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:	Alzheimer's Care Centre
Name of provider:	J & M Eustace T/A Highfield Healthcare Partnership
Address of centre:	Highfield Healthcare, Swords Road, Whitehall, Dublin 9
Type of inspection:	Unannounced
Date of inspection:	30 November 2021
Centre ID:	OSV-0000113
Fieldwork ID:	MON-0034978

About the designated centre

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

Alzheimer Care Centre is a 154 bed centre providing residential and respite services to males and females with a formal diagnosis of dementia over the age of 18 years. The centre also contains a unit specific to meeting the needs of people with a diagnosis of enduring mental illness. The centre is located on the Swords Road at Whitehall in Dublin within easy reach of local amenities including shopping centres, restaurants, libraries and coffee shops. The original single storey building consisted of two units with capacity for 64 residents. A large extension containing a further 90 beds over three floors was opened in 2012. Accommodation for residents is across seven units. With the exception of the Ryall and Grattan units, the remaining five consist of single bedrooms with fully accessible shower and toilet en suites, dining and sitting rooms and access to safe outdoor garden areas. The centre also contains, a large oratory for prayers and religious services, activity rooms, hairdressing salons, coffee dock, several private visitors rooms and designated smoking areas.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	147

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 November 2021	08:35hrs to 18:45hrs	Niamh Moore	Lead
Tuesday 30 November 2021	08:35hrs to 18:45hrs	Deirdre O'Hara	Support
Tuesday 30 November 2021	08:35hrs to 18:45hrs	Jennifer Smyth	Support
Tuesday 30 November 2021	08:35hrs to 17:55hrs	Marguerite Kelly	Support

What residents told us and what inspectors observed

Inspectors found that the quality of life and care provided to residents was inconsistent between the seven different units within Alzheimer's Care Centre. Some residents spoken with described staff as being nice and helpful, including providing positive feedback about the activity provisions. Inspectors observed staff to spend one-to-one time with residents and it was evident that staff knew residents well. However, some residents described being unhappy with aspects of their care within the centre. Inspectors observed that the poor physical premises in the Ryall and Grattan units negatively impacted on the quality of life for residents. Inspectors found that there were gaps in oversight arrangements in a number of areas in the centre. These findings, and other areas identified as requiring improvement, are discussed under the relevant regulations in this report.

This was an unannounced inspection and on arrival at the centre, inspectors were met by two reception staff who guided them through the infection prevention and control measures necessary on entering the designated centre. This included the wearing of personal protective equipment (PPE) such as face masks, temperature checks and hand hygiene.

Following an opening meeting, two of the inspectors were guided on a tour of the premises with the person in charge. The centre is a purpose built facility based on a campus owned by the registered provider. The buildings comprised of seven separate units, each of which functioned as a self-contained unit with dining and sitting room facilities in all. The designated centre was across three floors, the ground floor, the first floor and the second floor.

Inspectors found that the quality of the physical premises varied across the units. In the newer part of the building, it was seen to be brightly decorated with murals of shop and country scenes for residents to enjoy. The Delville/ Lindsey, Drishogue, Addison, Coghill/Daneswell and Clonturk units were observed to have a higher quality finish and better maintenance. The majority of bedrooms were single bedrooms except Drishogue, which has one twin room. All bedrooms in these units had en-suite bathrooms.

The Grattan unit had single bedrooms with shared bathrooms. There were outstanding premises upgrades required to the Grattan unit which were an outstanding action from the previous inspection. The bedrooms within the Ryall unit were multi-occupancy rooms. Inspectors found the layout of these rooms did not allow all residents the right to live their lives privately and prevented residents from exercising choice related to their environment, due to residents within this area requiring staff assistance to put in place a mobile privacy screen.

Inspectors found that the cleanliness and facilities on the Grattan unit were poor for the 32 residents' residing there. While there was a Christmas tree seen within this unit, the poor state of repair and dirt took away from the festive decor. For

example, inspectors observed heavily stained brown splashes to chairs that residents were sitting on. In addition, there were extremely damaged chairs where the covers were ripped and torn exposing the foam part of the chair. Two bathrooms had an extremely pungent smell and were not clean. Inspectors spoke with some residents' from this unit who raised concerns regarding the housekeeping on this unit, one resident voiced "cleanliness is not great" and told inspectors that they felt embarrassed when they had visitors. Inspectors saw in a residents meeting record from October where residents raised dissatisfaction about the hygiene and housekeeping within this unit.

The Grattan unit had a large sitting room which had a wall mounted television, two armchairs in bad repair and boxes of Christmas decorations. Inspectors observed some residents to use this space throughout the inspection but found that the minimal decor did not lend itself to a homely environment. While a significant number of residents within this unit were seen to enjoy smoking, there was insufficient space for them to enjoy smoking together as the sheltered smoking area was small. There were trees and plant beds in the surrounding courtyard which had not been maintained.

Inspectors observed the end of the breakfast meal-time within the Grattan unit where eight residents ate their breakfast in the dining room. Vacant tables and chairs, had not been wiped down, and were seen to have dried food and spills on them. The dining tables had rust on the legs. Inspectors observed a lunchtime meal within the Clonturk unit, where seven residents attended the sitting and dining room for their meal. There was a calm atmosphere with music playing in the background, and staff were observed to be supportive to residents. On the Ryall unit, two staff were seen to stand over residents when assisting them with their lunch and other staff sat while they gently encouraged residents to have their meal.

Inspectors saw that access to meaningful and engaging activities was inconsistent across the seven units. In the Coghill unit, residents were watching an old film, which they appeared to enjoy. A priest also attended this unit and facilitated prayers and hymns, which residents participated in. However, there was little planned group activities occurring in the Grattan unit as the activity coordinator was seen to assist with the breakfast meal-time and left the unit to accompany a resident to an appointment. In the Ryall unit, there were no planned activities happening as there was no activity coordinator for this unit at the time of the inspection.

Most residents told inspectors that the staff were very nice and easy going. However, one resident told inspectors that "staff are staff, sometimes they are nice and sometimes they are grumpy". Some residents' said that while they felt comfortable speaking to managers if they were unhappy with something in the centre, they did not feel reassured that there would be appropriate action taken following their complaint or concern. Residents from the Grattan unit, expressed dissatisfaction with the provision of services and the care, support and assistance provided. Two residents told inspectors that they were unhappy with how an incident was being managed within this unit. They informed inspectors that they had shared their concerns with staff but felt they were not being heard.

During the course of the day, inspectors observed many visitors arriving to the centre. One family member who spoke with inspectors was delighted to be able to take their family member out again and others said they loved being able to use the coffee shop located on the ground floor for their visits.

Several residents in the Grattan unit were seen to be unkempt with poor standards of hygiene. Their clothing was not clean, some residents were unshaven and one resident did not have appropriate footwear and their feet were unclean. This level of poor personal care impacted on residents' rights to maintain their personal dignity. Inspectors did not observe this level of poor personal care in the other units.

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

Capacity and capability

Inspectors found that governance and management systems did not ensure that residents rights to privacy and dignity were upheld throughout the centre. Inspectors were not assured that the registered provider had sufficient oversight to ensure the safe delivery of care, particularly in the areas of cleanliness, access to mandatory training, supervision of staff, records, the management of verbal complaints and notification of incidents.

J & M Eustace T/A Highfield Healthcare Partnership is the registered provider for Alzheimers Care Centre. There is an established governance structure in place which includes the registered provider who is the Chief Executive Officer of the designated centre, a Chief Operating Officer and a Director of Services and Strategic Development, whom the person in charge reported to. Despite this clearly defined management structure, the provider's governance and management arrangements had failed to substantively address key areas of concern found by inspectors.

The person in charge was responsible for the day to day operations of the centre and was supported in their role by an assistant care manager and a number of clinical nurse managers (CNMs).

There were sufficient staff seen on the day of inspection. Inspectors were told that the designated centre had a number of staff vacancies which they were covering with agency staff. The registered provider had devised an action plan to look at incentives to retain staff and attract new employees to fill these vacancies.

Inspectors were provided with a training graph, which detailed the percentage of staff who had been supported to attend fire safety training, managing challenging behaviour, cardio pulmonary resuscitation, breaking the chain of infection and safeguarding training. However, inspectors were not provided with a training records to detail all mandatory training attendance within the designated centre.

This was requested on the day of the inspection and not provided to inspectors.

There was a nurse in charge of each shift who was supported by the management team, whose role was supernumerary to the roster. However, gaps were seen in supervision of staff in one unit on the day of inspection. Induction plans supported the management team to ensure new staff were developing in their role appropriately. There was also a six month probation period completed by all staff members. Inspectors reviewed a sample of probation reviews and found them to be comprehensive.

Two staff records were examined and were found to be in accordance with the requirements of Regulation 21 as set out in Schedule 2, which included evidence of the person's identity and Garda vetting disclosures. However, inspectors found that improvements were required to ensure all records within the centre were stored safely.

Inspectors reviewed records of management meetings within the centre. There was a variety of oversight arrangements and meeting forums which met on a regular basis, such as board meetings, senior management meetings, and CNM meetings. Minutes showed discussion about key performance indicators and topics relevant to service delivery, such as workforce, mandatory training, COVID-19, and incidents. Inspectors were not assured that the current systems in place ensured that the service provided was safe and effectively monitored.

Some meeting minutes did not have action plans developed and it was hard to ascertain information that related solely to the designated centre. For example, there was poor oversight of maintenance within the centre and management systems failed to ensure that the findings of the previous inspection were satisfactorily addressed. In addition, provider oversight failed to identify deficits in management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their physical or social environment), protection and infection control found by inspectors.

Some audits seen did not drive quality improvements within the centre. For example, an audit on care plans for the Grattan unit for September 2021 found 100% compliance with care plans. This audit did not identify findings of inspectors where incidents relating to responsive behaviours and safeguarding that had not been recorded with sufficient assessments and plans in place to address these risks.

The registered provider had completed an annual review of the quality and safety of care delivered to residents within the centre. The format of this review covered January 2020- June 2021 and was completed on 14 June 2021. The provider measured themselves against the National Standards for Residential Care Settings for Older People in 2016. The registered provider rated overall compliance as 91%. Inspectors found that some themes which found full compliance such as Theme 1: person centred care and support and Theme 5: leadership, governance and management did not reflect inspectors' findings during the inspection.

Improvements were required to ensure the registered provider had submitted

notifications to the Office of the Chief Inspector in accordance with the time frames specified in Schedule 4 of the Health Act 2007.

There was a complaints policy dated November 2020 which identified the person in charge as the complaints officer for the centre. Inspectors saw that the complaints procedure was displayed prominently within the centre. Inspectors reviewed a sample of the closed complaints from the complaints register. Complaints were seen to be recorded in line with the regulations. However, not all complaints were seen to be investigated in a timely manner and inspectors found improvements were required with the management of verbal complaints.

Regulation 15: Staffing

On the day of the inspection, inspectors found that there was a sufficient number and skill mix of staff for the 147 residents.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors were not assured that all staff had access to all mandatory training. No evidence on attendance at manual handling training was provided.

Inspectors saw that due to poor supervision and allocation of staff, there were two staff in one unit to provide supervision for 32 residents while other staff went on their break. Inspectors found that this level of staffing was not appropriate, as the layout of the unit did not lend itself to the close supervision of residents with this reduced staffing level.

Inspectors were told that some residents had responsive behaviours, and regular supervision was required which was outlines in their care plans. There were gaps seen in supervision records for these residents.

Judgment: Substantially compliant

Regulation 21: Records

Information was not readily available to inspectors during the day of inspection. In addition, information requested following the inspection was not received, or was received outside the requested time frame. For example,

- Staff training records were requested and not made available on the day of inspection to identify the staff who had participated in training and what staff were booked for future training.
- Worked staff rosters did not detail that all vacancies had been covered in the weeks prior to the inspection.
- Records of deceased residents were not stored safely.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that the registered provider needed to improve the overall governance and management systems in the centre in order to ensure effective oversight and the sustainability of the safe delivery of care. For example:

- The registered provider had failed to make the improvements required to the Grattan unit, which were identified at the last inspection.
- Maintenance requests were not actively monitored to ensure that the premises met the required safety standards, such as a working call bell system.
- Robust oversight of premises issues which impacted on the infection control measures, fire safety and residents rights was required.
- Inspectors were not assured that the information documented from audits and incidents were analysed sufficiently as they had failed to identify issues found on this inspection. This included infection control audits which did not have quality improvement plans highlighting deficits and a responsible person identified to drive the required changes.
- The provider had not ensured that the fire evacuation procedures, such as compartments, were adequately identified so that they could be effectively monitored to ensure safe and timely evacuation of the centre in the event of an emergency.
- The registered provider failed to have sufficient oversight of safeguarding measures within the designated centre. Inspectors were not assured that the information documented in incident reports was analysed sufficiently to ensure all incidents or allegations of abuse were investigated appropriately and all measures to protect residents from abuse were implemented.

Judgment: Not compliant

Regulation 31: Notification of incidents

Inspectors found evidence where numerous notifications were not submitted to the

Office of the Chief Inspector as required in relation to:

- The unexplained absence of a resident from the designated centre.
- Any allegation, suspected or confirmed of abuse.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors were not assured that all complaints were investigated promptly. Inspectors reviewed the complaints log which recorded that a verbal complaint received was not acted upon in a timely manner. In addition, inspectors saw that complaints made within residents' meeting minutes were not recorded on the complaints register.

Judgment: Substantially compliant

Quality and safety

The findings on the day of inspection were that the provider was delivering good quality clinical care to residents with residents in most of the units were seen to have good access to healthcare. Most residents had opportunities to participate in activities in accordance with their interests and capabilities, however this was not seen for all units. Improvements required were identified within meeting residents assessed care needs, restrictive practices and managing responsive behaviours, protection, residents' rights, the oversight and maintenance of the premises, infection control and fire precautions.

Inspectors reviewed a sample of care plans and found that residents were comprehensively assessed before admission, care plans developed within 48 hours of admission and reviewed at regular intervals thereafter if residents' needs changed. There was evidence that residents were assessed by healthcare specialists and care plans were subsequently updated. Residents and their relatives, where appropriate, were consulted in the development and review of the care plans. However, inspectors found examples where residents' assessed needs were not met. One resident spoke to inspectors regarding their personal hygiene preferences. This resident told inspectors that they did not have their personal hygiene request need met, despite requesting assistance from staff on the day of inspection and the preceding days prior to the inspection. Inspectors reviewed this residents care records and found that the last entry in relation to this specific hygiene need was recorded on the 12 November 2021.

Inspectors observed that residents' health care was maintained by a good standard

of evidence based care and appropriate medical care intervention. Residents had timely access to a consultant geriatrician with psychiatry of older age that was available on the campus. Two general practitioners (GP) were available to residents with D Doc contactable during out of hours. Timely referral to allied health and social care professionals' was made when required or requested. Eligible residents were supported by the provider to access national screening services. End of life care was supported by a nearby hospice.

While inspectors found that the designated centre identified challenging behaviour as a risk on their risk register, inspectors found that some residents with responsive behaviours did not have individual risk assessments in place. Inspectors found that there was inconsistency in the management of responsive behaviours within the designated centre.

Inspectors reviewed the restraints register for the centre and found this did not incorporate all restraints. Staff members spoken to on the day of inspection were also unaware of all the different types of restraint. For residents who were unable to give consent, there was no evidence of multi-disciplinary recommendations. There was no evidence of a multi-disciplinary approach prior to the introduction of two bedrails.

Inspectors reviewed incident reports relating to one resident where incidents of responsive behaviour had occurred. This resident had no safeguarding risk assessment or plan in place to ensure that this resident was protected from abuse. Inspectors discussed this with staff and were told there were no safeguarding concerns for this resident. Thus inspectors found that there were gaps in staff knowledge on the detection, prevention and responses to abuse.

Inspectors observed some units had good activity provision, inspectors reviewed activity attendance records from the Grattan unit and found that residents' were regularly supported to attend one-to-one and group activities such as coffee mornings. However, the activity board in the Ryall unit recorded an activity was due to take place 'in the morning', however by 11am, staff from this unit did not know when this activity would take place. Inspectors found that this did not allow residents' to pre-plan their day.

While residents' meetings were occurring every three months in the Grattan unit, the last meeting was held on 19 October 2021 and residents' were not provided with the outcome of their feedback. Minutes showed that residents' requested alternative food options, more channels on the television and one resident raised a concern about their call bell not being answered in a timely manner. Inspectors were told that all items had been raised with management. There was no update available on the outcome and inspectors were informed residents' would be updated on the progress at the next meeting scheduled for 20 January 2022.

Inspectors were also not assured that the bedrooms of the Ryall unit would meet the size and occupancy requirements, without reconfiguration, which are contained in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016 S.I. 293 which is due to take effect

on 1 January 2022. Inspectors found examples where the observed design and layout of these bedrooms did not afford each resident a minimum of 7.4 square metres of floor space. The occupancy of rooms within the Ryall unit was also for five or six residents which is above the maximum number of four residents per room. Inspectors raised this with the management team and requested a review of the layout of these rooms in order to ensure that they complied with S.I 293 by 1 January 2022.

The maintenance and upkeep of the Ryall unit and newest part of the building were of sound construction. Inspectors were informed that half of the rooms in the Grattan unit had been refurbished, following the last inspection, and that upgrades had ceased due to the COVID-19 pandemic. This meant that the remaining rooms still required refurbishment. Other areas that needed improvement to meet the standards expected were identified. For example, there was insufficient call bells accessible from each resident's bed in the Ryall unit and the size of the smoking area in Grattan unit did not meet the needs of the residents using it. Furthermore, a review of storage of resident's possessions, maintenance and upkeep of internal flooring and courtyard grounds, to ensure that they were suitable and safe for use by residents, was required.

The centres' risk management policy contained all the requirements of the regulation, and specified risks were either part of the policy or referenced and described in accompanying policies. The risk register was discussed within board meeting minutes reviewed by inspectors.

There were some good infection control processes in place, however a number of improvements were required. The provider had recently recruited a part-time infection control nurse to support the two designated centres within the provider group. There was infection control policies available including up to date guidance from the Health Service Executive and the Health Protection Surveillance Centre. The COVID-19 response plan was extensive and described how each unit would act in the event of a COVID-19 outbreak. Some good practice was seen for example, the cleaners' room and equipment was clean, and the flushing of frequently used outlets was in place to help prevent the potential growth of legionella in stagnant water. However, the water temperatures checked in four resident and two clinical sinks felt too cool, and thus there was a risk of legionella growth in the water supply. There was an early recognition of a resident with potential COVID-19 symptoms. This resident was isolated and swabbed, yet, there was no PPE station set up outside the room. Further fundamental gaps in infection control within the centre will be discussed under Regulation 27: Infection Control.

Inspectors found that the centre was laid out in a manner that provided residents and staff with an adequate number of escape routes and fire exits. Alternative escape routes were available throughout and the provider had recently replaced all fire extinguishers. However, inspectors were not assured that the provider had sufficient oversight of fire precautions within the centre. While inspectors noted that all units were provided with an emergency lighting system, fire detection and alarm system and fire fighting equipment throughout, there was insufficient directional signage in two of the units. Further concerns in relation to the oversight of fire

precautions are recorded under Regulation 28.

Regulation 17: Premises

Some areas of the premises were not appropriate to the number and needs of the residents:

- There was insufficient area for smoking outside the Grattan unit. Residents were seen to sit very closely together and standing around smoking as there was insufficient seating for them.

Some areas of the premises did not conform to the matters set out in Schedule 6 of the regulations:

- Outside the fire escape on the Lindsay unit there was a large gap approximately 15cm between the raised footpath and the wall with no safety railing or wall. This could pose a trip hazard for residents or hinder residents if the area was required during an emergency evacuation.
- Footpaths leading from emergency exits from the Grattan unit were covered by moss and could pose a trip or slip hazard when used.
- There was only one call bell available at a bedside in one of the five-bedded multi-occupancy rooms in the Ryall unit should residents need assistance or for staff to alert each other in an emergency situation.
- Inspectors were informed that the call bell system in the Ryall unit had been turned off two weeks previously. There was no records made available to inspectors to show that it had been reported or followed up.
- External court yard in Grattan unit was littered with large amounts of leaves, continence wear, two full black plastic bags and two skip bags.

Inappropriate storage was observed:

- The housekeeping room contained items used for cleaning but also there were two inappropriately stored boxes which were holding clothes and food belonging to staff members.
- There was insufficient storage for resident's belongings in the Grattan unit, where resident belongings were seen to be stored in a general store room in plastic bags. It was seen to be stored next to PPE and a fuse box.
- Inappropriate storage was seen in assisted bathrooms in the Grattan unit and armchairs in the sluice room in the Lindsay unit.

Equipment and areas of poor repair were observed:

- Tiling in one bathroom in the Grattan unit was falling off the wall exposing plaster board which could not be cleaned.
- Flooring in communal room within the Clonturk unit was damaged with a large scrape through the floor covering.
- Flooring along the corridors and at fire doors of the Grattan unit was

generally stained, ripped and had gaps in the heat seals.
- Four out of four mattresses checked from a variety of units were worn, torn and cracked.

Judgment: Not compliant

Regulation 26: Risk management

There was a risk management policy in place dated April 2021 that included the information set out in the regulations. The registered provider had a suite of policies within their risk management framework. The registered provider had a major emergency plan which included the measures to take for emergencies such as fire, severe weather and flooding.

Judgment: Compliant

Regulation 27: Infection control

Improvements were required to ensure the registered provider was in compliance with the National Standards for Infection Prevention and Control in Community Services 2018. For example:

PPE and hand hygiene practices required review:

- There was no alcohol gel in rooms or staff wash hand basins, residents' wash basins should not be used for staff hand hygiene.
- There was no hand towels seen at a clinical hand wash basin.
- Some staff were seen with nail varnish and wrist watches which makes hand hygiene very difficult.
- Evidence of extensive use of vinyl gloves which offer limited protection against chemical or biomedical exposure.

Cleaning schedules and processes required review:

- The hygiene of the Grattan unit was poor. For example floors, furniture, walls and surfaces were very unclean, splashed with an assortment of fluids or similar.
- A shower room in the Grattan unit had an extremely pungent smell and was not clean.
- Shampoos and a wet towel was left in a sink within the Grattan unit for a considerable length of time, and were still in the sink at the end of the inspection.
- The nebulizer compressor machines within the Grattan unit were not clean

and the white filters did not appear to be changed as they were heavily stained brown.
- Several cleaners who spoke with inspectors gave the wrong dilution for using chlorine bleach. The policy guiding them also recorded the wrong dilution strength.
- Although the cleaning cloths were colour coded the mops were not.
- Four staff spoken to were unsure of the procedure for needle stick injury and how to clean up blood spills.

Storage of items created a cross-contamination risk:

- Despite the large size of the building, storage space on the units was limited. As a result there was inappropriate storage of equipment. For example, resident equipment such as wheel chairs and chairs were stored in the dirty utilities. Linen and resident stores such as gloves and continence wear were stored together.
- There were many examples of storing items on the floor which makes cleaning of that area very difficult and items may get contaminated.

Waste management required review:

- Inspectors observed the inappropriate placement of healthcare risk waste bins in resident bathrooms.
  Sanitary bins in the Grattan unit were left exposed with no lid in place and the areas where they were stored had a very offensive smell.

A review of single-use items was required:

- There was evidence of storing opened, partially used sterile dressings with unopened dressings. All resident equipment and supplies with single use sign should be discarded after use.
- Extensive evidence of communal toiletries in bathrooms and communal areas.
- The centre was using 'top-up' bottles for soap, shampoos and similar which encourages 'communal' use of products.
- There was multiple evidence that the centre was sharing hoist slings instead of resident's having their own slings.
- Evidence of communal hairdressing supplies and an electric razor seen were extremely unclean.
- The nebulizer acorns were being re-used and left sitting on the nebulizer compressor between doses. If the acorn is single use then it should be discarded after one use, if single resident use it should be cleaned and dried as per manufacturers recommendations.

Judgment: Not compliant

Regulation 28: Fire precautions

There were a number of areas of concern regarding the adequacy of fire precautions in the centre and improvements were required to comply with the requirements of the regulations, to ensure that residents and staff were adequately protected from the risk of fire. The registered provider was not taking adequate precautions against the risk of fire:

- In all units, there was a procedure to be followed in the event of a fire. However, there were no floor plans included and staff were not informed of the correct fire compartment boundaries to ensure safe evacuation of residents.
- Staff had not had up-to-date training in the use of fire fighting equipment.
- There had been no night time simulated fire evacuation drills to give the provider assurances that all persons in the centre could be evacuated in a timely manner in the event of an emergency.
- The most recent records for the servicing and testing of fire alarms, fire detection systems and emergency lighting was not available in the centre.
- Two fire doors were noted to have excessive gaps in the Coghill unit where double doors led to another designated centre.
- The fire door leading into the sitting room in the Grattan unit was damaged and a large gap was seen between doors when they were closed and part of the smoke seal was missing.
- The smoke seal on two doors was peeling away in the Lindsay and Clonturk units.
- In the Drishogue unit, a fire extinguisher was insecurely stored on the ground, as the wall bracket was damaged.
- Chairs in the external smoking area in the Grattan unit were not fire retardant, there was no smoking apron or blanket seen in this area. A plastic bag was hung from a large metal ashtray containing combustible material.

Inspectors were not assured that adequate means of escape was provided throughout the centre:

- Additional escape signage was noted to be required in the Grattan and Drishogue units to ensure directions of escape and exits were apparent.
- The access to two fire extinguishers were obstructed by furniture in the centre.
- An emergency exit door in the Addison unit was externally obstructed by three chairs and a large metal ash tray. The exit was blocked by a large white board in Grattan and a couch in another communal sitting room.
- There was a potential risk to resident safety as there was storage of equipment, furniture and large boxes for Christmas decorations in the emergency refuge areas which could cause a trip hazard or impact the area should it be required in the event of an emergency evacuation.
- Emergency directional signs were partially blocked from view on the first and second floors with Christmas decorations. The provider gave inspectors assurances that these had been removed on the inspection day.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

In the sample of care plans reviewed, inspectors found that not all residents' needs were met with regard to their personal hygiene and residents' choices. For example, one residents request for personal hygiene was not met despite the resident informing inspectors that they had requested assistance from staff. There was no smoking risk assessment and associated care plan for another resident.

Judgment: Substantially compliant

Regulation 6: Health care

Suitable arrangements were in place to ensure each resident had access to a GP and other specialist medical professionals. All recommendations made by these specialists were integrated into the care given to residents. Examples such as specialist seating and wound care were seen to be available and accessible by residents.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The restrictive practice register presented to inspectors did not include all environmental restraints in operation on the day of inspection. For example, the register did not indicate practices where residents were unable to exit their unit without the assistance of staff, due to the door being locked. In addition, the use of sensor alarms were not included on this register.

Inspectors found that for the care plan in place for one resident had not been followed. For example, the care plan documented that the guidance of the resident's medical professional was that they should be advised of any further incidents of aggression. Inspectors saw this had not occurred following two incidents of responsive behaviour. In addition, inspectors were not assured that this residents responsive behaviours were being managed appropriately as there was no risk assessments in place or recorded analysis of repeat incidents.

Inspectors found inconsistencies in the management of behaviours that challenge. For example whilst one resident within the Coghill unit had an antecedent behaviour chart which recorded events prior to responsive behaviours, another resident who

displayed similar behaviours in the Grattan unit, did not have such a record in place.

Judgment: Not compliant

Regulation 8: Protection

The Safeguarding policy had not been updated to reflect the centre's current designated safeguarding officer.

Inspectors were not assured that the registered provider had taken all reasonable measures to protect residents from abuse. For example, one resident whom inspectors were told had a history of incidents of peer-to-peer abuse, had no safeguarding risk assessment or safeguarding plan in place.

Inspectors also reviewed one safeguarding incident and found this had been closed without a sufficient investigation. Inspectors were communicating with the registered provider regarding this at the time of writing this report.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors were not assured that residents' rights within the Ryall unit to undertake personal activities in private were respected. For example, this unit had multi-occupancy rooms where residents were seen to be sleeping without privacy screens. Inspectors were told there was one screen available per area and as a result, while showing inspectors privacy screens, staff removed a screen from a resident during personal care.

Improvements were required in how the centre consulted and supported resident participation in the organisation of the designated centre. For example, meetings in some units occurred every three months and residents' had to wait for the next meeting to be informed of the outcome of their feedback. In addition, there was no consultation with residents' in the Ryall unit. Inspectors were told that no family or contact person surveys or communication were completed to ensure that the residents and families had a voice.

Inspectors were informed that the Ryall unit did not currently have an activity coordinator. The activity schedule seen on the day of inspection did not record the time activities were to take place. In addition, inspectors reviewed one resident's activity care plan which detailed that the resident enjoyed visits from the therapy dog. There was no record of when this resident was last visited by the therapy dog and three staff spoken with were unable to tell inspectors if visits were regular.

Judgment: Not 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	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Alzheimer's Care Centre OSV-0000113

Inspection ID: MON-0034978

Date of inspection: 30/11/2021

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1) Power PI Mandatory Training dashboards (which provide a summarily level of management information on training) were provided on the day of inspection. Detailed manual handling and Covid swabbing records were subsequently provided post inspection. The Training Committee will ensure that a training plan for 2022 will be reformatted to include details of mandatory training provided, dates on when it is carried out and records of attendance. Proposed timeframe: 31st March 2022 2) The unit has staggered break times and the CNM's will oversee staff adherence to this ensuring that staff are based on the floor during break times. Proposed timeframe: Completed 3) The CNM2 and CNM1 (Grattan) will continue to carry out regular care plan audits to ensure they address all resident needs. They will also monitor supervision arrangements as outlined in resident care plans to ensure there are no gaps in staff supervision of residents. Proposed timeframe: 31st January 2022	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records:	

1) The files of deceased residents have been removed from the unit (Ryall unit). CNM to conduct regular audit on records management on the unit and remind all staff to ensure all files are locked and files of deceased residents archived correctly. We are in the processing of introducing new system of records management and archiving.
Proposed timeframe: 31st March 2022

2) PIC to ensure worked rosters are maintained locally for inspection including last minute changes in staffing.
Proposed timeframe: Completed.

4) The Training Committee will continue to monitor mandatory training records and ensure all staff training records are readily available on inspection and up to date.

Proposed timeframe: 28th February 2022.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Development plan will be put in place to support local CNM's and improve supervision at Unit level. As part of a review of governance structures, a nursing home forum is to be established to ensure improved oversight at all levels. Completion of action plans will also be overseen by the Quality, Safety and Service Improvement group.

1) We are reviewing facilities management requirements to improve oversight of premises, infection control, and health and safety.

Proposed timeframe: 30th June 2022

2) A revised refurbishment plan of Grattan is now being finalized. This will include the provision of more suitable furniture that will better meet the needs of this client group. A number of damaged items have been removed and replaced.

Proposed timeframe: 30th June 2022 (subject to delivery lead times)

3) CNM2 to ensure all maintenance issues are logged and follow up with maintenance if any issues not resolved. The Maintenance Manager will monitor completion of all maintenance requests and print monthly maintenance logs for each unit. Monthly unit meetings. All issues to be monitored via Unit meetings and also at the new Nursing Home Forum.

Proposed timeframe: 31st January 2022

4) The CNM2 and CNM1 for Grattan unit will monitor all incidents and audits and ensure action plans are devised for non- compliances and follow up safeguarding plans implemented for safeguarding incidents. IPC nurse will support IPC practices and action planning for any non-compliances. Additional designated officer support will be identified. The Designated officer for the centre will support the management of all safeguarding incidents arising out of challenging behaviour on the unit. All incidents of safeguarding will be discussed at quarterly safeguarding meetings to ensure appropriate and sufficient actions have been taken to mitigate risks. Monthly unit meetings take place and these areas are reviewed at the meetings.

Templates for action plans will be revised to clearly include details on who is responsible for follow up and agreed timelines for completion.

Proposed timeframe: 31st January 2022

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1) PIC and ADON will monitor closely all allegations, suspected or confirmed of abuse ensure notifications are submitted to the Office of the Chief Inspector as required. Issue was brought to the Safeguarding committee in December and a sub -group is being convened to review peer to peer challenging behaviour and how best to notify, manage and the policy reviewed accordingly. Additional training has been procured for Designated Officers for March to upskill more staff in this area. The safeguarding committee will continue to monitor all incidents of safeguarding to ensure appropriate actions have been taken. The Safeguarding Committee reports to the Quality, Safety and Service Improvement Committee.

Proposed timeframe: 31st March 2022

2) There were four incidents reported internally of an unexplained absence of a resident from their unit in 2021. None of these incidents involved a resident leaving the designated centre. These were not reported as the residents did not leave the designated centre. No harm came to any resident.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints

procedure:
1) The Quality & Patient Safety Department issued a reminder to all units and CNM's in December to ensure that all complaints and feedback is logged on the online feedback system. This will be reinforced at unit level meetings. This includes a new system of logging feedback provided at resident meetings to enable CNMs to monitor all complaints and ensure they are followed up and acted upon in timely manner. A new nursing home forum is being established and this will be a standing item on the agenda.

Proposed timeframe: Completed

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1) In relation to the gap between the raised footpath and the wall outside the fire escape on the Lindsay unit, a risk assessment is being carried out to identify fall hazards. Remedial action to be taken as required, including the removal of moss from pathways and a grab rail erected.

2) The primary purpose of the system on that unit is for staff. The repair of call bell system on Ryall unit is being fixed.

Proposed timeframe: 31st January 2022

3) Initial cleaning of the garden is underway. The Grattan smoking area, courtyard and garden is to be reviewed with additional cleaning carried out. Smoking aprons are available on the unit. The garden will be reviewed as part of refurbishment plans.

Proposed timeframe:30th June 2022.

4) Additional storage areas will also be identified by the PIC. Floor plans will be reviewed by the Chief Operating Officer with current practices and existing space with the aim to assign designated storages.

Proposed timeframe: 31st January 2022

5) Tiling on Grattan unit has been under review by Maintenance Manager and will be replaced.
Proposed timeframe: 31st January 2022

6) A mattress audit will be being implemented and a programme of replacement implemented, where necessary. A log will be maintained of all equipment to ensure appropriate servicing and maintenance.

7) Floors on Grattan will be repaired and flooring in other units is being examined with a

view to remedying issues identified.

Propose timeframe: 1st April 2022

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The organization appointed a part-time IPC nurse in October 2021. The IPC nurse along with our IPC committee will oversee and monitor all IPC matters and actions arising. More specific details are provided below.

1) More alcohol gel dispensers have been ordered for all units. The number and use of hand gels will be kept under review by the IPC Nurse and IPC committee.
Proposed timeframe: 31st January 2022

2) Education is ongoing by CNMs to all clinical staff that they should be free from nail polish, wrist watches and jewellery, to ensure adherence with policy Hand Hygiene audits are completed by CNMs on monthly basis. More regular spot checks are performed by CNMs to ensure compliance with the IPC policy. The IPC nurse will continue to provide information, education and demonstration on proper hand hygiene.
Proposed timeframe: 31st January 2022

3) The IPC nurse will demonstrate and provide education on the correct usage of gloves with staff and ensure the appropriate gloves are worn.

Proposed timeframe: 28th February 2022

4) Close monitoring is ongoing by housekeeping to ensure enough hand towels are provided at clinical hand wash basins. Local management to utilise reporting systems that are in place.

5) The cleaning policy of external cleaning company has been corrected and updated with correct formula and the IPC nurse has met with and will consult with the Cleaning Supervisor on correct formulations.
Proposed timeframe: Completed.

6) The cleaning hours are being increased on Grattan unit and a deep cleaning has been completed. A weekly audit will be completed by the CNM and the cleaning company.

Proposed timeframe: 31st January 2022

7) Storage on all units is being reviewed by PIC to identify additional storage areas.

Proposed timeframe: 31st January 2022

8) Waste management education is ongoing by the IPC nurse. Memos were issued in December to all staff to ensure correct procedures are being followed in waste management and the management and cleaning of sanitary bins. Higher level of monitoring to be carried out at unit level.
Proposed timeframe: completed.

9) All staff have been reminded to dispose of all single use items once used. The IPC Nurse will review practices on the unit around toiletries to ensure correct procedures are being followed and appropriate IPC measures are being taken. All residents to use their own hairdressing supplies and razors. Single use razors in use.
Proposed timeframe: 31st January 2022

10) Each resident has their own nebulizer mask. The machine is being cleaned as per IPC policy. SOP on cleaning of equipment is prepared by CNM and ADON. IPC education is ongoing by IPC Nurse.
Proposed timeframe: 31st January 2022

11) A manual handling audit is being completed on Ryall and all slings will be reviewed by Physiotherapist and Therapeutic Service Coordinator as part of the audit and new slings will be ordered to ensure all residents have their own sling.
Proposed timeframe: 31st March 2022

12) We have met with the cleaning company with a view to correct usage of mops. We have also been seeking advice from the HSE on this area.

Proposed timeframe: 28th February 2022.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Prior to inspection, we had commissioned a fire consultant to review all fire safety practices and ensure we are up-to-date with best practice. Below are some specific actions being taken.
1) All units have an emergency evacuation plan available. In addition to this, floor plans to illustrate compartments will be made available on the corridor of all units for safe evacuation in case of a fire.

Proposed timeframe: 28th February 2022.

2) A series of day- time drills had been completed. Have these been documented? Night-time fire evacuation drills will be simulated by CNM and ADON to ensure all staff is

familiar with the emergency procedures.
Proposed timeframe: 31st March 2022

3) Records of fire servicing and testing, fire detection and emergency lighting are available and further details requested were sent to the Inspector.
Proposed timeframe: completed.

4) The bracket for the storage of fire extinguisher on Drishogue unit is being fixed by Maintenance.
Proposed timeframe: 31st January 2022

5) External fire Consultant reviewing all fire doors as part of the wider fire safety review commissioned in early November to ensure they are in good working order.
Proposed timeframe: 30th June 2022

6) The PIC and Maintenance Manager have reviewed the courtyard and smoking area to ensure suitable fire retardant chairs as well as smoking aprons/blankets are in place. Unsuitable chairs will be replaced. These areas will be added to a more regular cleaning schedule.

Proposed timeframe: 30th April 2022

7) Escape signage on Grattan and Drishogue unit to be reviewed by the fire consultant with a view to establishing where additional signage may be required. Additional signage is being procured, as required.

Proposed timeframe: 31st January 2022

8) Fire exits on all units are checked daily by CNM/staff nurse to ensure no obstruction of exit in case of an emergency.

9) In spite of the Covid-19 pandemic, fire training continued through blended learning. This included the move to an online training platform, table- top exercises at unit level and post fire drill debriefing. The current fire training provided to staff will be reviewed by the fire Consultant and H&S committee to ensure it is compliant with the regulations.

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:
1) Care plan audits are completed by CNMs on monthly basis to ensure each care plan addresses all needs of the resident including personal hygiene and choices. Education is ongoing by PIC and CNMs to ensure all residents are supported in line with their

assessed needs and preferences.

Proposed timeframe: 31st January 2022

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
1) The Occupational Therapist is rolling out specific restrictive practice training for staff which will cover the types of restrictions, risk assessment, and documentation. MDT review to take place periodically of all restrictive practices being used and documented. The restrictive practice register is in process of updated by ADON and DON to ensure all restraints are included.

Proposed timeframe: 31st January 2022

2) Refresher education to be held with staff on managing challenging behaviours to ensure a consistent approach is adopted. This shall include the recording and monitoring of these behaviours. For each resident that displays challenging behavior individual risk assessment will be in place. A standardized template will be introduced to support documentation.

Proposed timeframe: 31st March 2022.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1) The safeguarding procedures have been reviewed and updated. The safeguarding policy will be formally revised. A more thorough review of the policy will take place during the year. Additional supports put in place for designated officers and a new forum that meets monthly is in place for support designated officers. The Safeguarding committee will oversee and report directly to the Quality, Safety and Service Improvement committee.
Proposed timeframe: 31st March 2022

2) Educations is ongoing to all staff by PIC and ADON to ensure all peer-to-peer incidents are recorded with risk assessments and safeguarding plans being put in place where the need is identified.

Proposed timeframe: 31st March 2022

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1) We have reduced capacity on Ryall unit to ensure sufficient privacy for all residents is maintained at all times including during the delivery of personal care. Additional privacy screens are being reviewed on the four bays in Ryall.

Proposed timeframe: 31st January 2022

2) Quarterly resident and/or family meetings/consultation to takes place on all units. A record will be maintained of all meetings and consultations. The outcome of each meeting will be documented and communicated back to residents/families by CNM's/AT's before the next meeting. These minutes will be brought to local management meetings to ensure all actions have been followed up. Minutes will also be logged on our feedback system to ensure appropriate close out. Family meetings have been on an individual basis online during the pandemic. A family survey is planned for Q1/Q2 2022.

Proposed timeframe: 28th February 2022

3) There are five Activities therapists in the centre. Volunteers also support activities and were doing so on the day of inspection. A new Occupational Therapy Assistant (OTA) has started on Ryall unit as this role was determined to best meet resident needs. The OTA will introduce herself to residents and families and find out what activities residents/families would like to see take place on the unit. Records will be maintained of attendance at all activities.

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)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/03/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/01/2022
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	01/04/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular	Not Compliant	Orange	30/06/2022

	designated centre, provide premises which conform to the matters set out in Schedule 6.			
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.	Not Compliant	Orange	28/02/2022
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	31/03/2022
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	31/01/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/03/2022

Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/04/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	18/01/2022
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/04/2022
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	31/03/2022

	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	28/02/2022
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	28/02/2022
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	31/03/2022
Regulation 34(1)(d)	The registered provider shall	Substantially Compliant	Yellow	18/01/2022

	provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	31/01/2022
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	31/03/2022
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	31/01/2022
Regulation 8(1)	The registered provider shall take	Not Compliant	Orange	31/03/2022

	all reasonable measures to protect residents from abuse.			
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	31/01/2022
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.	Not Compliant	Orange	31/01/2022
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	31/03/2022