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:	Belmont House Private Nursing Home
Name of provider:	Belmont Care Limited
Address of centre:	Galloping Green, Stillorgan, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	30 July 2024
Centre ID:	OSV-0000014
Fieldwork ID:	MON-0043166

About the designated centre

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

Belmont House is a 156-bed centre providing residential, respite and short-stay convalescent care services to male and female residents over the age of 18 years. The centre was originally a Georgian country house and was owned by a religious order. The building has been extended and completely refurbished while retaining some of its older features. It is located on the Stillorgan dual carriageway, close to the village of Stillorgan, with access to local amenities, including shopping centres, restaurants, libraries, public parks and coffee shops and good access to public transport. Accommodation for residents is across seven floors. There are also areas for residents to socialise and relax, including activity rooms, a coffee dock and quiet areas. The majority of bedrooms are single rooms, and there are 25 twin rooms. There is 24-hour nursing care with access to both in-house and specialist healthcare as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	140

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 30 July 2024	08:30hrs to 17:30hrs	Helena Budzicz	Lead
Tuesday 30 July 2024	08:30hrs to 17:30hrs	Frank Barrett	Support
Tuesday 30 July 2024	08:30hrs to 17:30hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

The overall feedback from residents was that they were happy living in Belmont House Private Nursing Home. The inspectors observed the interactions between staff and residents to be kind, encouraging and respectful. Residents gave positive feedback and were complimentary about the staff and the care provided; they said that their independence and autonomy were supported, and they felt well-informed about different events in the centre.

The inspectors saw that a number of residents were mobilising independently throughout the centre and outside the centre during the day. They were seen to be enjoying sitting on the balcony outside the coffee shop and the centre's terrace. There was a pleasant atmosphere throughout the centre, and friendly and familiar chats could be heard between residents, staff and visitors.

Staff were observed attending to residents' requests for assistance with their morning care in their bedrooms and engaging with residents in a respectful manner. It was clear that staff were familiar with residents' care needs and that residents felt safe and secure in their presence.

Overall, the general environment and residents' bedrooms and communal areas appeared clean. Since the last inspection, improvements have been noted in the cleanliness, storage practices, and premises, most notably in some twin-occupancy bedrooms and the privacy space for residents. Despite these improvements, there were areas of the centre that needed maintenance and further actions in the management of premises and fire safety were required. These findings are discussed in detail later in the report.

Inspectors observed the dining experience at lunch time and saw that the meals provided were of a high quality and well presented. Residents could choose where they wished to eat, and many residents were observed to go to dining rooms in the centre for their meals. Menus were available for residents to choose their meals. Residents who spoke with inspectors said, 'The food is excellent like in the hotel', 'the portions were big', and that there was plenty of food available to them. Inspectors observed that meals served for residents with specialised nutritional needs appeared appetising, and the presentation was lovely. However, one resident expressed dissatisfaction that the kitchenette on the first floor had been out of order for a prolonged period of time, which was frustrating as it limited their access to the fridge. Inspectors observed that the kitchenette was in the process of being refurbished.

Residents' meetings were taking place regularly which gave residents the opportunity to be consulted in the running of the service. Information regarding advocacy services was displayed in the reception area of the centre, and the inspector was informed that residents were supported to access this service if

required. Inspectors observed that residents' choices, personal routines and privacy were respected by staff.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

Overall, improvements were found since the previous inspection of January 2024, the oversight of the governance and management team had strengthened and there were effective management systems to monitor the quality of care to residents. The inspectors found that the registered provider had progressed parts of the compliance plan from the previous inspection and improvements were found in respect of training, records management, directory of residents, infection control, residents' rights and the management of complaints. The provider had also taken some action to improve the systems for the management of personal possessions, storage and premises, however inspectors identified further action was required to achieve full regulatory compliance. Notwithstanding the works in respect of fire safety, this inspection also identified ongoing non-compliance with Regulation 28: Fire precautions.

This was an unannounced inspection to monitor ongoing regulatory compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

Belmont Care Limited is the registered provider of Belmont House Private Nursing Home, which is part of the wider Emeis Group. The person in charge is supported by two assistant directors of nursing and five clinical nurse managers. The management team were found to be knowledgeable about individual residents needs, wishes and their life stories. There was a clearly defined management structure in place with identified lines of accountability and authority. Supervision and on-call arrangements were in place for weekends. Further support was provided to the management team through the group directors and a regional director. There was evidence of regular governance and oversight of the centre with clinical governance meetings held on a regular basis.

There was a comprehensive audit schedule in place. Key performance indicators were also used to support the monitoring of clinical care practices in areas such as falls, incidents, infection, wounds and restraint. However, the inspectors identified that the fire safety audits were not sufficiently robust and that they had not identified some of the findings of this inspection.

The provider had taken action to ensure staff personnel files contained the information required under Schedule 2 and 4 of the regulations. This included records of written references and qualifications.

The training matrix indicated that the majority of staff received training appropriate to their various roles. There was a training schedule in place to ensure that all staff had an opportunity to access training according to their roles and responsibilities.

An annual review of the quality and safety of care delivered to residents in 2023 was completed, and quality improvement plans were outlined for 2024.

The service was responsive to the receipt and resolution of complaints. Records of complaints were maintained in line with the requirements of the regulations.

Regulation 16: Training and staff development

Staff had access to training and had completed all necessary training appropriate to their roles and responsibilities. There were arrangements in place for the ongoing supervision of staff through management presence and formal induction and performance review processes.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents contained all the information specified in paragraph three of Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

The inspectors reviewed a sample of staff files and found that all of the information required under Schedules 2 and 4 of the regulations was available. There was evidence that each staff member had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had a current certificate of insurance, which indicated that cover was in place against injury to residents and which met the regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had management systems in place to monitor the quality of the service provided; however, some actions were required to ensure that these systems and processes in place were sufficient to ensure the services provided are safe, appropriate and consistent. For example:

- The inspectors viewed the documents in relation to residents' petty cash and found that the current processes in place were not sufficient to safeguard residents' finances. For instance, the overview of receiving and dispatching residents' money was not always clearly displayed and double-checked by two signatures.
- Clinical governance oversight was not sufficient to ensure effective monitoring of residents' nursing assessments and care planning arrangements, including, for example, the monitoring of residents post falls in line with their policy.
- The oversight of residents' personal possessions required review as the labelling system was not effective.
- The local policy did not reflect the specific evacuation restrictions that are in place at the centre, such as the evacuation routes and the lack of refuge space. Fire door audits carried out monthly at the centre did not pick up on deficiencies presented in fire doors. The policy document referenced the fire door "ironmongery to be suitable for use on fire doors," which was not adhered to as outlined in Regulation 28: Fire precautions.
- While works were on going to address fire safety, the findings of this inspection was that further works were required to protect residents from the risk of fire. Fire safety audits while carried out did not identify some of the areas identified on this inspection for example concerns relating to the means of escape, and the strategy for the evacuation of high dependency residents without available refuge space in floors above the ground floor.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A complaints policy was in place, and the complaints procedure was displayed in the centre. A review of the records found that complaints and concerns were promptly managed and responded to in line with the regulatory requirements.

Judgment: Compliant

Regulation 24: Contract for the provision of services

The provider ensured each resident was provided with a contract for the provision of services, in line with regulatory requirements.

Judgment: Compliant

Quality and safety

Residents living in Belmont House Private Nursing Home received a good standard of care and support to ensure that they could enjoy a good quality of life. However, the registered provider was required to take further action in respect of management of premises, personal posessions, fire safety and inidividual assessment and care planning to ensure the service provided was safe at all times.

The inspectors found that residents' needs were comprehensively assessed using validated assessment tools and care plans were reviewed at regular intervals. However, from the sample of residents' care plans and assessments reviewed, there was a disconnect between the data collected in the assessments, the outlined plan for care in the resident's care plans and the guidance from the centre's relevant policies. This is further discussed under Regulation 5: Individual assessment and care plan.

Residents had access to a safe supply of fresh drinking water at all times. The food served to residents was of high quality, wholesome and nutritious and was attractively presented. There were adequate numbers of staff to assist residents at meal times, and the dining experience was observed to be unhurried and relaxed.

Arrangements were in place to provide residents with appropriate care and comfort as they approached the end of their life. Records reviewed evidenced that the centre had access to specialist palliative care services for additional support and guidance if needed.

Inspectors reviewed the premises available to residents. The centre is laid out over seven levels. A lower ground floor consisted of resident bedrooms, day spaces, the laundry area and an enclosed garden space. The ground floor consisted mainly of day spaces, a café, and a dining area, with the main kitchen, hairdressing room, and

staff ancillary rooms. The first, second, third, fourth, and fifth floors mainly consisted of resident bedrooms with day space/dining space on the first, fourth, and fifth floors. The premises were clean and well-maintained overall. There was a kitchenette on the first floor, which was undergoing refurbishment and was not available to residents on the day of inspection. This project had been ongoing since the previous inspection; however, it was not clear when the kitchen would be completed and when it would be usable.

As there were a number of floors where residents were situated, access through the floors required some attention. One stairwell had unfinished surfaces, while another internal stair, which linked floors one and two, was very dark. There were two lifts available for residents to use. Some bedrooms were grouped together with a lobby corridor accessing the rooms and a shared bathroom for the residents within the pod. Other bedrooms had access to en-suites. However, one single bedroom on the lower ground floor did not have access to an en-suite or direct access to a shared bathroom without traversing the main corridor. This impacted on the resident's privacy and dignity. This bedroom also did not have a sink for residents' use as required by regulations. A review of the suitability of this bedroom was required.

The first floor of the centre had access to a garden terrace; however, it was noted the decking boards fitted were uneven, presenting a trip hazard. A section of glazing overhanging a walkway near the entrance was damaged. There was furniture blocking access to this area of the walkway to prevent the glass from falling on any person below it. However, this furniture was blocking an exit route and was required to be removed. Some wear and tear damage was evident throughout the inspection. However, the provider had implemented a maintenance programme to address these issues. Premises are discussed further under Regulation 17: Premises.

Inspectors reviewed arrangements in place at the centre to protect residents from the risk of fire. Management at the centre had completed work to improve fire safety within the centre and address concerns raised in previous inspections. A fire safety risk assessment was completed by a competent external contractor in 2021. As the centre is laid out over multiple floors, emergency evacuation of residents on upper floors was identified as a risk that required ongoing monitoring. The evacuation procedures available to staff at the centre highlighted this; however, the evacuation stairs at each upper level did not contain any refuge space for use in the case of a fire evacuation. A refuge space within protected stairs would afford high-dependency residents a level of protection from a fire event during an evacuation. High-dependency residents were located on each level of the centre and may require the assistance of evacuation equipment and/or additional staff to evacuate. In addition, a link stairwell between level one and level two was not a protected stair and did not open directly to the outside. This meant that the escape route did not provide an enhanced level of protection for residents' staff or visitors in the event of a fire evacuation and required users to cross a corridor at the bottom of the stairs to reach an emergency exit. An external gate was installed on the exit from the internal courtyard on the lower ground floor. There was a lock on this gate, which one staff member had the key to. There was no alternative key available. The provider fitted a break glass box beside the gate with a key inside during the inspection. Concerns were noted in relation to containment, with some bedroom

doors having hinges and handles that were not identified as fire-rated. Some doors had hinges and smoke seals painted over, which would impact their performance in the event of a fire. Fire safety is discussed in more detail in Regulation 28: Fire Precautions.

The provider had implemented a quality improvement plan following the findings of the January 2024 inspection of the centre, which also focused on infection control procedures. The centre was visibly clean on inspection. There were effective quality assurance processes in place to ensure a satisfactory standard of environmental, clinical and equipment hygiene was maintained.

Residents' rights were protected and promoted. Residents could choose from a variety of activities, such as arts and crafts or social gatherings, and where to spend their day.

Regulation 12: Personal possessions

Inspectors found that the labelling systems for residents' clothes were not effective, as they saw unmarked underwear and unlabelled socks stored in one of the units. The staff informed the inspectors that these items were for communal use, and would be given to the residents who required it. In addition, inspectors observed badly damaged hip protectors that were not fit for purpose, being laundered to be returned to the unit. These items were all removed on the day of inspection, however improved oversight of the management of residents' personal possessions was required to prevent recurrence of these issues.
Stronger oversight of the management of resident's petty cash was required to ensure transparency of records and alignment with local policy.

Judgment: Substantially compliant

Regulation 13: End of life

End-of-life care plans were developed following an assessment of the resident's physical, emotional, social, psychological and spiritual care needs. There was involvement of the community palliative care team, if required, in conjunction with the general practitioner.

Judgment: Compliant

Regulation 17: Premises

Improvement were required of the registered provider to ensure that the premises is in line with the Statement of Purpose and the floor plans for which the designated centre is registered. For example:

- A kitchenette on the first floor was not available for use by residents. This room was undergoing refurbishment however, an end date for the works was not available on the day of the inspection.
- An area designated as a terrace for resident use was not accessible for residents due to low guard rails on the perimeter and uneven decking boards, which posed a trip hazard. Access to the area was restricted, which meant that residents could not use it.

Improvements were required from the registered provider, having regard to the needs of the residents at the centre, to provide premises that conform to the matters set out in Schedule 6 of the regulations. For example:

- A bedroom on the lower ground floor was not provided with a resident sink. This bedroom did not have an en-suite or direct access to a bathroom.
- Storage cupboards were obstructed by hoists on the fourth floor. This storage space was used to store linen; however, the hoists were placed in front of the doors, which required the removal of the hoists in order to access the cupboards.

Some areas of the premises required maintenance attention internally:

- A broken glazing panel was in place over a walkway at ground floor level. The provider was aware of the need to replace this panel and was awaiting a specialist contractor to complete the work. In the meantime, the area beneath the glazing panel was cordoned off so that residents or visitors could not access it. This impacted the walkway and the escape route from the adjacent stairs.
- A stairwell at the north-western corner of the building did not have suitable floor finishes fitted. There were slight changes in levels due to different materials, which could pose a trip hazard. The walls of this stairwell also required attention as there were no appropriate wall finishes applied.
- The ceiling was damaged outside the stairs on the first floor.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with wholesome and nutritious food choices for their meals, and snacks and refreshments were made available at the resident's request. Fresh drinking water, flavoured drinks, milk, snacks and other refreshments were available at mealtimes and throughout the day. The dining experience, observed to be of a high standard, featured a beautifully set table with flowers, wine glasses,

and a variety of condiments. Residents who required assistance with their nutritional needs were provided with discreet assistance as needed, and staff were observed to offer various choices of meals to residents.

Judgment: Compliant

Regulation 27: Infection control

The registered provider had ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control practices.

Judgment: Compliant

Regulation 28: Fire precautions

Inspectors acknowledged the improvement works completed at the centre to upgrade fire safety and the ongoing improvement efforts being made by management and staff at the centre to protect residents from the risk of fire. However, significant improvements were required to comply with regulation 28 in a numbers of areas outlined below.

Improvement was required by the registered provider to take adequate precautions against the risk of fire, for example:

- Storage was impacting on the risk of fire at the centre. Hoists were noted to be positioned in front of storage cupboards to charge. In order to access the cupboards the hoists needed to be removed into the escape corridor. This impacted on the escape route. Storage cupboards on the first floor had numerous flammable and combustible items stored together, such as hand gels, toiletries and cardboard boxes of personal protective equipment (PPE). Some storage cabinets and electrical mains switch panels were not fire rated, therefore there were no containment measures in place to protect the escape route in the event of a fire within the cabinets.

The registered provider did not provide adequate means of escape, including emergency lighting, for example:

- An exit route from the second floor was through an internal link stairs to the level below. These stairs were not contained within fire-rated construction and, therefore, not a protected escape route. This stairway formed part of a single means of escape for three bedrooms adjacent to the stairs.
- The escape stairways within the centre did not have a disabled refuge space. This would provide a place of relative safety for residents of high dependency

residents during an evacuation. The lack of disabled refuge space presented a risk that residents with high dependency needs could not be evacuated to the next compartment if they were situated in the compartment where the fire occurred, and the only direction of escape was into the stairwell. This could also impact on the ability of other residents staff and visitors to escape through the stairs in the event of a fire.

- A central means of escape from the ground floor, which was a staircase exit for each floor above, was obstructed externally by furniture. The blocking of the exit would present difficulties and delays to evacuation in the event of a fire.

Improvement was required from the registered provider to ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and, in so far as is reasonably practicable, residents are aware of the procedure to be followed in the case of a fire. For example:

- Extensive fire drills were being recorded at the centre; however, some discrepancies existed in the recorded outcomes of the fire drills and some were not in line with their own centre construction and or policy:
    - There was no record to indicate that staff had simulated a call to the fire brigade as part of the fire drills. This was identified on the drills as a failing; however, this failing was repeated in later drills. No resolution of this was evident in the record of fire drills at the centre.
    - The drills were not reflective of the structure of the centre and did not take cognisance of the lack of disabled refuge space. Staff understanding of where to evacuate high dependency residents would significantly impact on evacuation times in the event of a fire.
    - Fire drills were not adequate to assure inspectors that residents would be evacuated safely in a timely manner. No evidence of a practice of evacuation to the external assembly point was available.

The registered provider did not make adequate arrangements for detecting or containing fires. For example:

- The centre was equipped with a category L1 fire detection and alarm system. However, inspectors noted devices to detect fire were not in place in a sluice room or in some of the storage spaces along the protected corridors.
- Measures in place to contain fire, smoke and fumes at the centre were assessed, with a number of areas requiring action. For example
    - Service penetrations through compartment walls were noted in a service shaft beside the lift on level five. Services penetrated the walls, floor, and ceiling of this area, which were not sealed to contain fire, smoke and fumes in the event of a fire.
    - An electrical services cupboard on the lower ground floor required action to ensure that containment measures were in place. A door fitted to the room recently did not have a fire rating visible, and some of the smoke seals were missing. There was no evidence of fire sealing of the door frame to the adjacent wall. A fire alarm cable penetrated the wall above the door and was not sealed. There were also chairs

stored within the room, which was contrary to the requirements to keep the room clear of any storage.
    - Inspectors could not be assured that a evacuation stairs from the second floor, which linked to the first floor was constructed as a protected stairwell. These stairs were linked to the floor below and were not fitted with a door at the lower level. Due to the lack of containment measures of the door at the second floor, this meant that the lift and corridor space below were not separated effectively from the floor above. This is a breach in the compartmentation of the building and could result in fire, smoke and fumes spreading more easily through the escape routes and floors in the event of a fire.
    - Inspectors could not be assured of the fire rating of several doors in the centre, due to issues with ironmongery, large gaps around doors, doors which were damaged, and some which did not close fully. This included bedroom doors, compartment doors and doors to ancillary rooms. A full assessment of the fire doors was required to ensure that they would perform as expected in the event of a fire.
    - Storage cabinets on the corridor near the central stairs on the first and third floors were not fire-rated cabinets.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident were assessed and an appropriate care plan was prepared to meet these needs. This could provide misleading information to staff and lead to errors or omissions in residents' care. For example:

- The content in the care plans did not reflect the most current condition and care plan proposed for a resident as there was historical data which was not valid.
- The care plans did not always reflect the findings and actions required from the validated nursing assessments. For example, where the residents' MUST (Malnutrition Universal Screening Tool) scored 2 or more, the weights of the residents' were not taken weekly as per the centre's policy but continued to be taken monthly, which was not in line with policy or best-evidence practice.
- The nutritional care plan did not reflect residents' baseline with respect to food and fluid intake.
- A care plan for a resident who was did not have a diagnosis of Diabetes had actions in place stating to monitor their blood sugar levels, without a reasonable rationale provided.
- The neurological observations were not completed following a fall where the head injury was documented as sustained.

Judgment: Substantially compliant

Regulation 8: Protection

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff spoken with demonstrated an appropriate awareness of their safeguarding training and detailed their responsibility in recognising and responding to allegations of abuse.

The registered provider was a pension agent for a number of residents, and a separate client account was in place to safeguard residents' finances.

Judgment: Compliant

Regulation 9: Residents' rights

There were facilities for residents' occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. Residents expressed their satisfaction with the variety of activities on offer.

Residents enjoyed access to communal and private spaces in the centre where they received visitors in private, watched television or listened to the radio without impacting others around them. They were also seen enjoying a coffee shop and chatting with their friends and loved ones.

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 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 24: Contract for the provision of services	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: End of life	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	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Belmont House Private Nursing Home OSV-0000014

Inspection ID: MON-0043166

Date of inspection: 30/07/2024

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	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The process of lodgments and withdrawals made by residents or their nominated visitor has been reviewed and improved by use of the electronic recording. This practice is audited regularly by the PIC to ensure compliance with the agreed procedure- complete

Enhanced supervision by clinical managers is in place to ensure improved guidance for clinical staff for care planning and specifically in the areas of falls prevention and management of residents following a fall. This is overseen by the Person in Charge who will conduct monthly care plan audits and post falls reviews. The findings will be included in the monthly governance meetings for review and trend analysis with the Regional Director- complete

The process of labelling all items of clothing on admission and throughout the stay of the resident has been reviewed to ensure greater efficiency. The laundry staff have received additional guidance in labelling and the management of all resident' s property in a more person centered manner- complete

By 31st December 2025, the maintenance team onsite will receive refresher training to conduct robust fire door audits 6 monthly to ensure that any emerging issues are identified and addressed in a timely manner

A further Fire Risk assessment is scheduled for H1 2025

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

The process of labelling all items of clothing upon admission and throughout the stay of the resident has been reviewed to ensure greater efficiency. There are no universal items of clothing currently in use in the centre. The laundry staff have received additional guidance in labelling and the management of all resident' s property in a more person centered manner- complete

The process of lodgments and withdrawals made by residents or their nominated visitor has been reviewed and improved by use of the electronic recording. This practice is audited regularly by the PIC to ensure compliance with the agreed procedure- complete

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The Kitchenette on Maple 1 Floor is now fully functional and accessible – complete

A process is now in place to improve communication with residents and families including timeframes for planned works in the centre which are likely to impact resident communal space or quality of life- complete

Works to increase the height of the balcony rail to 1.8m and replacement of decking is due for completion by 31/12/24

Hand wash sinks in bedrooms without en-suite facilities are scheduled for installation by 30/11/24

The storage cupboards blocked by the hoists have been emptied and are no longer in use allowing for greater accessibility & safer storage of the hoists- complete

The glass panel above the external walkway is scheduled for replacement by 30/11/24
A safety assessment identified that this shattered tempered glass will not break and therefore the space below is no longer deemed a risk and is fully accessible - complete

A schedule of works has been agreed to improve the floor and wall surfaces of the north eastern stairwell. These works are due for completion by 31/12/24

Regulation 28: Fire precautions	Not Compliant

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

Storage has been reviewed in the centre. All flammable items are now stored in the external housekeeping store- complete

The storage cupboards blocked by the hoists have been emptied and are no longer in use allowing for freer movement and safer storage of the hoists- complete

Fire rated doors and fire containment measures will be applied to storage cabinets and electrical service cupboards/ mains switch panels by 31st December 2024

Staff have been reminded of the importance of keeping fire escape route clear of obstructions. Adherence to this will be supervised on day and night shifts by the Person in Charge- complete and ongoing

The fire certificate for the building did not require such fire rating construction or compartments for the internal link stairs. However, taking on board the feedback to increase protection for residents, we propose to upgrade 30min fire doors in the 2nd floor corridor to 60min. This will allow an additional protection in addition to fire certificate granted. Works will be completed by 31 January 2025

Regarding disabled refuge space, a review of the fire certificate granted will be completed and where the building allows, upgrades to corridor doors will be completed from 30min to 60min to increase a safe space. Note building is as per the fire certificate granted. This will be completed by 31 January 2025.

An enhanced suite of Fire Training is now underway for all staff. All managers have received this training which includes the following:
(1) Training in alerting the fire brigade services
(2) Centre Specific Evacuation Simulations drills for maximum dependent residents
(3) Training includes simulation drills to the external assembly point
(4) Improved drill reports to identify actions required to improve staff response
(5) Improving knowledge and awareness of clinical managers to facilitate them to conduct increased frequency of drills with staff

Sluice room on Maple 1 and corridor outside the sluice room on Beech 1 have had smoke detectors fitted- complete

Works to identify any service penetrations and to seal them has commenced and will be completed by 31st October 2024.

A full assessment of all doors is being completed by an external expert this will be complete by 30th November 2024, this is to note any recommendation of works needed to fire doors and confirm if the appropriate thickness & material of the doors is aligned to 30 / 60 min doors. Post this review, fire doors issues noted by this external expert will be completed and separately where needed an external expert will review again the fire rating of doors. This will be complete by 31 March 2025

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:

Enhanced supervision by clinical managers is in place to ensure improved guidance for nursing staff with regard to care planning specifically in the areas of falls prevention and management of residents following a fall. This is overseen by the Person in Charge who is conducting monthly care plan audits and post falls reviews. The findings will be included in the monthly governance meetings for review and trend analysis with the Regional Director- complete

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	01/10/2024
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	30/12/2024

Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/06/2025
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.	Substantially Compliant	Yellow	31/03/2025
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/03/2025
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at	Substantially Compliant	Yellow	01/10/2025

	suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2025
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	01/10/2024