arrangements. They provided details of the services to be provided, fee charged and the room number and occupancy.

Judgment: Compliant

Regulation 34: Complaints procedure

Inspectors reviewed records of two recent complaints from the complaints log. Each was investigated promptly and the outcome was communicated to the complainants. A record of the complainants' satisfaction levels were recorded and lessons learned from the second complaint were communicated to staff and documented clearly.

Judgment: Compliant

Regulation 21: Records

Inspectors viewed two staff files and found that all of the required information under Schedule 2 was contained within the files.

Judgment: Compliant

Quality and safety

Residents had access to good quality health care however action was required in respect to individual assessment and care plans, residents' rights, infection prevention and control practices, fire safety and premises.

There were care plans in place for residents, reflecting their health care needs, and the documents were reviewed at least every four months. However, inspectors

found that while they were reviewed, they were not consistently updated to reflect the current needs of the resident. This is further discussed under Regulation 5: Individual Assessment and Care plan.

The registered provider ensured that residents had appropriate access to health care through regular visits from the medical officer who visited twice a week and four General Practitioners GP's who visited weekly. Residents had access to physiotherapy group sessions three times per week. Access to a speech and language therapist, dietitian, occupational therapist and chiropodist was through a referral system.

The Safeguarding Policy was reviewed in August 2022. Inspectors spoke with staff who had good knowledge in relation to recognising and reporting safe guarding incidents. Residents had access to an advocate, and advocacy arrangements were advertised on public notice boards on all three floors.

There were opportunities for recreation and activities. An activity schedule was advertised which included weekends. Residents reported to particularly enjoy the music events. The Ballinteer male choir had visited the previous week. Residents were encouraged to participate in activities in accordance with their interests and capacities. Residents were viewed participating in activities co-ordinated by staff, those residents with dementia were included.

Residents were facilitated to exercise their civil, political and religious rights. Residents had access to radio, television, newspapers both local and national, together with access to the Internet.

The registered provider has arrangements in place for residents to receive visitors in suitable communal facilities or in private facilities or alternatively to make use of the garden space provided. However visiting was restricted, as in so far as, visitors had to book in advance. There was no risk assessment carried out to warrant this measure.

While there was some evidence of good practice there were significant findings of inappropriate infection prevention and control in the centre as further detailed in Regulation 27: Infection Control. These included inappropriate storage, hand hygiene and inappropriate wearing of personal protective equipment PPE, unhygienic equipment and lack of oversight of staff practices.

In the main, the oversight of fire safety management required improvement. The in-house fire safety checks were all being completed as required and were up to date, however, those checks were not effective in identifying deficits noted by inspectors.

The centre was laid out in a manner which provided an adequate number of escape routes and exits. The exits from the extension each led to an external stepped route, however these had not been tested with the evacuation aids.

Most staff spoken with were knowledgeable on the evacuation procedures in place and confirmed they had attended training and fire drills.

In view of the fire safety concerns identified during this inspection, the inspectors were not assured that the fire safety arrangements adequately identified fire safety risks to protect residents from the risk of fire in the centre. There were a number of areas identified that required action to ensure compliance with fire precautions, as detailed under Regulation 28.

There had been recent maintenance works completed in the centre; there was new flooring along circulation spaces and the corridors had recently been painted. Some day rooms had also been redecorated and these were finished to a high standard.

Recent alterations to the footprint of the building, included the provision of a new dining room at ground floor. Feedback from residents and observations by inspectors concluded that there was inadequate space and lack of natural lighting to ensure a comfortable dining experience for residents. The former dining room was being altered at the time of inspection and this presented risks to residents both in terms of fire safety and the consequence of dust not being adequately contained.

Adequate consultation had not occurred with residents in relation to the new dining room, residents reported that their needs and preferences had not been taken into account in the planning and design of the room on the ground floor. This is further discussed under Regulation 9: Residents' rights.

Regulation 17: Premises

The registered provider did not ensure that the premises were appropriate to the number and needs of the residents and in accordance with the Statement of Purpose. The provider had changed the purpose and function of a number of areas in the centre, which had a detrimental impact on the lived experience for the residents. For example:

- The registered provider made a decision to alter the footprint of the ground floor by rearranging resident dining and sitting areas. Residents were moved to a smaller dining room from a larger sitting and dining area. This impacted negatively on the lived experience of residents. For example, three residents spoken with told inspectors the dining room was too warm, too dark and poorly ventilated. Inspectors observed this to be the case during mealtimes with the room observed to be overcrowded and dark with insufficient space for the number of residents using the dining room. Furthermore there was no space for the residents mobility aids which restricted their movement and their ability to come and go as they wished. The provider was in the process of sub-dividing the existing dining/day room into a multi-purpose room and a separate day room. This area was under construction and was inadequately contained to protect residents from the impact of the construction. For example a dividing structure between the rooms contained holes at the top which allowed dust to enter the residents day room.

Notwithstanding the changes to the premises since the previous inspection, action

was required to ensure compliance with Regulation 17 and Schedule 6;

- There was insufficient storage for items such as hoists and bins; they were noted along corridors. Store rooms were noted to be cluttered and disorganised
- Two cleaning trolleys were not suitably stored. They were kept in the clean laundry storage room. This storage practice did not support the separation of clean and dirty items which could lead to cross contamination.
- Ceiling tiles in a number of areas were either stained, displaced, missing or ill-fitted, for example the first floor corridor
- A pull cord in a residents en-suite was missing, which meant that the resident could not call for assistance if required.
- The premises were not kept in a good state of repair internally and externally. For example there was damage and scuff marks to residents bedroom doors and en-suite doors throughout. Externally, the paving slabs around plant beds in the ground floor courtyard had a build-up of a black coating and hadn't been cleaned.
- The floor and walls of a number of day spaces were marked
- A skirting board was missing where a door had been blocked up and replaced with a window
- There was inadequate lighting and ventilation. For example a new dining room was not afforded adequate natural light, and had one small window.

Judgment: Not 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. This was evidenced by:

- Alcohol gels and handwash sinks were not within easy walking distance of all bedrooms and accessible at the point of use to support good hand hygiene practices.
- Dual use of resident hand wash sinks in en-suites, staff reported that they washed their hands in the residents' sinks. This dual purpose increased the risk of cross infection.
- The Hydro bathroom on the second floor had communal items such as a hoist sling, barrier creams, hair rollers and deodorants. There was also inappropriate storage for example a staff tunic and shoes, teaspoons and a bed table. The bath, the bath step and a bath mat were visibly dirty. The cleaning schedule had been signed off as complete.
- Laundry had cross over between the clean and dirty laundry which was coming through the same entrance. This increased the risk of cross contamination.
- Inappropriate storage in the laundry, for example cleaners trolleys, a

refrigerator, a couch, lost property as in unmarked clothes and a scooter. This posed a risk of cross contamination.
- Staff reported dual use of a wash sink with turn taps for manual washing of laundry and hand washing. This practice posed a risk of cross contamination.
- Inappropriate storage of black waste bags, red alginate bags on two sluice floors posed a risk of cross infection.
- Access to sinks were blocked in sluices with trolleys, which posed a risk of cross contamination.
- Shower chairs were not clean underneath, there was hair visible on one chair.
- Cleaning schedules were not signed for two days in some areas.
- Shelving in the sluice rooms were non-permeable, as a result they could not be effectively cleaned and decontaminated.
- All areas did not have a bin and towel dispenser for example a cleaners room and a staff toilet, which meant effective hand washing could not be carried out.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had failed to meet the regulatory requirements in relation to fire precautions and had not ensured that residents were adequately protected from the risk of fire. Immediate action was required by the provider during the inspection to address risks identified, including:

- the alterations to the former dining room, which had commenced, created a risk to residents. The provision of a new partition wall resulted in no fire detection to one side of the wall, and only heat detection to the other side. This meant that a fire would not be detected until it had escalated in this space. The inspectors also noted unsafe electrical wiring, where a ceiling tile had been demounted and was supported by electrical wiring
- a room external to, but in close proximity to the main building, which had electrical distribution boards was being used for storage, which presented as a risk of fire.
- the internal plant room was being used for storage.

Immediate assurance was sought and received for the above.

In addition to the above, the registered provider was not taking adequate precautions against the risk of fire, for example:

- the storage of oxygen cylinders was not in line with the centre's own policy. They were stored in rooms used for charging hoist batteries. One cylinder was out of date
- fire doors were noted to be held open by means other than appropriate hold

open devices connected to the fire detection and alarm system.

The means of escape were not adequate, for example:

- the provision of emergency lighting to the external escape routes was not adequate
- builders material was obstructing an external escape route and there was loose furniture and miscellaneous storage outside some exits. This may lead to potential obstructions on escape routes
- hoists and mobility equipment were being stored along escape corridors
- escape signage was not provided from some day spaces

The arrangements for maintaining fire equipment were not adequate, for example:

- a number of emergency lighting units externally were not working. Service records for the emergency lighting system highlighted deficits and these had not been actioned
- inspectors noted an external storeroom where the smoke detectors was fitted with a dust cover, preventing its effective operation to detect fire. This was immediately removed during the inspection

Arrangements for the containment of fire were not adequate, for example:

- deficiencies were noted to fire doors throughout the centre; there were excessive gaps to the bottom of a number of doors, some doors were not fitted with automatic closing devices, a compartment door was noted to be held open by the floor covering and there were missing heat and smoke seals noted. A fire door audit was completed in September 2021 and deficits had not been actioned.
- assurance was required from the provider that adequate containment of fire and smoke is achieved by the fire doors throughout, where air intake units penetrate bedroom corridor walls and where lifts open directly to the bedroom corridors

Action was required to ensure early warning of, and adequate detection of fire:

- the electrical cupboards along bedroom corridors were not fitted with fire detection

The arrangements in place for evacuating residents were not adequate;

- Further assurances were required from the provider regarding the safe evacuation of the larger fire compartments when staffing levels were lowest.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Some improvements were required to ensure that formal reviews were person centred and met each resident's needs. For example:

- A resident with a pressure ulcer did not have complete records for two hourly re-positioning as directed by their care plan.
- A resident who was recovering from surgery, did not have the date of their next out patients appointment in their care plan to confirm the date of an essential post surgical procedure.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider has provided appropriate medical and healthcare, including a high standard of evidence-based nursing care, in accordance with professional guidelines issued by An Bord Altranais agus Cnaimhseachais.

Judgment: Compliant

Regulation 8: Protection

There was a policy in place for the prevention, detection and response to allegations or suspicions of abuse. Inspectors found that safeguarding incidents had been appropriately investigated.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors were not assured that residents' right to be consulted about and participate in the organisation of the designated cent For example:

Residents had not been fully consulted about the new dining room or the multi-function room. Residents informed inspectors of their disappointment with the new dining room , they preferred the old dining room it had more space and was brighter. One resident stated that there had been very little consultation in relation to the change in the dining room location. They were informed of the move, they had "no input into the location or design of the room". They stated that they would have liked to have been consulted in relation to the colour and décor. Residents reported that they had been told there was going to be a wall mural and a sky light,

but the room had opened without either. Three residents spoken with complained that the dining room could get very warm and uncomfortable.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 21: Records	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for The Marlay Nursing Home OSV-0000108

Inspection ID: MON-0037861

Date of inspection: 15/09/2022

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:
CareChoice will ensure that any new areas constructed in any home will not be occupied prior to consultation with the Inspector and registration.

All contractors working in the home are required to submit a methodology and H & S statement in relation to all works to be undertaken. This includes mitigation of aspergillosis, fire safety and the protection of residents.

Storage spaces identified and items stored appropriately. The store room is de-cluttered and combustible materials removed from the room.

All Fire Safety issues have been addressed as following:

Provide protocol for use of the evacuation lift

Protocol has been generated and will be displayed in the home and staff trained appropriately. The protocol has been incorporated into the Emergency plan.

Confirmation of extension door system - lock casing sizes and flush bolts - & review of any gaps throughout the new facility.

The Fire Safety Cert for the extension calls up for FD30S doors from rooms into protected corridors. The bedroom doors are supplied by Vicaima Ltd and have been tested
by Warrington Fire.
With regards to the lock casings, these are in compliance with the fire safety cert provided for the door, as the test report advises that the maximum plate dimensions must be 235mm high, 28mm wide and 4mm thick. We confirm that the iron mongering installed is within these parameters.

Regarding the flush bolt's arrangement, these are in compliance with the fire safety cert provided for the door. The door system has been tested both 'latched' and 'unlatched' and achieves above the fire rating requirements in both instances. The 'unlatched' test is carried out with a head restraint to facilitate the test, which is the arrangement currently within the facility's extension.
Confirming that a full review of all new door gap sizes and install completeness has been actioned and will be verified before occupation.

Assurance is required as to the suitability of the evacuation aids intended for use in the event of an external evacuation.

Confirming that having reviewed the external evacuation routes CareChoice are assured that the evacuation aids proposed, which are consistent within the Home, will serve to successfully evacuate residents in the associated areas should the event arise –

To date we have completed orientation and familiarisation with the new build evacuation procedures with current staff. In advance of receiving residents into the new facility and once staffing levels for the new beds are engaged, CareChoice will complete full external evacuation drills and training to the largest compartment with the lowest staffing numbers.

Confirmation no fire detection heads are covered throughout the building

During inspection on 15th Sept, this was raised to CareChoice Staff by HIQA inspectors and actioned immediately – Confirming that a site wide review has also been completed since the inspection and that no fire detection heads are covered.

Confirmation that a plan is in place to complete internal and external audit actions in a timely manner.

The home has a comprehensive robust audit schedule in place which is supported by the Quality Department. Action plans are in place and the clinical management team are working to complete all actions with many of the actions closed

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
All issues identified under Premises have been addressed.

All equipment inappropriately stored on corridors has been removed and is stored safely, in designated areas.

New cleaning room is available on the ground floor now.

Missing and damaged ceiling tiles have been replaced

All call bells are present and operational in resident's rooms

Water supply and drainage pipes to a sensory bathroom have been boxed and secured on 16th September 2022.

Home has deep cleaning schedule in place for all areas along with regular cleaning to ensure the areas are cleaned and any damages addressed.

Skirting board replaced on 17th October 2022.

Home had previously sourced external cleaner to remove buildup of black coating on the ground floor courtyard however the effort was unsuccessful. New paving's ordered to replace the old paving's.

New dining room has been repurposed as a multi-functional room for resident's use, the old dining/day room has been refurbished and returned to its original function on 27th October 2022.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
All issues raised under Infection Control have been addressed.
Blue aprons are used with food in the dining room and when delivering room service where food is being delivered to residents. Blue aprons are only available in the dining room and kitchen for use only with food products. Staff use white aprons when delivering personal care therefore there is a colour distinction to ensure compliance to PPE's in the home. It is good practice to use blue aprons during food practices to prevent spillage on uniforms and to prevent uniforms being contaminated from previous care practices for example, personal care etc. Giving food without a blue apron means there could be cross contamination therefore I would like the comments reviewed on the basis of good PPE measures in this case.

Dual use of resident's hand sinks where staff wash their hands in residents' sinks. All rooms have hand gel stations and additionally residents sink to wash hands. Staff, having to leave the room to find a sink to wash their hands when hands are visibly soiled is a cross contamination risk on door handles, equipment etc therefore it makes sense to wash in the area that care was given. CareChoice completed a risk assessment on this area and detailed procedures are in place.

Alcohol gels have been redistributed and an external audit of handwash sinks has been commissioned.

The hydro bathroom on the second floor has had all inappropriate items removed and has been cleaned on 16th September 2022.

The laundry has been re-organized to ensure segregation of clean and dirty laundry to reduce cross contamination.

All inappropriate items have been removed from the laundry.

Manual sluice sink is removed and staff have access to hand wash sink in the laundry to use on 17th October 2022.

All inappropriate storage of waste bags and red alginate bags in sluice room removed and also increased waste collection times to reduce the amount of waste stored in the sluice at any given time.

Shower chairs are cleaned and is added to daily cleaning checklist.

Refresher training of cleaning staff in relation to tasks and cleaning schedules has taken place.

Permeable shelving in sluice rooms is removed on 28th October 2022.

Housekeeping room and staff toilets has bins and paper towel dispensers in place.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Provide protocol for use of the evacuation lift

Protocol has been generated and will be displayed in the home and staff trained appropriately. The protocol has been incorporated into the Emergency plan.

Confirmation of extension door system - lock casing sizes and flush bolts - & review of any gaps throughout the new facility.

The Fire Safety Cert for the extension calls up for FD30S doors from rooms into protected corridors. The bedroom doors are supplied by Vicaima Ltd and have been tested
by Warrington Fire.
With regards to the lock casings, these are in compliance with the fire safety cert provided for the door, as the test report advises that the maximum plate dimensions

must be 235mm high, 28mm wide and 4mm thick. We confirm that the iron mongering installed is within these parameters.
Regarding the flush bolt's arrangement, these are in compliance with the fire safety cert provided for the door. The door system has been tested both 'latched' and 'unlatched' and achieves above the fire rating requirements in both instances. The 'unlatched' test is carried out with a head restraint to facilitate the test, which is the arrangement currently within the facility's extension.

Confirming that a full review of all new door gap sizes and install completeness has been actioned and will be verified before occupation.

Assurance is required as to the suitability of the evacuation aids intended for use in the event of an external evacuation.

Confirming that having reviewed the external evacuation routes CareChoice are assured that the evacuation aids proposed, which are consistent within the Home, will serve to successfully evacuate residents in the associated areas should the event arise –

To date we have completed orientation and familiarisation with the new build evacuation procedures with current staff. In advance of receiving residents into the new facility and once staffing levels for the new beds are engaged, CareChoice will complete full external evacuation drills and training to the largest compartment with the lowest staffing numbers.

Confirmation no fire detection heads are covered throughout the building

During inspection on 15th Sept, this was raised to CareChoice Staff by HIQA inspectors and actioned immediately – Confirming that a site wide review has also been completed since the inspection and that no fire detection heads are covered.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A reminder has been provided for staff regarding the safety checks, and recording of same in a timely manner, has been included in our daily safety huddles and in all handovers. This will ensure that a record exists in the resident's careplans and reflect the preventative care required for pressure ulcers. Nurses have been reminded to check touch care records prior to the end of their shift.

We have reviewed our policies and refreshed staff on same to ensure compliance with policy, in addition training has been reviewed with staff on the floors.

• There is a process in place for the allocation of resident's assessments and care plans to the nursing team and these are audited on an ongoing basis with feedback provided to the individual nurse. Medication care plans which are mandatory to all residents are completed within 72 hours post admission and reviewed every 4 months or as required if needs changed. All Medication care plans have the times of medications to be given in the plans however associated care plans don't for example, the safety care plan.

• Each nurse has received a toolkit on how to complete assessments and care plans and this is supported by the experienced ADON's in the home. There is a monthly schedule in place for completing care plan audits to ensure that the residents' preferences and updates of any changes related to the resident's care is documented. Changes in residents care needs are discussed at daily handover, this will ensure that all staff are aware of the resident's care needs.

• A review took place of care plans not updated with post-surgical information in regards to the removal of stitches. Training is given to staff to update care plans and regular auditing is undertaken.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Confirmation that Marlay Nursing has a resident committee and sub committee in place. Residents committee and subcommittee meeting are held every four months and recorded. Any opinions and suggestions from these meetings are valued and acted upon by the nursing home.

• Residents do have access and avail independent advocacy service, information about this service is easily accessible to residents if they wish to avail.

• In light of subsequent comments by residents, the decision regarding the dining room was reviewed and reverted to its original purpose, thus demonstrating Resident's rights were observed.

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	17/10/2022
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	17/10/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure	Not Compliant	Orange	17/10/2022

	that the service provided is safe, appropriate, consistent and effectively monitored.			
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	17/10/2022
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	Orange	17/10/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	17/10/2022
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and	Not Compliant	Orange	17/10/2022

	building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	17/10/2022
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	17/10/2022
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Substantially Compliant	Yellow	17/10/2022
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.	Substantially Compliant	Yellow	17/10/2022
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	17/10/2022

Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	17/10/2022