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:	Firstcare Blainroe Lodge
Name of provider:	Firstcare Blainroe Lodge Limited
Address of centre:	Coast Road, Blainroe, Wicklow, Wicklow
Type of inspection:	Unannounced
Date of inspection:	10 September 2024
Centre ID:	OSV-0000016
Fieldwork ID:	MON-0044907

About the designated centre

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

Firstcare Blainroe Lodge Nursing Home has four floors; a lower ground, ground, first and second floor. The centre can accommodate 72 residents. Residential accommodation is across the four floors which are accessed by a lift and stairs. Care can be provided for adults over the age of 18 years with general care needs within the low, medium, high and maximum categories. A pre-admission assessment is completed in order to determine whether or not the service can meet the potential resident's needs. Twenty-four-hour nursing care is provided. In total, there are 38 single rooms with full en-suite facilities, 25 single rooms with toilet and wash-hand basin and two additional single rooms with wash-hand basins. There are three twin rooms with toilet and wash-hand basin facilities. There were adequate communal areas and private areas for residents to receive visitors. Other areas include a kitchen, laundry, oratory, hairdressing salon, smoking room and activities room. There are several well-maintained enclosed garden areas for residents' use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	50

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
Tuesday 10 September 2024	10:15hrs to 18:15hrs	Mary O'Mahony	Lead
Tuesday 10 September 2024	10:15hrs to 18:15hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

According to residents and relatives, Blainroe Lodge Nursing Home was a nice place to live, where residents were facilitated to avail of comfortable accommodation and pleasant surroundings. There was a homely atmosphere promoted, which was immediately apparent on arrival in the centre. In the morning, inspectors observed that a number of residents were availing of late breakfast in their bedrooms, which they said supported their choice that day. During the day, inspectors spoke with the majority of the residents and with ten residents in more detail. Inspectors spent time observing residents' experiences and the care interactions, in order to gain insight into their lives in the centre. Residents informed inspectors that, in general, staff were "kind" and "respectful. All residents were observed to be nicely dressed, content with their surroundings and in general, they appeared happy.

This inspection was unannounced. On arrival at the centre it was apparent that the building was well maintained. The external painting and gardens had been attended to, and it looked very welcoming, on the day of the inspection. Following an opening meeting with the person in charge, inspectors were accompanied on a walk about the premises. There was a lively atmosphere apparent, with residents being accompanied, from their bedrooms, to the communal sitting rooms on the ground and first floors. Visitors were seen to come and go, and they were welcomed by staff. Those who spoke with inspectors praised aspects of the care and spoke highly of staff. Relatives were observed to use the nicely furnished alcoves, bedrooms and communal rooms for their visits, which meant that there were choices available to residents, in relation to the venue for visits. Residents said that staff and relatives provided welcome community news about activities and events in the locality.

Fifty residents were living in the centre on the day of inspection, with 22 vacant beds. The centre was laid out over four floors. The lower ground floor (Bayside), contained six single rooms, these were vacant at the time of inspection. The ground floor contained two units - Brittas and Seafield consisting of 41 single rooms in all. Brittas contained an open plan sitting, dining room, activities room, a bar and oratory. The person in charge stated that they were fortunate to have mass available to them, every fortnight. Residents spoken with were very glad of this service. Seafield was the newest unit. It was a purpose built extension and was equipped with a snooezelen (relaxation) room, visitors' room and open plan sitting and dining room. The first floor (Silverstrand) was a dementia specific unit, with 12 single rooms and three twin rooms. Seaview (second floor) contained seven single rooms. Only two of these were occupied by residents at the time of inspection. On the morning of inspection, a number of residents were sitting in the large comfortable sitting rooms. Enclosed gardens were accessible on the lower ground and ground floor, and doors to the gardens were open for residents' use. There was lift access to the upstairs floors. The inspectors observed that communal rooms and dining rooms were decorated in a personalised manner, with pictures, menu boards, plants, dressers and large screen televisions. Nonetheless, Silverstrand was in need of decoration and personalisation, due to the importance of an interesting and

homely environment for those with dementia. In addition, where one bed was vacant in a twin room, the vacant bed had not been dressed, and this lent an untidy, de-personalised look, in those bedrooms. These issues were addressed under regulation 17.

A number of bedrooms had en suite toilet and wash hand basins, others had full en suite facilities, and a number of residents shared communal showers and additional toilets. These were observed to be within easy access of residents' bedrooms, dining and lounge facilities. Most bedrooms were observed to be decorated with personal items from residents' homes, such as, pictures, small furniture items, art and books. Resident said they were happy with their accommodation. One resident spoken with said that their room was "comfortable" and they said they enjoyed the privacy of the single room.

Throughout the day inspectors observed how the needs, and rights, of residents were met and addressed. The hairdresser was on site on the day of inspection, and residents expressed their satisfaction about the fact that they could get their hair done in the centre. They were seen to be coming and going from the salon during the morning. One person told inspectors how happy she was to have an "easily accessible service" and how well she felt after the "hairdo". While the majority of interactions observed during the day were kind, and a number of staff were seen to be very attentive and caring, there were some incidents which indicated that increased training was required for staff, and supervisors, in providing timely interventions. Delays were seen in staff responding to some residents needs. Additionally, it was not clear if there was an effective, meaningful and inclusive activity programme available in the afternoon, as there was a reliance on the TV and singing along to the music. Due to the layout of the centre, over the three floors in use, inspectors were not assured that the social, toileting and emotional needs of the other 25 residents, who were not in attendance at that session, or were in their bedrooms, were met. Further details, on the available activities, were described under the quality and safety dimension of the report.

Residents' meetings were held at intervals and the minutes of these were reviewed. At each meeting a range of issues, such as food choices, events, visits and staffing were discussed. However, the minutes were brief, and more details were required, to ensure that all residents' issues were being discussed and addressed. There was a residents' representative appointed, from the resident group. In a small sample of survey results and complaints reviewed, inspectors saw that there were a number of positive comments, as well as other comments about lack of staff availability, or poor care and lack of assistance at mealtimes, on some occasions. Some residents highlighted dissatisfaction with some staff, where care was rushed and not explained to them. This was brought to the attention of the management team who said it would be addressed.

Since the previous inspection, increased staffing had been provided for the activity programme.There were two staff member allocated to the role of activity leaders daily, and plans on expanding the programme were under way, according to the management staff, in line with expressions of preferences from residents.

Residents spoke positively with regards to the quality of the food in the centre, which was prepared by an external catering company employed by the service. One resident said they were happy with the "variety and choice of food". Food was observed to be attractively and carefully presented. Menus were available and there was a sufficient amount of staff on duty, to assist those who needed additional support. The inspectors were informed that the dining experience was reviewed regularly, with the aim of enhancing the social aspect of dining. Residents described the food as "tasty" and said they wanted to thank the chef for meeting their preferences.

The next two sections of the report detail the findings in relation to the capacity and capability of the centre, and describes how these arrangements support the quality and safety of the service provided to the residents. The levels of compliance are detailed under the relevant regulations in this report.

Capacity and capability

This was an unannounced inspection, to monitor ongoing compliance with the regulations and standards, and to follow-up on information and notifications received since the last inspection. Additionally, the inspectors assessed the overall governance of the centre and established whether actions, outlined in the compliance plan from October 2023, had been implemented, in key areas, as follows: Regulations 15: Staffing, 23: Governance and management, 27: Infection Control and 28: Fire Precautions. The inspectors were in receipt of solicited information in the form of notifications, and unsolicited information in the form of concerns, particularly around care issues, which were looked into during the inspection, Some of these issues were substantiated and are discussed throughout the report.

On this inspection, inspectors acknowledged that the governance and management of the centre was clearly defined, however, due to new members in the senior management team it was still in transition. Overall, the findings of this inspection were that, although there had been improvements since the previous inspection, particularly in staffing levels and staff training, some aspects of the governance and management of Blainroe Lodge required improvement, to ensure that residents received good quality, safe care and services. While the provider and staff stated that they were committed to a process of quality improvement, findings on this inspection demonstrated that further action was required, to ensure compliance with the regulations, in aspects of resident's' rights, fire safety management, complaints management, premises, responsive behaviour management and protection, as outlined throughout this report.

Firstcare Blainroe Lodge Limited is the registered provider for Blainroe Lodge, a company comprised of four directors. The centre is part of a wider group, Emeis, who own a number of nursing homes throughout the country. The lines of

accountability and responsibility were clearly defined. The person in charge who was newly appointed, since July, was being supported in their induction, on a weekly basis, by the regional manager. The regional manager in turn, reported to the group Chief Operating Officer (COO), one of the directors, who acted as the person responsible on behalf of the provider, for the purposes of regulation and registration. From a clinical perspective, the person in charge was supported in their role by clinical nurse managers, who worked on a full-time supernumerary basis, including on alternate weekends. Staff nurses, health care assistants, housekeeping, catering, maintenance, activities staff, administration and laundry staff, all contributed to the care team. Staff training was up to date, as evidenced by the training matrix and staff confirmation. Minutes of staff meetings, for all grades, were reviewed. These meetings as well as daily care "huddles", were held to support communication about residents' needs, and any changes that were identified.

The centre had a complaints procedure in place, which was on display in a number of areas. A log of all complaints was maintained. However, all the required elements of the complaints process had not been followed, as outlined under regulation 34. Complaints, documented in the complaints log, indicated that staffing and care issues were the main issues of concern. As found on the previous inspection, the management team stated that full occupancy was not envisioned, until staffing levels were optimal and the new person in charge had resolved the supervision issues, and improved outcomes for residents. The inspectors were informed that the provider had been proactive and admissions to the centre had been paused, for a period of time.

The registered provider had completed an annual review for 2023, which included a time bound action plan. Areas for improvement included care planning, supervision, training, activities and premises issues. The centre had yet to commence regular outings for residents in line with a previous plan, to improve community connections and expand residents' experiences. Systems of communication were in place. The person in charge provided a comprehensive monthly report to the regional manager and these were discussed and actioned. The registered provider had an audit schedule in place. Audits were comprehensive, identified issues and contained action plans. Notwithstanding the good practices, improved oversight of issues identified on inspection such as, fire safety management, staff supervision and premises issues, was required. All incidents were reported to the Office of the Chief Inspector in line with regulations. The majority of incidents relating to reports of allegations of omission of care. This was a repeat finding from the last inspection and this was addressed under regulation 16: Training and development and regulation 23: Governance and management.

Regulation 14: Persons in charge

The person in charge was newly appointed.

She was a registered nurse, working full time in the post and had the necessary experience and qualifications, as required by regulation.

She was supernumerary to other nursing staff and actively engaged in the governance and operational management of the service.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels on the day of inspection were sufficient to meet the needs of residents.

The skill mix on duty was appropriate and registered nurses were on duty over the 24 hour period.

Judgment: Compliant

Regulation 16: Training and staff development

Action was required in the area of staff supervision and staff knowledge:

- This was evidenced by the large number of notifications, related to alleged omission of attention to care needs of residents.
- Some residents highlighted dissatisfaction with some staff, where care was rushed and not explained to them.
- The inspectors saw incidents where enhanced staff supervision was required during the inspection, by way of example, on one occasion inspectors saw that, while there were sufficient staff available to attend to a resident who required the toilet, there were not timely responses to support residents' rights and needs, as the resident was asked to wait in line for a toilet visit.
- A second example was observed, in the afternoon in another unit, where three residents were seen to sit around a table, without interaction or any item of distraction or activity on the table, for long periods of time. These residents were only attended to when the issue was raised with staff, and fresh cups of tea were offered, as well as a toilet visit.

Judgment: Not compliant

Regulation 21: Records

Not all the records required to be maintained by regulation were in place:

For example, in a small sample of staff files reviewed there was only one reference available for one staff member.

Two references were required, under the regulations, for each member of staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

While there were a number of comprehensive management systems established, further managerial oversight and action was required, to address a number of outstanding issues :

This was evidenced by:

- a lack of oversight of issues related to fire safety management: For example: a fire safety risk assessment, and action tracker plan, did not provide sufficient assurance that the issues identified were addressed, there was a lack of oversight of simulated evacuations these issues are discussed further under regulation 28.
- there was a lack of comprehensive supervision processes: a substantial number of notifications and a number of unsolicited receipts of information, highlighting similar themes in the concerns raised around care issues. This is further outlined under regulation16.
- there was a lack of oversight of premises issues, such as, flooring and other matters: detailed under regulation 17: Premises.
- not all residents' rights and choices were adequately supported, as described under regulation 9: Residents' Rights.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

This key document required some amendments to meet the requirements of regulations.

Changes had been made to the management structure, these were yet to be updated in the statement of purpose.

For example, reference to an assistant director of nursing (ADON) was not accurate.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incident management and incidents records were maintained in the centre.

All the specified incidents, set out in regulation as requiring notification to the Chief Inspector, had been submitted.

Judgment: Compliant

Regulation 34: Complaints procedure

Some action was required in the response and management of complaints:

- The resolution to some complaints had not been documented.
- The satisfaction or not of all complainants had not been recorded.

Judgment: Substantially compliant

Quality and safety

Overall, residents were generally complimentary about the staff and said that they had good relationships with them. Since the previous inspection there had been improvements in infection control, some aspects of activity, nutrition and staffing. Nevertheless, additional action was required in fire safety, premises, protection and appropriate activities, in this aspect of the report.

Resident's had access to good medical and nursing care. The general practitioners (GP) were described by residents as "attentive" and "always available". Residents' assessments were undertaken, using a variety of validated tools and care plans were developed based on the assessments. A sample of care plans, viewed by inspectors, were seen to be person-centred and detailed. They were updated four monthly, in line with regulations and were sufficiently detailed to guide staff in the provision of care.

The centre was nicely decorated overall, with colourful pictures and good quality furniture. Residents' rooms were spacious, with plenty storage for residents' belongings. Beds were seen to be dressed with very light covers however, which required review due to the cooler weather. Wardrobes were maintained in a very

tidy manner, which indicated respect for residents belongings. Since the previous inspection infection control issues had been addressed, and sluice rooms and janitorial rooms had been brought up to standard. There was an updated infection control policy in place and staff had received appropriate training in infection prevention and control. Some issues, requiring action, related to the premises, were described under regulation 17.

Since the last inspection HCAs were no longer required to do kitchen duties, which meant there were additional staff available at mealtimes, Sufficient staff were seen to be on duty on the day of inspection, to support residents at meal times. However, there were a small number of complaints seen, about late breakfast and breakfasts that were not sufficiently hot. This indicated that mealtimes required continued and effective supervision, as the centre was laid out over four floors.

Signage to guide staff on the evacuation routes was on display, in a number of locations throughout the centre. Each resident had a personal emergency evacuation plan (PEEPs), which was located inside residents' wardrobes, for ease of access. Evacuation ski-sheets were available on residents' beds and these were seen to be securely placed under the mattress. The fire detection and alarm systems and emergency lighting servicing, were completed at recommended intervals. Daily, weekly and monthly checks had been completed. Fire drills were being carried out, however similar to findings on the last inspection, a recent fire evacuation drill, of the largest compartment, had not taken place. Findings, in relation to fire safety management, are further detailed under regulation: 28.

The registered provider had an up-to-date policy on managing behaviours that challenge. Overall, there was a person-centred approach to managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) in the care plans seen. Some aspects of this regulation required action, as described under regulation 7.

Independent advocacy services were available to residents, and the contact details for these were displayed on notice boards. Residents religious rights were respected and mass was said, twice a month. Life story information was compiled for each resident and individual details regarding residents' hobbies and interests was completed. An external group attended the centre every two weeks, to do exercises with residents and provide physiotherapy expertise. Chair yoga was facilitated, as well as art, and music was provided on Sundays. Staff had trained in facilitating a "Happiness" programme which was being rolled out to residents and a well-attended barbecue was held in August. However, while the activity programme was under development, there were challenges in the adequate provision of activities to all residents, due to the design and layout of the centre, over so many floors. This was described under regulation 9, residents' rights.

Regulation 10: Communication difficulties

Care plans had been developed for those who had communication difficulties. These contained strategies for staff to optimise communication with residents.

Music and other sensory activity sessions were available and staff explained how these activities stimulated interaction.

Residents, who had communication difficulties were spoken with in a kind and reassuring manner by staff, who were familiar with their life histories and their specific needs.

Judgment: Compliant

Regulation 17: Premises

Certain aspects of the premises did not conform with the requirements of Schedule 6 of the regulations:

- Some walls required painting due to scuffing, and wear and tear.
- A number of bed tables were seen to have rusty bases.
- A broken drawer was found on a locker in one bedroom
- Areas of the flooring required repair.
- Warmer bedclothes were required due to the lowering temperatures. Two bedrooms were cold and the top windows were open. All vacant beds were not dressed.
- Bolts were located on top of some wardrobe doors, which, while not in use at the time of inspection, were not conducive to personalised, homely care.
- Some items, in the kitchenette cupboards, in the Silverstrand unit were not clean, such as a foot spa. These cupboards contained an excess of equipment.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents' nutrition and hydration needs were met.

- Home baked desserts and cakes were a daily feature of mealtimes, and the kitchen was clean and well equipped.
- Residents were seen to be consulted about their likes and dislikes.
- Systems were in place, to ensure residents received a varied and nutritious menu, and dietetic requirements such as, gluten free diet or modified diets were accommodated.

- Residents' nutritional status was assessed monthly, weights were recorded and a dietitian was consulted, where necessary.
- Improved staff involvement and oversight was now in place at meal times, to address issues found on the previous inspection.

Judgment: Compliant

Regulation 27: Infection control

Improved practice was found in infection control processes.

Since the previous inspection a number of improvements had been made to comply with the standards and regulations.

- The hairdressing salon was clean,
- Sinks throughout the home were clean.
- The rusting medicine trolley had been replaced.
- Yellow clinical waste bins had been acquired.
- Antimicrobial stewardship was undertaken, to ensure safe and effective use of antibiotics.
- Staff signed when cleaning tasks were completed, which enabled effective audit.
- Staff training in aspects infection control management, and procedures, was seen to have been delivered.

Judgment: Compliant

Regulation 28: Fire precautions

Some action was required to ensure adequate precautions against, and protect residents from, the risk of fire, for example;

- A fire safety risk assessment and action tracker was made available to inspectors. Nonetheless, a number of actions were unclear and lacked defined time frames, for completion of the works. In addition, some actions were vague and one response questioned the regulations. This did not provide assurance that fire safety management was robust and comprehensive. The provider was asked to provide these assurances following the inspection.
- The inspectors reviewed fire drill records. While fire drills took place and simulated various scenarios, the reports lacked detail. There was no evidence of evacuation drills of the largest compartment, at times when reduced staff were on duty, such as night time. Therefore, considering that this was a four

storey building there was not sufficient assurance that residents could be evacuated in a timely manner, when at the lowest staffing levels.

- Simulated evacuations of compartments had not been undertaken, outside of those led by an external facilitator, to be assured that staff were fully aware of the actions to be taken, if a fire occurred, when the trainer was not present in the building.
- In the lower ground floor, evacuation processes were not straightforward, as they were described as vertical only, by the stairs, and not from compartment to compartment, in a horizontal manner. This meant that consideration will be required, as to the mobility and needs of any resident, who might be admitted there in the future, as this floor was vacant at the time of inspection.
- Some windows were very high and the opening was right at the very top and inaccessible by staff. Some of these open windows were located in locked bedrooms. In the event of a fire, this risk required assessment, as it would be very difficult to close all these windows in a speedy manner. Some staff said they had to stand up on the window sill to close the top windows openings, while others said there was a hooked, closure stick available to them, which was not apparent on the day of inspection.
- An oxygen cylinder was located on the wall behind a door on the top floor. While signage was in place, the signage was also behind the door. This meant that in the event of fire, this combustible gas was not signposted and might accelerate a fire, if not removed. The management staff undertook to move it to a more suitable location.
- Work on the lift was pending since the last inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans were well managed.

A review of a sample of residents' care plans indicated that they were completed within 48 hours of admission, and reviewed four monthly, in accordance with regulatory requirements.

Assessments of need were completed using a range of validated, evidence-based, risk assessment tools.

Care plans were developed in a personalised manner, to provide guidance on meeting residents' social and healthcare needs.

Judgment: Compliant

Regulation 6: Health care

Residents' health and well-being was promoted, and residents had timely access to the general practitioners (GP) services.

Residents had access to a range of professional expertise, such as the dietitian and the the speech and language therapist (SALT), the physiotherapist, the chiropodist, the pharmacist, dental and optical care and palliative and wound care expertise. This meant that care issues were quickly identified and addressed, which led to improved health care outcomes for residents.

Weights and observations were completed monthly or more regularly if required.

Residents with weight loss were identified, and referred to a dietitian or speech and language therapist (SALT), where necessary.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Some action was required in relation to the management and support of residents with behaviour associated with the effects of dementia or other brain disorders.

Residents who went into other residents' rooms, and occasionally hit out at other residents, required one-to-one supervision, to protect their dignity and protect other residents from any injury or invasion of their privacy. One resident informed inspectors that this had happened to them and they were now fearful of a repeat occurrence.

Judgment: Substantially compliant

Regulation 8: Protection

Sufficient measures had not been implemented to protect residents from abuse:

The centre was pension agent for four residents, with one resident awaiting approval from the department of social welfare,

- Although there was a residents' account set up where residents pension monies were lodged, there was excess money in this account and it was not clear what monies belonged to residents, and what monies belonged to the

centre. The regional manager explained that this was in transition and the matter was to be resolved shortly after the inspection.

The systems in place for ordering and paying for medicines, and additional items from the pharmacy, was not sufficiently robust to protect the residents. The staff in the centre ordered items on behalf of residents, however there was no oversight of charges for these items, as the families were invoiced directly and there was no sign-off on these invoices by staff in the centre, when receiving these items.

The systems required, to return monies to the estates of deceased residents required review.

A large number of notifications, submitted to the Chief Inspector, indicated that there were supervision and care issues which had not being adequately addressed, to ensure the optimal care and welfare of residents.

Judgment: Not compliant

Regulation 9: Residents' rights

Some aspects of supporting residents' rights required action:

While this was a work in progress, and activity staff were very enthusiastic and kind, action was required by the registered provider, to ensure that all residents' had opportunities to participate in activities, in accordance with their interests and capabilities, as this was not evident for all residents, on the day of the inspection.

Diet sheets, with residents' names and food requirements were located on the walls, over residents' beds. This did not promote residents' rights to privacy and dignity, and these forms required a more discrete location.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Firstcare Blainroe Lodge OSV-0000016

Inspection ID: MON-0044907

Date of inspection: 10/09/2024

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Blainroe Lodge is currently recruiting one Assistant Director of Nursing to support clinical supervision and support in the centre. This will be completed by 31 December 2024. A series of Leadership and Supervision workshops have been scheduled with the clinical nurse managers and nursing staff over the course of Q4 2024. These will be facilitated by Senior Nurse Managers across the group. This will be completed by 31 December 2024. Audit, observations and meeting schedules have been reviewed which will enhance supervision and oversight on the floor. New schedules will be implemented from 1st January 2024.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: From 1st October 2024, a HR Staff File Audit will be completed weekly and presented to governance meeting each month. Oversight of this and any identified corrective actions will be the responsibility of the Regional Director and Regional HR manager- commenced and ongoing.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review of the action plan tracker for the Fire Safety Risk Assessment has been undertaken to ensure there is accurate recording and timely closure of all actions – complete

Audit, observations and meeting schedules have been reviewed which will enhance supervision and oversight on the floor. New schedules will be implemented from 1st January 2024.

A series of Leadership and Supervision workshops have been scheduled with the clinical nurse managers and nursing staff over the course of Q4 2024. These will be facilitated by Senior Nurse Managers across the group. This will be completed by 31 December 2024.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose has been reviewed and updated to reflect the current management structure- Completed

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
From 1st October 2024- all complaints will be responded to in the centre as per the centre's complaint policy and the complaint file will be updated to reflect this. The regional director will oversee this process monthly at the governance meeting –complete and ongoing

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A full environmental audit, to review bedroom furniture, painting and flooring was completed in September 2024.

Painting will be completed in all areas identified in audit by 31 March 2025

All bed tables identified in audit will be replaced by 30 November 2024

Flooring will be replaced in a number of areas identified in audit by 31 January 2025

Duvets have been provided to all residents and are available for their use, if they wish to utilize them – complete and ongoing review.

Director of Nursing will ensure that all staff are aware of how to respond to resident requests for additional bedding- complete

Although not in use, bolts have been removed from all wardrobes – completed on 10th October 2024

All kitchenettes have been deep cleaned and have been included on the daily cleaning checklist – complete and ongoing

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Additional information requested in relation to the fire safety risk assessment was provided to the Authority on the 27/09/2024.

An updated Fire Safety Risk Assessment is scheduled to be completed before 31 March 2025.

A number of Fire Drills were facilitated by an external fire safety trainer on the 03 October 2024. A series of announced and unannounced drills will take place weekly by the Director of Nursing to improve staff knowledge and confidence. These drills will include the largest compartment and vertical evacuation – commenced and ongoing

Closure devices for all high windows has been ordered and by 30 November 2024 will be installed at each window to ensure easy access.

Oxygen storage has been relocated to a more suitable area – completed on 11/09/2024

Outstanding elevator works were completed on the 02 October 2024.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Refresher Responsive Behaviour Training is now taking place in person in the centre to improve staff knowledge and confidence. All staff will have completed this in person training by 15 Dec 2024.

The nursing allocation has been reviewed. Nurses have a clearly defined allocation of residents and will be responsible for coordinating the supervision throughout the day– commenced and ongoing.

All residents are individually risk assessed and have supportive care plans in place to support their individual needs. Where additional supports are required to meet a resident's needs, the Person in Charge will explore additional supports from the multidisciplinary team and external agencies if required -Complete and ongoing

All residents have access to a range of community services and MDT members to support their care in the centre, such as; Psychiatry of Later Life, Medicine for the Elderly, Frailty Team as well as their own GP – Complete and ongoing

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Security of Residents' Accounts and Personal Property policy has been reviewed and updated to guide staff members on the safeguarding of resident's accounts and management of pension agent accounts. Training on this policy has been scheduled for roll out in Q4 2024. The policy is operational from 14th October 2024

The provider has engaged with the Chief State Solicitors Office over the last number of months to devise a process in returning of monies to the estate of the deceased residents. We are awaiting their guidance in relation to complex cases and in the interim can provide assurance that monies are held separately and securely and are subject to annual audit – Complete

Blainroe Lodge will introduce an electronic medication prescribing, ordering and administration recording system, provided by the pharmacy. This will give clear visibility of items ordered, dispensed, returned and invoiced for on behalf of residents by the nursing team. Reports will be available for each medication or pharmacy product being billed to the resident before invoicing. This is currently being rolled out with training provided and will be fully implemented by 31 December 2024.

In-person safeguarding training has been completed with all staff members in Blainroe Lodge - Completed

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Diet sheets have been removed and relocated to a more discreet location – Completed on 8/10/2024

The provider is currently employing an Activity Provision Lead for the group, who will provide resources, auditing tools and events types to the centre. The resource will be in post from 1st January 2025.

A review of activity provision in the centre will take place by the Person in Charge and Regional Director to ensure there is a variety of activities available as per resident's wishes, needs. The reviewed activity plan will be discussed at the resident council meetings before implementation. This full review will be completed by 31 December 2024.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/01/2025
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.	Substantially Compliant	Yellow	31/03/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	31/12/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	31/01/2025

	place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
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	31/03/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	31/03/2025
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	Substantially Compliant	Yellow	31/12/2024

	equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/12/2024
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	01/10/2024
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are	Substantially Compliant	Yellow	01/10/2024

	fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	15/12/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	31/12/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/12/2024
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/12/2024