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:	St Paul's Nursing Home
Name of provider:	Blockstar Limited
Address of centre:	St Nessan's Road, Dooradoyle, Limerick
Type of inspection:	Unannounced
Date of inspection:	20 August 2024
Centre ID:	OSV-0000433
Fieldwork ID:	MON-0041159

About the designated centre

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

St. Paul's Nursing Home is a purpose-built designated centre and has been in operation since 1963. The nursing home was opened and operated by the Bons Secour De Troyes until 2010 when it was purchased by Blockstar Limited, who are the current registered providers. The centre is registered to accommodate 57 residents in four two bedded rooms (two with en suite facilities) and 49 single bedded rooms (seven with en suite facilities). The centre provides 24-hour residential care for both female and male residents and provides general long-term care, palliative care, convalescent care and respite care. The centre is registered to care for persons over the age of 18 but most residents are over 65 years of age and can cater for residents assessed as being from low to maximum dependency levels' as per the modified Barthel Index.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	56

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 20 August 2024	09:45hrs to 16:45hrs	Leanne Crowe	Lead
Wednesday 21 August 2024	08:45hrs to 14:00hrs	Leanne Crowe	Lead
Tuesday 20 August 2024	09:45hrs to 16:45hrs	Sean Ryan	Support
Wednesday 21 August 2024	08:45hrs to 14:00hrs	Sean Ryan	Support

What residents told us and what inspectors observed

There was a relaxed atmosphere within the centre. Inspectors observed staff to be responsive and attentive to residents' needs or their requests for assistance. Residents felt that the nursing home met their individual needs to a good standard.

St Paul's Nursing Home accommodates up to 57 residents over three floors of the designated centre. On the day of the inspection, 56 residents were living in the centre. Bedroom accommodation comprised four twin bedrooms and 49 single bedrooms. A total of 10 of these bedrooms provided ensuite facilities. Communal shower rooms, a bathroom and toilets were located throughout the building. A variety of communal areas were available including a visitor's room, day rooms, dining rooms, a quiet room and a church. A secure garden area was accessible from the ground floor, which contained colourful plants and shrubbery. A number of lifts and stairs were available to facilitate residents' movement between floors.

On arrival to the centre, the inspectors were greeted by the person in charge. Following an introductory meeting, the inspectors and person in charge completed a walk around the centre. Many residents were observed in communal rooms, engaging in activities or chatting with one another. Staff were busy attending to residents' requests for assistance; during these interactions staff were seen to be friendly and respectful.

Inspectors spoke with a number of residents throughout the two days of the inspection, as well as a small number of relatives. Residents were very positive in their feedback and expressed satisfaction about the quality of the service they received. Residents confirmed that they knew the staff well and that they were kind, caring and attentive. Residents confirmed that their call bells were answered promptly with the occasional wait for assistance if staff were busy elsewhere. Residents were aware of ongoing maintenance works to improve the quality of the environment they lived in.

Residents’ bedrooms were clean, bright and personalised. There was sufficient space for residents to store their personal items. Some residents had decorated their bedroom with pictures, ornaments, plants and furniture from home. One resident described the centre as "a home away from home". The inspectors observed that there were televisions in all bedrooms.

Residents were complimentary about the food they received. They confirmed that snacks and juices were readily available throughout the day, upon request. The inspectors spent time observing the residents' dining experience. Mealtimes were seen to be a social occasion, where residents enjoyed their meals in a relaxed manner. Residents who chose to have their meals in their bedroom were provided with assistance and support from staff. Residents confirmed that they could choose items that were not on the menu, if they wished.

Residents' personal clothing was laundered within the nursing home. Residents expressed their satisfaction with the service provided, and described how staff returned their clean laundry to their bedrooms promptly.

Residents were provided with opportunities to express their feedback about the quality of the service during daily one-to-one interactions with the management, and through formal resident forum meetings. Records of these meetings indicated that updates regarding the ongoing structural works were discussed, as well as items such as staffing, food quality and environmental hygiene. Residents told the inspectors that staff sought their feedback on how to improve the service. There was evidence that residents' feedback was acted upon to improve the service they received in areas such as the activities programme and menu choices.

Visitors attending the centre throughout the inspection were welcomed by staff. Residents and visitors confirmed that flexible visiting arrangements were in place and that they were satisfied with such arrangements. Residents said that they could spend time with visitors in communal areas or in the privacy of their bedroom.

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 on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection, carried out over two days, by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors followed up on the actions taken by the provider to address regulatory non-compliance identified on the previous inspection in April 2023. Findings in relation to deficits in fire safety on inspections in December 2021, July 2022 and April 2023 had resulted in a restrictive condition being applied to the designated centre's registration, requiring the provider to complete a range of fire safety works by 31 March 2024.

At the time of this inspection, a significant proportion of the fire safety works had been completed, including the review and reduction of the building's fire compartments, works to the emergency lighting system, fire stopping works throughout the building, and the replacement or repair of the majority of the centre's fire doors. However, this inspection found that the works were not fully completed.

Additionally, this inspection found that the registered provider had failed to put effective management systems in place to ensure that the service provided was safe and appropriately monitored, particularly regarding fire safety. Inspectors found that the oversight of fire safety procedures and staff knowledge in relation to fire was

inadequate to ensure the safety of residents in the event of an emergency. Consequently, an urgent compliance plan request was issued to the provider following the inspection, seeking assurances in relation to the management of fire safety systems, within a required time-frame. A compliance plan submitted by the provider was accepted by the Chief Inspector.

Inspectors also followed up on issues of non-compliance identified on an inspection in April 2023 in relation to Regulation 23, Governance and Management, Regulation 27, Infection Control and Regulation 5, Individual assessment and care plan. This inspection found that some action had been taken to address the issues identified, however, a review of these areas on this inspection found that these regulations were not in full compliance with the regulations.

Non-compliance identified in April 2023 in relation to Regulation 21, Records, had been addressed in full. The provider had ensured that documentation was now stored securely while also being fully accessible, as needed.

Blockstar Limited is the registered provider of St Paul's Nursing Home. The lines of accountability and responsibility were clearly defined. A director of the company and a regional manager participated in the management of the centre at a senior level. The person in charge worked full-time in the centre. They were supported in their role by two clinical nurse managers (CNMs), as well as a team of nurses, health care assistants, catering, housekeeping, activities staff and maintenance staff.

The management systems in place to monitor the quality of the service were not in line with the requirements of the regulations. While the provider had established a system of oversight through a programme of audits and data collection, this did not consistently identify or address deficits in quality and safety. In addition, the systems in place to oversee, identify and manage risk in the centre were not effective. For example, the systems in place to ensure that all staff had appropriate training and knowledge in relation to fire safety was not adequate. Additionally, the oversight of fire safety checks had not ensured that an area containing gas supply pipes was effectively monitored.

An annual review of the quality and safety of care delivered to residents in 2023 had been completed. This contained an overview of key areas of the service and included quality improvements that the provider planned to complete during 2024.

On the days of the inspection, there were adequate staffing resources to ensure the effective delivery of care, in accordance with the statement of purpose, and to meet residents' individual and collective needs. The inspectors reviewed a sample of staff files and observed that Garda vetting was obtained for staff before they began employment in the centre. The files contained all of the information required by Schedule 2 of the regulations.

Staff were facilitated to attend training that was appropriate to their role. This included fire safety, people moving and handling and safeguarding of vulnerable adults. Other training was made available to staff, including dementia care. With the exception of fire safety, staff who spoke with the inspectors demonstrated good

knowledge of how they implemented the training that they had received.

The centre's complaints management policy and procedure had been updated to reflect the amendments to the regulations. A record of complaints was maintained, which demonstrated that complaints were managed effectively.

Regulation 15: Staffing

On the days of the inspection, the staffing levels and skill-mix were appropriate to meet the assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training in areas such as fire safety, moving and handling procedures and the safeguarding of residents.

Staff knowledge of fire safety procedures is detailed under Regulation 28, Fire precautions.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had a current insurance policy in place which covered the risks of injury to residents and the loss or damage to residents' property.

Judgment: Compliant

Regulation 23: Governance and management

The management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored were not in line with the requirements of the regulations. For example:

- There was inadequate management and oversight of fire safety systems, including oversight of the completion of fire safety works, staff knowledge

and access to all areas of the centre for fire safety checks. Additionally, it was not clear when the outstanding fire safety works would be completed. This resulted in the Chief Inspector issuing a request for an urgent compliance plan to ensure the non-compliances were addressed promptly
- Systems of oversight in place to monitor and respond to issues in relation to staff supervision, maintenance of the physical environment, assessment and care planning and infection prevention and control were not sufficiently robust.

Judgment: Not compliant

Regulation 34: Complaints procedure

A complaints policy and procedure was available in the centre, which had been updated in line with recent legislative changes.

The registered provider maintained records of complaints made in relation to the service. These records contained all of the information required by the regulations, including the investigations carried out and any improvement plans developed. The satisfaction of the complainants with the outcome of complaint investigations were also recorded. Advocacy services were made available to complainants to support them in making a complaint, if required.

Judgment: Compliant

Quality and safety

Overall, residents' health and social care needs were maintained by a satisfactory standard of evidenced-based care and support from a team of staff who knew their individual needs and preferences. Residents were satisfied with their access to health care, and reported feeling safe and content living in the centre. This inspection found that, while the provider had taken significant action to improve the physical environment to meet the care and safety needs of residents in relation to fire safety, the action taken was not sufficient to bring the service into full compliance. This inspection found that there were some aspects of the premises and associated facilities that were in a poor state of repair and did not support effective infection prevention and control management. Additionally, residents' individual assessments and care plan were not updated to ensure they were reflective of their actual care needs.

Inspectors reviewed the arrangements in place relating to fire safety. There were daily, weekly and monthly checklists which included testing of fire equipment, fire

alarm testing, emergency lighting, means of escape and fire exit doors, all of which were up-to-date. Significant fire safety works were in progress and the provider had replaced a significant number of fire doors throughout the centre and fire compartments had been reduced in size to support the safe and timely evacuation of residents in the event of a fire emergency. Inspectors found that some fire safety works, including the repair or replacement of some fire doors had not been completed. Additionally, significant non-compliance was found in relation to the management and oversight of fire safety systems. Management oversight of staff knowledge in relation to procedure to be followed in the event of the fire alarm sounding, and the evacuation procedure was poor. This posed a risk to residents' safety. This is discussed further under Regulation 28, Fire precautions.

Inspectors found that some action had been taken following the previous inspection to support effective infection prevention and control measures. There was a programme of repair and replacement in place to ensure the surfaces of furniture were appropriately maintained to support effective cleaning. Many areas of the centre were observed to be clean during the inspection, such as sluice rooms, corridors and communal areas. However, a shower grid and support equipment used by residents were not visibly clean. Furthermore, there were aspects of the premises and associated facilities that were in a poor state of repair and did not support effective infection prevention and control management.

Residents' health and social care needs were assessed on admission to the centre to inform the development of care plans that provided guidance to staff in the provision of individuated care. However, a review of a sample of residents' assessments and care plans found that care plans were not always informed by an assessment of the resident's care needs. Consequently, the care plans reviewed did not always reflect person-centred, evidence-based guidance on the current care needs of the residents. For example, some residents assessed as being at risk of malnutrition and impaired skin integrity did not have an appropriate care plan developed to meet their needs.

Arrangements were in place for residents to access the expertise of health and social care professionals such as dietetic services, speech and language, physiotherapy and occupational therapy through a system of referral. Residents were provided with appropriate access to medical and health care services.

The person-in-charge was actively promoting a restraint-free environment and the use of bed rails in the centre was appropriately monitored. Residents who experienced responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) received non-restrictive care and support from staff that was kind and respectful.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre. Arrangements were in place to

support residents to manage their finances.

Residents' rights were promoted in the centre. Residents were free to exercise choice in how to spend their day. Activities were observed to be provided by dedicated activities staff, with the support of health care staff and external providers. Residents told the inspector that they were satisfied with the activities on offer.

There were opportunities for the residents to meet with the management team and provide feedback on the quality of the service.

Visiting was observed to be unrestricted, and residents could receive visitors in either their private accommodation or a visitors areas, if they wished.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 27: Infection control

Infection prevention and control procedures were not consistent with the National Standards for Infection Prevention and Control (IPC) in community settings published by HIQA. This was evidenced by:

- Inadequate oversight of infection prevention and control. This included the cleaning procedure and the quality of environmental hygiene in areas such as the laundry facilities. Hand sanitiser dispensers were visibly unclean throughout the centre. There were poorly maintained areas of the premises that impacted on effective cleaning where floors and surfaces of furniture were damaged.

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

- The dedicated room for the storage of cleaning equipment or preparation of cleaning chemicals was located adjacent to the laundry. The location and layout of this room meant that both clean and soiled linen was required to be transported through the housekeeping room in order to access the laundry area. This created a risk of cross contamination
- Some facilities and support equipment used by residents were not all clean on

inspection. For example, a shower tray in a communal shower room and some specialised chairs were observed to be visibly unclean.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Oversight of fire safety systems was inadequate and did not fully ensure the safety of residents against the risk of fire. For example;

- A room containing gas supply equipment was not accessible on the first day of the inspection. This meant that the area could not be checked for potential fire risks such as inappropriate storage of combustible items, and electrical and fuel services. On the second day of the inspection, the room was found to contain a supply of linen, which was not in line with the centre's fire safety policy
- Staff had received training in fire safety management, however, some staff spoken with on the day of the inspection demonstrated incomplete knowledge of fire safety and evacuation procedures. The effectiveness of the fire training delivered was not reviewed by the provider.

As a result of these findings, the Chief Inspector issued the provider with a request for an urgent compliance plan. The providers response to the urgent plan provided assurance that the risk was adequately addressed.

In addition to the above, arrangements for detecting and containing fire in the designated centre required action. For example:

- There were a small number of fire doors in the centre that required repair or replacement. This could pose a risk to the containment of smoke and fire in the event of a fire emergency
- There were a small number of areas of the premises noted to have service penetrations. This had the potential to impact on fire containment measures in the event of a fire
- Some poor practice was observed where bedrooms doors were held open by by floor wedges. This had the potential to impact on the function of fire doors to contain the spread of smoke and fire in the event of a fire emergency.

The arrangements for maintaining the fire equipment, means of escape, building fabric and building services were not adequate. For example:

- There was no periodic inspection report of the electrical installation available to ensure the electrical installation was free of fault or risk
- There were no service records available to confirm inspection and maintenance of the gas appliances such as cooking equipment.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A sample of resident's assessments and care plans reviewed found that they were not always in line with the requirements of the regulations.

Care plans were not always guided by a comprehensive assessment of the residents care needs. For example, residents identified as being at risk of malnutrition or at risk of pressure related wounds were not always identified as such within their care plan.

Care plans were not always reviewed when a residents condition changed. Some residents who had experienced a fall related incident did not have an assessment of their needs completed or a review of the current support interventions in place to ensure their care plan was reflective of their needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate health and social care professional support to meet their needs. Residents had a choice of general practitioner (GP) who attended the centre, as required or requested.

Services, such as physiotherapy, were available to residents weekly and other services such as tissue viability nursing expertise, speech and language and dietetics were available through a system of referral.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Restrictive practices, such as bed rails, were managed in the centre through ongoing initiatives to promote a restraint free environment. Restrictive practices were only initiated following an appropriate risk assessment, and in consultation with the multidisciplinary team and the resident concerned.

Residents who experienced responsive behaviours had appropriate assessments completed, and person-centred care plans were developed that detailed the supports and intervention to be implemented by staff to support a consistent

approach to the care of the residents. Care plans included details of non-pharmacological interventions to support the resident to manage responsive behaviours. Interactions observed between staff and residents was observed to be person-centred and non-restrictive.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. Safeguarding training was up-to-date for all staff and a safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

The provider supported residents to manage their pension and social welfare payments. Arrangements were in place to ensure residents finances were managed in line with best practice guidelines.

Judgment: Compliant

Regulation 9: Residents' rights

Staff demonstrated an understanding of residents' rights and supported residents to exercise their rights and choice, and the ethos of care was person-centred. Residents' choice was respected and facilitated in the centre.

There were facilities for residents to participate in activities in accordance with their interests and capacities. Residents were consulted about the activity schedule to ensure it was enjoyable and engaging for all residents. Residents complimented the provision of activities in the centre and the social aspect of the activities on offer.

Residents said that they were kept informed about changes in the centre and they attended regular meetings and contributed to the organisation of the service. Residents confirmed that their feedback was used to improve the quality of the service they received in aspects of the service such as the provision of activities, the menu, and the laundry service.

Residents were provided with access to religious services in the centre. Residents were provided with information about services available to support them, such as independent advocacy services.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St Paul's Nursing Home OSV-0000433

Inspection ID: MON-0041159

Date of inspection: 21/08/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider has put systems in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored to comply with regulation. • The Provider submitted an urgent compliance plan following the inspection. Deficits in staff knowledge identified at inspection were immediately addressed with enhanced fire training, over and above what is rolled out anually. This enhanced programme of training and education continues through daily fire safety huddles and repeated fire drills. The Regional Operation's Manager visits the centre regularly and appraises the Provider of progress in this regard. The Provider will assess effectiveness of the initiative during regular visits to the centre. • The Provider's program of works was nearing completion on the day of inspection and works have since completed with the fitting of the nine remaining fire doors. The Provider has oversight of all building works through her regular visits to the centre and her engagement with the builder, external contractor and engineer. • The provider has implemented additional training for staff on care planning with a plan to further improve the existing person centered care plans. • The Provider has introduced an enhanced cleaning system to address areas of concern in relation to IP&C. The initiative includes a new cleaning schedule with the introduction of "I am clean stickers." This system will give accountability to staff performing the task and the DON will oversee the iniative. The ROM and RPR will audit the initiative during visits to the home. • The Provider is fully comitted to the implementation of ongoing quality initiatives to improve the lives of the residents in the centre.	

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• The Provider has introduced an enhanced cleaning system to address areas of concern in relation to IP&C. The system will include all areas and equipment within the centre including the laundry area. The initiative includes a new cleaning schedule with the introduction of "I am clean stickers." This system will give accountability to staff performing the task and the DON will oversee the iniative. The ROM and RPR will audit the initiative during visits to the home.

• All hand sanitisers throughout the centre will be changed out for a foam-type sanitiser. It is estimated this will be completed by the end of October.

• The management of clean, used and infectious linen has been risk assessed. A covered laundry cage will been ordered and it will be used to transport all used and infectious linen to the Laundry. Clean linen will be transported to residents rooms in a covered container. These initiatives will eliminate the risk of cross contamination.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

1. The Provider has engaged the services of a suitably qualified person to train up all staff on what to do in the event of a fire. This training will be in addition to any fire training already completed and will form part of our initiative on enhancing staff knowledge in the area of fire prevention and management.

2. Fire drills have been conducted 7 days a week over 30 days since the inspection and the DON is in the processing of assessing staff knowledge and competence.

3. The Provider has committed to conducting fire drills in the centre at a minimum weekly thereafter for a period of time until staff knowledge and competence has been deemed effective.

4. Fire Safety Huddles have been completed daily since the inspection. The DON is in the process of reviewing the effectiveness of the initiative through short questionnaires. These questionnaires will focus on what information and skills staff will need to respond efficiently and effectively in the event of the fire alarm sounding. The Person in Charge will use the information gained from these Fire Safety Huddles to assess effectiveness of training, tailor future training and ensure that staff knowledge can stand up to scrutiny. The Fire Evacuation Policy has been updated to cover the staff rest area in the adjoining building. The Policy will detail how staff can differentiate between the fire alarm in the building housing the staff rest area and the Fire alarm in the centre. The Fire Safety Huddles will contain information and audible recordings on the different alarms and staff will be assessed on how to identify each alarm. Fire Safety Huddles and Fire Training will cover different scenarios and will contain information on where to shut of services such as gas, water and electricity, where fire hydrants are located and where to evacuate, should a full evacuation of the centre be needed. A member of the centre's senior management team will have special responsibility for staff education in this area and will

appraise the Provider weekly of progress.
5. The Provider has instructed that Fire, be a standing item on the Governance Meeting Minutes and that they contain progress on this initiative. The Person in Charge will ensure that the initiatives outlined in this report can easily be demonstrated through comprehensive record keeping. This emergency compliance plan was initiated on 26.08.24. Additional fire training was completed on 27th and 28th of August and is ongoing. Fire Huddles continue daily for the foreseeable future. The Fire Policy has been updated to cover the staff rest area in the adjoining building and this was completed on 29.08.24.
6. The room adjacent to the laundry has been cleared of all stored linen, the door has been removed and an additional smoke detector has been installed. This will ensure the area can be effectively monitored. This was completed by 23.08.24.
7. There were nine fire doors to be replaced as part of on-going fire safety works. These doors have been delivered and installed. This work was completed on 09.10.24.
8. On the day of inspection there were a small number of areas where there were service penetrations. These areas have been surveyed by an Engineer and have subsequently been fire stopped. This was completed by 09.10.24.
9. On the date of inspection some door wedges were noticed to be in use. These have been removed and door hold-open devices suitable for fire doors have been installed as part of on-going fire safety works
10. A service engineer has been booked for Service of gas Cooker and Hob. This will be completed by 25.10.24.
11. PIR to be completed by 31.12.24.

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:
• All residents have comprehensive assessments in place and these recognized assessments are used to inform the care plan.
• All residents have risk assessments in place and where risks are identified, they will be referenced in the care plan and person-centered evidence-based care plans will be developed to meet their needs and reduce risk.
• The staff will have ongoing training from members of the senior management team to assist them in identifying risk, managing risk and incorporating this information into the care plan.
• Training in the above areas will be ongoing, be tailored and specific to the outcome of ongoing audits in this area.
• The resident identified at inspection as not having an assessment and care plan adjusted post fall has now had a falls risk assessment, care plan reviewed and adjusted and has seen the physio. Going forward, such actions will be completed in a timely manner post incident.

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 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/11/2024
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.	Substantially Compliant	Yellow	30/11/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of	Not Compliant	Red	23/08/2024

	fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.			
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	31/12/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/11/2024
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a	Not Compliant	Red	30/08/2024

	resident catch fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/10/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	31/10/2024
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	31/10/2024