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:	17 January 2024
Centre ID:	OSV-0000014
Fieldwork ID:	MON-0042498

About the designated centre

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

Belmont House is a 157-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 health care as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	145

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 17 January 2024	18:30hrs to 21:00hrs	Helena Budzicz	Lead
Thursday 18 January 2024	07:50hrs to 18:50hrs	Helena Budzicz	Lead
Thursday 18 January 2024	07:50hrs to 18:50hrs	Aislinn Kenny	Support
Thursday 18 January 2024	07:50hrs to 18:50hrs	Geraldine Flannery	Support

What residents told us and what inspectors observed

This inspection was conducted over two separate days. The inspectors spent time in the centre to see what life was like for residents living at Belmont House Private Nursing Home. The atmosphere in the centre was relaxed and calm. Some residents told the inspectors that they 'felt safe in the centre and were well cared for by staff'. Other residents, due to speech or cognitive impairment, were unable to elicit their opinion on the service being provided in the centre; however, they appeared happy and content in their interactions. Inspectors found that although the residents were well cared for by staff, some significant improvements were required to ensure the safety of the residents and compliance with the regulations which will be discussed further in the report.

The first day of the inspection commenced in the evening at 18:30hrs. The inspector was welcomed to the centre by the receptionist. A brief introductory meeting was held on the first evening of inspection with the clinical nurse manager (CNM). The person in charge (PIC) arrived shortly after and completed a walkaround the premises with the inspector. There was an outbreak of COVID-19 infection in the designated centre, which had impacted a small number of residents in one of the units.

There were 145 residents residing in Belmont House Private at the time of inspection. The resident accommodation is set out in seven units over seven floors: Beech Unit 1, Beech 3 Unit, Cedar Unit, Evergreen Unit, Maple 1 and 2, and Oak Unit.

Inspectors observed that the reception area and foyer appeared calm, bright and inviting. There was a coffee dock provided for all residents and their visitors. This had a coffee machine, various minerals, water and treats and comfortable seating for residents to relax in. Only a small number of residents and visitors were observed using this space on both days of inspection. The inspectors observed many residents spending time in the Evergreen Unit, sitting in the main communal day room watching TV or conversing with the staff members on both days of the inspection. On the floors where there were no communal areas, residents were observed eating their food in their bedrooms, while others who had communal areas had their meals in the communal space. While the dining experience was limited due to the COVID-19 outbreak, inspectors observed that the food appeared appetising and nutritious. Staff were observed to be respectful and assist residents discreetly during meal times.

On the second day of inspection, residents who had a communal room in their unit were seen to spend long periods of time in their chairs, with limited stimulation other than music or television playing in the background. Several singer-musicians were observed in the centre throughout the day of inspection. Due to the COVID-19 outbreak, they were observed playing at the lift on each unit or in the corridors outside rooms. There was an extensive programme of activities on display.

However, inspectors were not assured that all activities took place as planned. For example, the crafts activity on the Maple unit between 15.00hrs and 16.00hrs due to take place on the day of inspection did not happen. In a satisfaction survey in 2023, relatives asked that activities would be broader and more sensory for residents so all residents could enjoy activities suitable to their interests and capacities.

Residents had access to communal day spaces in the reception area and other communal rooms on the ground floor, including dining rooms, a library, a sitting room and an activity room. There were several communal day rooms or dining rooms available in the Evergreen Unit, Maple 1 Unit, Oak Unit and Cedar Unit. The residents residing in the Beech 1 Unit, Maple 2 Unit and Beech 3 Unit did not have any communal areas available in their units, and these residents could use the communal areas on the ground floor. The floors were connected by a lift and stairs, and the inspectors observed that the doors to the units stayed open, so the residents were able to use the lift independently.

There was access to two outdoor areas for residents in the lower-ground Evergreen Unit. The inspectors were informed that this was mainly a unit for high-dependency residents living with cognitive impairment. The outside areas contained suitable seating areas and seasonal plants. However, only one of these outdoor areas, a small courtyard, was safe and secured with a wall around it, as the other outdoor area led to the centre's car park and to the side entrance of the centre. Residents' access to the safe outdoor area was restricted, and the key was held by the staff nurse. The staff informed inspectors that they would open the door if the residents asked for it; however, not all these residents had the ability to verbalise choices and preferences. There were also terraces on the upper floors; however, all entrances to these terraces were locked. Another small enclosed courtyard with a smoking shed was freely accessible to residents who smoke. This is further discussed under Regulation 9: Residents' rights.

Bedroom accommodation comprises both single and multi-occupancy bedrooms. Some residents chose to personalise their rooms with items of significance, including ornaments and pictures. On the upper floor units, the bedroom windows to the front of the building provided residents with views of Dublin mountains and Dublin city, and the windows at the back of the building were overlooking Dublin Bay. Inspectors observed that a number of unoccupied but registered bedrooms were used for storage purposes, such as hoists, wheelchairs or cleaning trolley storage. Furthermore, inspectors observed that there was no wardrobe in two single-occupancy bedrooms in the Beech 3 Unit. Other twin-occupancy bedrooms did not have a suitable layout of the privacy screens to ensure that each resident's privacy needs were met, as further discussed under Regulation 17: Premises and Regulation 9: Residents' Rights.

Significant fire safety concerns were observed on the first day of inspection across all units, including corridors that were fully blocked by storing hoists, linen trolleys, a table used as a nursing station and chairs or other residents' assistive equipment. The inappropriately stored equipment blocked an entrance to a resident's bedroom and evacuation escape routes, as well as blocked residents' access to the windows and enjoying the view. This posed a risk in respect of the safe and timely evacuation

of residents in the event of a fire. An immediate action plan was issued that evening, and while some of the corridors were cleared from obstructions by the second day of the inspection, some other corridors remained blocked. This is further discussed under relevant regulations.

The inspectors spent periods of time chatting with residents and observing interactions between residents and the staff. All of the residents who were spoken with were complimentary of the staff. Staff were observed to speak with residents kindly and respectfully, and to interact with them in a friendly manner.

Visitors who spoke with inspectors all praised the care, services and staff that supported their relatives in the centre. None of the visitors spoken with expressed any concerns and were very complimentary about the service.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre and how governance and management affect the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, this inspection found that there was a clearly defined management structure in place, with established management systems to oversee the delivery of care and services to residents. However, the findings of this inspection were that the provider had failed to fully implement their compliance plan following the previous inspection completed on 12 April 2023. While some of the actions had been completed, some areas were still outstanding, and additional new areas of non-compliance were identified. The centre had a good regulatory history. However, this inspection found that significant action was now required by the registered provider to ensure a safe and high-quality service was consistently provided to the residents living in the designated centre.

This was an unannounced risk inspection. The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 (as amended). In preparing for this inspection, the inspectors reviewed actions from the last inspection, the information provided by the provider and the person in charge and unsolicited information received by the Chief Inspector of Social Services.

Belmont Care Limited is the registered provider of Belmont House Private Nursing Home, which is within the Orpea Group. The centre had a full-time person in charge who was supported in their role by two assistant directors of nursing, five clinical nurse managers, a team of nursing staff, care staff, housekeeping, catering, administrative and maintenance staff. Although this inspection found that there were established governance and management structures in place, improved oversight by the provider was necessary to ensure the effective and safe delivery of

care in accordance with the centre's statement of purpose. Insufficient oversight of staff practices and reporting culture resulted in the failure to recognise and report risks associated with fire safety, health and safety and infection control, as evidenced in this report.

There were systems in place to monitor the quality and safety of the service, such as monitoring the quality care indicators and audits for end-of-life care, wound and falls analysis or environmental walk around. While an action plan and time-frame for completion were in place, there was no nominated person responsible for implementation and follow-up review. Furthermore, some of the audits presented to the inspectors were checklists with no quality improvement action plan and plan on how to deliver improvements in place.

The inspectors could not establish if staff had regular access to appropriate training as the training record available on the day of the inspection was not up-to-date, and the majority of the staff either did not have training dates recorded or were due for a refresher training. The inspectors requested that assurances were submitted to the Chief Inspector following the inspection. The training matrix submitted one week after the inspection demonstrated that the provider had a training schedule in place.

The inspectors reviewed written policies and procedures and found that with the exception of complaints procedure, they were compliant with the legislative requirements. A directory of residents was maintained in the centre; however, upon review, inspectors found that not all the information required under the regulation was recorded.

There was a complaints procedure displayed in the main reception area of the designated centre. This was not observed in any other area of the centre and was not available on any of the individual units and floors. The procedure that was on display did not contain any information on advocacy services. Residents spoken with did not fully understand the complaints procedure and staff spoken with on the day of inspection did not demonstrate an understanding of advocacy services. There was a nominated person who dealt with and oversaw the management of complaints. The complaints log was reviewed, and inspectors observed while there was evidence of investigations taking place, complainants were not always provided with a written response advising them of the outcome of their complaint.

Regulation 14: Persons in charge

The person in charge fulfilled the requirements of the regulations. They had the appropriate experience and qualifications.

Judgment: Compliant

Regulation 15: Staffing

Inspectors found that there was an adequate number and skill-mix of staff in place with regard to the needs of the current residents and the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix provided to inspectors for review on the day of the inspection did not give a clear overview of staff training as not all staff members working in the centre were accounted for. The training matrix was only available for nursing and care staff. In addition, many staff members either did not have an attendance date or were overdue with the mandatory training.

The supervision of staff in the centre was not effective and did not ensure that the centre's infection prevention and control policies, procedures, fire safety and awareness of respecting of residents' rights were implemented at all times. For example:

- Staff members were not aware of some of the fire escape routes and kept them blocked. Staff who spoke with the inspectors provided inconsistent accounts in respect to the fire evacuation procedure and routes. This posed a significant risk to safety and required prompt action by the provider.
- There was a lack of oversight of the centre's cleanliness and storage practices, as evidenced under Regulation 27: Infection Control, which would increase the risk of cross-contamination in all areas.
- Inspectors observed a lack of understanding and support of residents' rights as detailed under Regulation 9: Residents' rights.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents maintained in the designated centre did not include all the following information under Schedule 3 of the regulations:

- The name, address and telephone number of the resident's general practitioner (GP).
- Where the resident had died at the designated centre, the date, time and

cause of death when established.

Judgment: Substantially compliant

Regulation 21: Records

On the first day of inspection, the inspectors provided a list of documents to be made available for review on the second day. Despite this, the inspectors experienced significant delays in obtaining some of the requested documents, such as the risk assessment for the COVID-19 outbreak and training matrix. The training matrix available on the day of the inspection was not up-to-date with details of all current employees and training available in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to complete all actions from the previous inspection report as per commitments given to the Chief Inspector. For example:

- Not all work to address fire safety issues in the centre had commenced. This was in spite of commitments from the registered provider that works were to have been completed by 30 June 2023.
- Not all actions were completed under Regulation 27: Infection Control. For example, the provider had not nominated the infection prevention and control link practitioner.

The management systems in place did not ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example;

- There was ineffective staff supervision at night, resulting in a lack of resident and staff supervision, especially during night duty. For example, the oversight of staff practices with respect to storage practices, fire precautions and respecting residents' rights was not adequate as detailed under relevant regulations.
- The quality assurance systems were not effective in ensuring the quality and safety of the service. For example, the environmental audits did not identify the risks and findings of this inspection. In some of the audits, the person responsible for the actions being implemented with the time-bound date and follow-up review was missing. Some of the audits were in the form of checklists, where it was not clear how the findings would inform the action plan as there was no quality improvement plan outlined.
- The management systems in place to address previously identified non-

compliances were not effective. The general oversight of the physical environment and the centre's infection control and prevention was not robust, as evidenced under Regulation 17: Premises and Regulation 27: Infection control. An immediate action plan was issued to the provider in respect of the insect infestation observed in the Maple Unit. This had been known by staff and not appropriately escalated through the relevant reporting channels. The provider submitted the report from pest control following the inspection, confirming appropriate interventions.

- The management systems to provide assurance in respect of fire safety were insufficient. Oversight of the fire safety measures in the centre to ensure emergency exit routes were kept clear of obstruction at all times was not effective. An immediate action plan to remove all obstructions from key areas was issued to the provider on the evening of the first day of the inspection. This was only partially completed by the end of the inspection, and some corridors remained blocked.
- Management oversight for staff training and education was inadequate, as evidenced under Regulation 16: Training and staff development.
- Improved oversight, communication and management of risk at the time of residents' transfer was required as described in the Quality and Safety section and associated Regulation 25.
- The rights of residents were not always understood by staff members and upheld as detailed under Regulation 9: Residents rights.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose (SOP) relating to the designated centre, which had been updated within the last year. An updated SOP was also submitted to the office of the Chief inspector following the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

The Chief Inspector of Social Services had been informed of all incidents which occurred in the centre within the required time-frame.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure on display in the centre did not meet the requirements of Regulation 34 as outlined in S.I No. 628 of 2022. For example:

- The complaints procedure did not include information on advocacy services.
- Residents spoken with were not aware of the procedure, which was observed to be displayed in the reception area only.
- The complaints log was reviewed, and while there was evidence of investigations carried out, the complainants were not always provided with a written response advising of the outcome.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing the policies and procedures as set out in Schedule 5 of the regulations.

Judgment: Compliant

Quality and safety

Overall, the service had a good history and aimed to deliver good-quality care to the residents, aided by a team of staff who were respectful and kind. However, significant improvements were now required in several areas, specifically infection prevention and control, fire precautions, premises and residents' rights to ensure that the care provided was safe and appropriate at all times.

Residents had access to telephones, newspapers, televisions and religious services. The hairdresser visited the centre every day, and residents informed the inspectors that they 'love getting their hair done'. Inspectors found that the rights of the residents were not upheld at all times, and there were concerns in respect of privacy and participation in activities as further detailed under Regulation 9: Residents' rights.

The premises were of suitable size to support the numbers and needs of residents living in the designated centre. There was a variety of communal and private areas available for residents. Action from the previous inspection in respect of premises had been completed, such as the reconfiguration of room 6 and the provision of lockable storage space in rooms 421 and 423. However, further improvements were needed, as further detailed under Regulation 17: Premises.

Residents were observed in their rooms throughout the day of the inspection and many rooms were decorated with personal items including furniture. Resident's clothing was well laundered and there was a system in place to have laundry returned promptly. Inspectors found some residents' wardrobes were located outside of their bedrooms or bed space and this meant they had to leave their room or bed space to access their personal belongings. Further improvements were also required to provide adequate storage for residents, this is discussed further under Regulation 12: Personal possessions.

There was a 'Residents guide' available in the centre, this was in the format of a corporate brochure and provided a summary of the services and facilities in the centre. However, it did not contain all the required information such as the complaints procedure or information regarding independent advocacy services.

Inspectors reviewed a sample of seven residents' care records and found that transfer letters accompanied most residents upon transfer to another service, and copies of these letters were maintained on-site. Comprehensive information was provided to the receiving centre to enable care to be provided in line with the current assessed needs, wishes and preferences of the resident. Notwithstanding, one resident was discharged to another residential setting with no transfer information documented. Inspectors also observed an ambulance that arrived at the centre on the day of inspection. Inspectors observed the paramedics let themselves into the centre without a staff member there to greet them to provide direction or information on the resident. They were also not informed prior to their arrival that there was an outbreak of COVID-19 in the centre.

Inspectors reviewed arrangements at the centre to manage the risk of fire. An immediate action plan was issued to the provider in respect of a fire safety risk assessment and review to be carried out by a competent safety professional. During the inspection, inspectors requested records to show that the emergency lighting and fire alarm had been tested by an appropriately qualified person on a quarterly and yearly basis. As not all records were available on the day of the inspection, these were submitted following the inspection and confirmed that regular quarterly and annual reviews were completed. Preventative maintenance of fire safety equipment, including fire extinguishers, was conducted at regular recommended intervals. There were comprehensive Personal Emergency Evacuation Plans (PEEPs) developed for each resident. These included residents’ mobility needs to inform staff of residents’ needs in the event of an emergency evacuation. However, the registered provider did not take adequate precautions against the risk of fire and fire safety precautions to ensure the safety of residents required action as discussed under Regulation 28: Fire precautions.

Inspectors found that some procedures were not consistent with the National Standards for Infection Prevention and Control in Community Services (2018), and the compliance plan from the inspection in April 2023 was not completed. This will be discussed further under Regulation 27: Infection control.

Regulation 10: Communication difficulties

The registered provider ensured that residents with communication difficulties could communicate freely, having regard for their well-being, safety and health and that of other residents.

Judgment: Compliant

Regulation 12: Personal possessions

Not all residents had access to their personal clothes and did not have adequate space to store their clothes. This was evidenced by:

- Residents' personal wardrobes were found to be outside of residents' rooms in a communal space. This meant that residents' personal possessions could not be appropriately safeguarded as other residents, staff, and visitors could access their wardrobes at all times.
- Some wardrobes did not close properly due to excessive pad storage in the wardrobes.
- Residents' personal belongings and items were seen stored in bathrooms and communal storage spaces.
- There was not adequate space to store possessions in smaller rooms due to the storage of other items in the room, such as wheelchairs.

Judgment: Not compliant

Regulation 17: Premises

The registered provider did not ensure that the premises conformed to all requirements of Schedule 6 of the regulations; for example:

- Some multi-occupancy rooms in the designated centre were not of a suitable layout to meet each resident's needs. The provider identified one of the twin-occupancy rooms in the Evergreen Unit and converted it to a single-occupancy bedroom. They committed to submit the application to vary Conditions 1 and 3 of the centre's registration to reduce the occupancy. However, some other issues with the layout of other twin-occupancy bedrooms remained not addressed. For example, the floor circulation space available for some residents did not include a comfortable chair and personal storage space. Residents in beds located away from the window did not have access to natural light if the residents whose bed was located beside the window had their privacy curtains closed. This required review to ensure each

occupant of a bedroom had sufficient space to meet their needs.

- Some areas of the centre were not well-maintained, and parts of the centre required painting and repair. For example, inspectors observed damaged bed frames, wardrobe and door frames, broken ceiling tiles, and leak markings on the ceilings in some areas.
- Two communal areas, a family room and a quiet room on the Evergreen unit had no emergency call-bells available as required.
- Appropriate ventilation and heating were not in place in all areas of the designated centre. Temperatures in some areas within the centre were not appropriate, reaching 31 degrees Celsius in one of the nurses' rooms. Inspectors were informed that the air conditioning was broken, which impacted some areas.
- Insufficient and inappropriate storage was observed throughout the centre. Assistive hoists, air cooling fan, chairs, cleaning trolley and other assistive equipment were stored in corridors and in bedrooms blocking fire evacuation routes; commodes were stored in an en-suite bathroom making entry almost impossible and it appeared that there was no coherent system in place of oversight of storage areas. There was also a lack of storage facilities in the centre for household and cleaning equipment as inspectors observed that the centre used storage premises, which were connected to the designated centre for the daily storage of cleaning equipment, and these were not registered as a part of the designated centre.

Judgment: Not compliant

Regulation 20: Information for residents

The Residents' guide in respect to the designated centre did not contain the following information:

- The complaints procedure
- Information on advocacy services.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

- Upon review of seven residents' files, the inspectors found that there was no transfer documentation available for the discharge of one resident from the designated centre.
- The ambulance crew that arrived at the centre on the day of the inspection was observed by inspectors to let themselves into the centre without a staff member there to greet and guide them; they were also not informed prior to

the arrival of a COVID-19 outbreak in the centre.

Judgment: Substantially compliant

Regulation 27: Infection control

Improvements were required to ensure that the centre complied with procedures consistent with the National Standards for Infection Prevention and control in Community Services (2018). For example;

Infection prevention and control governance arrangements did not ensure the sustainable delivery of safe and effective infection prevention and control practices and antimicrobial stewardship. For example;

- The was no appropriately qualified infection prevention and control link practitioner in place to increase awareness of infection prevention and control and antimicrobial stewardship issues locally. This was a recurrent finding from the inspection in April 2023.

The environment was not managed in a way that minimised the risk of transmitting a health care-associated infection. This was shown by:

- Live insects were observed in several areas of the home. The staff members working in this unit informed the inspectors about the insects and admitted that they failed to report them to the management. Assurances were received the following day that control measures had been put in place.
- The cleaning processes in the centre were not in line with best practices, both for the overall management of the environment and equipment. Inspectors observed visibly unclean shower drains and commodes. Dust and dirt were observed on the carpets in some bedrooms and on the fire extinguishers and covers. The carpet in some bedrooms was deeply stained, including some of the bedrooms in Maple 1 Unit.
- Several items of resident equipment and furniture observed during the inspection were visibly unclean and were not being fully cleaned as per national and evidence-based guidelines. For example, bathroom cabinets, the kitchen trolley, and the cutlery tray required deep cleaning, and intravenous trays, lockers, and bedside tables were visibly dirty.
- Some items of furniture and equipment required repair or replacement as there were breaks in the integrity of the surfaces, which did not facilitate effective cleaning and decontamination. For example, broken bed frames, door frames, lockers and cabinets in en-suite bathrooms were observed. Cabinets in en-suite bathrooms in rooms 315A and 422 were damaged with exposed medium-density fibreboard (MDF). This was a finding from the previous inspection, and there was an associated risk with porous surfaces that they could not be effectively cleaned. Other equipment was observed to be rusty, including commodes or shower chairs for residents to use.

- There was a lack of assurance in respect of the safe management of sharps; sharps bins were not assembled properly and did not include the signature and date of opening or closing to allow for effective contact tracing.
- Out-of-date equipment, including oxygen tubing and masks that had an expiry date of 2020, was observed in emergency kit bags and required full review and oversight.
- Inappropriate storage practices and facilities as detailed under Regulation 17: Premises posed a cross-contamination risk.

The provider had not ensured that all precautions for effective infection control were part of the routine delivery of care to protect people from preventable health care-associated infections. This was shown by:

- Inspectors observed poor practices with regard to the use of personal protective equipment (PPE). For example, staff were seen wearing their face mask under their nose and under their chin on numerous occasions.
- Nebuliser compressor machines were unclean and not maintained as per the manufacturer's instructions. Inspectors observed oxygen concentrators with stagnant water left in the humifider.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider did not make adequate arrangements to provide adequate means of escape, including emergency lighting and for maintaining of all fire safety equipment, means of escape and building fabric. For example:

- There was no key-guard box with a key available for easy access in the event of an emergency to evacuate the day room in the Evergreen Unit. The staff nurse on duty held a key to the door. An immediate action was issued in this respect due to the risk, and this was rectified on the day.
- Fire exits and escape pathways were noted to be obstructed. Inspectors observed inappropriate storage in a protected corridor with furniture, nursing station, chairs, hoists and other residents' assistive equipment and under a stairwell that was used as a protected means of escape to evacuate residents. This practice was not acceptable and may pose a risk in the event of an evacuation.
- There was a lack of clarity in respect of evacuation routes from some bedrooms in the Evergreen unit. For example, a door in bedroom 14 had a fire exit sign on the door but had no fire exit signage. It was blocked with a hoist, two wheelchairs and two chairs.
- Some of the internal escape route signage had no illuminated signage and posed a risk to the safe evacuation from the building in the event of a fire. For example, there was no illuminated signage outside bedrooms 210, 211 and 212 and on some escape routes corridors.

- The evacuation escape routes, such as the staircase at the side of the building, were not adequately maintained. The staircase was without adequate floor coverings, which could pose a risk in terms of safe evacuation of residents.

The registered provider did not take adequate precautions against the risk of fire:

- There was a lack of signage to direct residents to the external assembly point.
- The storage of oxygen bottles was not appropriate. There were bottles of oxygen stored at each nurses' station and in the sluice room on Beech 3, with some bottles out-of-date dating to July 2022. There was no safety signage in use to denote the potential hazards where oxygen was stored.
- Fire evacuation plans were not displayed in prominent areas in some units. For example, in Maple 2 Unit.
- Due to discrepancies in staff rotas and training records, it was not possible to establish the levels of staff fire training on the day of inspection. However, the staff who spoke with the inspectors were not aware of some of the evacuations routes and evacuations emergency procedures.

The arrangements for the containment and detection of fire were not adequate:

- Some fire doors were not being maintained in good working order. Examples of deficiencies included: gaps under doors and automatic closers not effective to fully close the door. For example, there were gaps at the door in the kitchenette and the door was held open by a hook on the wall. There was a non-functioning automatic door closure device on the door. A fire door at the lift on Evergreen Unit had a broken automatic closure device. The deficits in fire doors meant that fire doors were not capable of effectively restricting the spread of fire and smoke in the centre. Some of the fire frames required review as there were visible gaps between the wood components.
- There were breaches in fire-rated ceilings, which required to be sealed up as it posed a fire containment risk. For example, inspectors observed holes in the ceiling in bedroom 13 with wires hanging down and also in the store room in Maple 2 Unit.
- A bin was blocking a fire door in Maple 1 Unit and despite inspectors asking it to be removed it was still there at the end of the inspection.
- A smoke alarm was missing from a storage room on Maple 2 Unit where a number of mattresses were stored.
- A kitchenette on the Evergreen Unit had a fire extinguisher and fire blanket over a sink. This required review to ensure ease of access by staff.
- A fire blanket was located in an unlabeled metal cabinet in the smoking area. This requires to be placed in a visible location for immediate use.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medication storage practices were not in line with best practices or local policy, which led to some unsafe practices. For example:

- Some medicinal products supplied for residents were not stored safely or in line with the product advice. Inspectors saw the temperature records for the nurses's station where medication was stored, showed a room temperature of 31 degrees Celsius for a number of days. Labelling of the medications stated that storage was required at a temperature maximum of up to 25 degrees Celsius. This could pose risks in respect of efficacy of those medications.
- Some general medicinal products were observed stored in communal storage areas across the centre. This was not appropriate, and there were no temperature records available for those areas.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to general practitioner (GP) and multidisciplinary team specialist services, including physiotherapy, occupational therapy, dietitian, tissue viability, chiropodist and palliative care. The nursing documentation reviewed supported the care being delivered.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors were not assured that residents' rights were being upheld at all times, as evidenced by the following;

- Residents' rights to privacy were not always respected. A number of shared bathrooms in the Evergreen Unit did not have privacy locks fitted to en-suite toilets. For example, bedroom 11 had no privacy lock on one door and room 13 had no lock on either door of a Jack and Jill bathroom.
- Residents did not have unrestricted access to outdoor enclosed spaces. Some institutionalised practices were observed where residents had to ask to go outside, and a staff nurse held the key to open the door. In a satisfaction survey in 2023, this was highlighted by relatives who had requested easy access to secure outdoor spaces.
- The absence of call-bells from communal spaces in the Evergreen Unit impacted negatively on residents' right to have the opportunity to seek help if required.
- There was no activity schedule displayed for residents in the Evergreen Unit.

This restricted residents the opportunity to be informed or reminded of the options available to them.

- Poor storage practices throughout the centre negatively impacted on residents' rights. Inappropriate storage was observed in several bedrooms and attached corridors, such as hoists, kitchen trolley, housekeeping cart and chairs stacked on each other. One hoist for communal use was charging in a bedroom whilst a resident was lying in their bed in their room with the bed rails up. This practice did not support residents' rights for privacy as well as posing additional fire safety risks.
- Action was required to ensure that all residents were provided with opportunities to participate in activities in accordance with their interests and capacities; the activities schedule did not truly reflect the activities on the day of inspection; for example, crafts between 3 pm and 4 pm did not happen.
- Some residents in the twin occupancy rooms could not sit or stand beside the large window to enjoy the view as the other residents' personal possessions such as beds, chairs, televisions, and privacy screens, did not allow it.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Belmont House Private Nursing Home OSV-0000014

Inspection ID: MON-0042498

Date of inspection: 18/01/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The training records have now been moved to a single electronic system which can provide a comprehensive updated report- complete. This enhanced system of recording ensures that all current staff are automatically included in the training report. The system will be updated weekly and reviewed by the Person in Charge with effect from 15th March 2024 Training requirements as well as the accuracy of the training records will be overseen monthly by the Regional Director with effect from 31st March 2024. An additional programme of supplementary fire training is being delivered by an external provider to reinforce staff understanding of previous training, evacuation procedures and safe exit routes. Staff's level of understanding and confidence is evaluated at the end of each session and feedback provided to Person in Charge- this will be completed by 30th April 2024	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Directory of Residents has been migrated to the electronic system and updated to include all required documentation- complete	

The Directory will be audited weekly to ensure it remains up to date and fully complete from 8th March 2024.

The Person in Charge will review these audits and the Regional Director will oversee this process at the monthly governance meetings from 31st March 2024.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A system has been established to ensure records regularly requested to evidence compliance are readily available in the centre and that all nurse managers are familiar with the location of these records- complete by 30th April 2024.

The training records have now been moved to a single electronic system which can provide a comprehensive updated report- complete.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A comprehensive schedule of fire improvement works commenced in Q3 of 2023 and is ongoing. This includes compartmental sealing, emergency internal and external lighting, signage and access. This work is due for completion by 31st March 2024.

An ADON completed IPC Lead training in March 2024 which ensures that the centre has a designated IPC lead with dedicated time to oversee practices and training- complete

Immediately following the inspection, the Person in Charge revised the supervision arrangements in place for night staff to ensure fire safety measures and storage practices by staff are appropriate. The duties of the CNM who works in a supernumerary capacity until 21.00hrs now specifically includes oversight of fire safety processes, safe storage and respect for resident's rights. Documented feedback is provided to PIC/ADON on the following morning or sooner should the need arise- complete

PIC/ADON will conduct bi-monthly unannounced night visits to enhance supervision in the home from 8th March 2024.

These documented night inspections are reviewed monthly by the Regional Director to ensure that findings are actioned and improvements evident. This will commence from 31st March 2024.

From 1st March 2024, daily handovers and staff huddles now include staff responsibility and accountability for maintain fire safety and appropriate storage- complete

The rostered Senior Nurse in Charge at night been assigned specific duties relating to fire safety, respect for resident's rights and appropriate storage-complete

All fire safety checks and procedures are reviewed weekly by the Person in Charge and monthly by the Regional Director from 31st March 2024.

Additional training has been provided to CNMs/ADONs to ensure risks and audit findings are documented appropriately to include identified remedial actions required and to ensure that they escalate risks in a timely manner. Completion of audits and tracking of actions identified is reviewed monthly by the Regional Director-complete

A review of the cleaning schedules and practices is being undertaken by Group Head of Housekeeping. The results and recommendations will be discussed with PIC and regional director and actions addressed. This review will be complete by 31st March 2024

Enhanced supervision and spot check inspections have been implemented by the Housekeeping Manager from 18th January 2024. This is overseen by the Person in Charge (or designate) who will also conduct visual checks of the premises daily to ensure appropriate standards are maintained. The Regional Director will review housekeeping audits monthly and support the Person in Charge to implement any identified remedial actions in a timely manner from 29th February 2024.

Enhanced pest control support from the existing external specialist has been secured to visit the home more regularly providing on-sight inspections and treatments as required-complete

Refresher training has been provided to staff to ensure that they are aware of the process of timely escalation to managers when risks have been identified-complete

Additional training has been provided to all nursing staff regarding the process for safe transfer of residents to hospital, including documentation- complete

A checklist is now in place to guide staff to ensure all documentation is completed. An audit of transfers will be completed monthly by the Person in Charge or delegated person to ensure compliance with this. The regional director will review this audit and actions arising at the monthly governance meeting from 31st March 2024.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints process displayed has been amended to accurately reflect the centre's complaints policy which includes information on advocacy services-complete

The updated residents guide which is currently being prepared will also include this information. This will be complete by 31st March 2024.

The complaints process, including information on advocacy services was discussed at the most recent resident's council meeting held on 28/02/24 and will continue on the agenda as per residents wishes-complete

The Person in Charge is monitoring complaints management weekly to ensure all complaints are managed in line with the policy to include a written response- complete

An analysis of complaints and management of same are reviewed at monthly governance meetings by the Regional Director from 31st March 2024.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
2 additional storage areas have been identified and works to facilitate their use will be complete by 31st March 2024

The layout of the twin rooms has been reviewed and alternative furniture has been sourced to provide additional space and storage-complete

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Application to vary for bedroom No. 15 to reflect change to single occupancy was submitted on 5th March 2024- complete

The layout of the twin rooms has been reviewed with appropriate furniture sourced and

ordered. This will be in place by 31st March 2024.

The privacy curtain rails in the twin rooms have been reviewed to ensure both residents have access to natural light- complete

A planned schedule of works for phased flooring replacement and painting has been agreed and commenced from 14th March 2024.

A system to support timely identification and actioning of maintenance repairs, replacements for all equipment and premises is planned for implementation by 30th March 2024

The two nurse call bells in the communal area are in situ- complete

A facility management company have been engaged to provide an appropriate solution for 4th and 5th floors air conditioning units by 30th June 2024.

2 additional storage areas have been identified and works to facilitate their use will be complete by 31st March 2024

The household storage area is now included on the floor plans and was included in the Application to Vary submitted on 5th March 2024.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
The updated residents guide is currently being finalized and will include the complaints process and advocacy service information. This will be complete by 31st March 2024.

The revised resident's guide will be distributed to every resident in the Centre and will be provided upon admission from 31st March 2024.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:

Additional training has been provided to all nursing staff regarding the process for safe transfer of residents to hospital, including documentation. A checklist is now in place to guide staff to ensure all documentation is completed. An audit of transfers will be completed monthly by the Person in Charge or delegated person to ensure compliance with this. The regional director will review this audit and actions arising at the monthly governance meeting from 31st March 2024.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
An ADON has completed IPC Lead Training and Train the Trainer in March 2024 which will ensure that the centre has a designated IPC lead with dedicated time to oversee practices and training- complete

Enhanced pest control support from the existing external agency has been secured to the home more regularly providing on-sight inspections and treatments as required- complete

Training has been provided to staff to ensure that they are aware of the process of timely escalation to managers when risks have been identified-complete

A review of the cleaning schedules and practices is being undertaken by Group Head of Housekeeping. The results and recommendations will be discussed with PIC and regional director and actioned addressed. This review will be complete by 31st March 2024

Enhanced supervision and spot check inspections have been implemented by the Housekeeping Manager from 18th January 2024. This is overseen by the Person in Charge (or designate) who will also conduct visual checks of the premises daily to ensure appropriate standards are maintained. The Regional Director will review housekeeping audits monthly and support the Person in Charge to implement any identified remedial actions in a timely manner from 29th February 2024.

The training and supervision of housekeeping staff will be enhanced to include further training on cleaning methodology and the importance of accurate documentation of cleaning schedules. This will be undertaken by the Housekeeping Manager, supported by Group Head of Housekeeping and overseen by the Person in Charge. This will be complete by 31st March 2024.

IPC audit outcomes and analysis of trends is overseen monthly by the Regional Director at monthly governance meetings with support given to the Person in Charge to ensure all identified improvements are in place. This will be in place form 31st March 2024

A planned schedule of works for phased flooring replacement and painting has been agreed and commenced from 14th March 2024.

A review of the furniture has taken place with removal of all broken furniture identified- complete

Safe management of sharps training has commenced for all nursing staff to ensure compliance and will be completed by 31st March 2024

Oxygen, nebuliser machines and emergency bags have been included in the weekly CNM checklist for auditing and actioning accordingly. This will be overseen by the Person in Charge and reviwed monthly by the Regional Director as part of the Governance meeting from 31st March 2024.

All staff in the centre will have completed HSE land Training in Donning and Doffing PPE by 31st March 2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: A comprehensive schedule of fire improvement works commenced in Q3 of 2023 and is ongoing. This includes compartmental sealing, emergency internal and external lighting, signage and access. This work is due for completion by 31st March 2024.

A review of the access to external areas for residents in Evergreen Unit, Maple 1 and Cedar unit has been completed. Coded door access will be installed by 30th April 2024.

Back stairwell flooring has been reviewed and works to repair damage will be completed by 31st March 2024

Issues on the day of the inspection i.e. the position of the fire blanket and fire extinguisher over the sink in Evergreen were immediately placed in a more accessible area in the kitchenette, the smoking apron is now placed in a highly visible area for the residents to easily access same- complete

Fire Evacuation plans have been enhanced to comply with ISO 23601 and same will be on display from 31st March 2024

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A facility management company have been engaged to provide an appropriate solution for 4th and 5th floors air conditioning units by 30th June 2024.

The storage of nutritional supplements has been reviewed and more appropriate storage systems are now in place- complete

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Privacy locks which had been removed for painting purposes have now been refitted and are in working order- complete

A review of the access to external areas for residents in Evergreen Unit, Maple 1 and Cedar unit has been completed. Coded door access will be installed by 30th April 2024.

Review of the activity timetable will be completed with a view to improving activities for the residents particularly during outbreak periods. The contingency measures for activities during an outbreak will be updated in the contingency plan and communicated to all staff by 30th April 2024.

A lead activity staff member will commence in the home by 30th April 2024 to ensure effective use of internal and external activity resources and to ensure that activities meet the needs and preferences of all residents.

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.	Not Compliant	Orange	31/03/2024
Regulation 12(c)	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 he or she has adequate space to store and maintain his or her clothes	Not Compliant	Orange	24/03/2024

	and other personal possessions.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/04/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2024
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.	Not Compliant	Orange	30/06/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	31/03/2024
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure respecting complaints, including external complaints processes such as the Ombudsman.	Substantially Compliant	Yellow	31/03/2024
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	Not Compliant	Orange	30/04/2024

	the Chief Inspector.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/06/2024
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.	Substantially Compliant	Yellow	31/03/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by	Not Compliant	Orange	31/03/2024

	staff.			
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	30/06/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/04/2024
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.	Not Compliant	Orange	30/04/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/04/2024
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation	Not Compliant	Orange	30/04/2024

	procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a 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	30/04/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/04/2024
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.	Not Compliant	Orange	30/04/2024

Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Substantially Compliant	Yellow	30/06/2024
Regulation 34(1)(a)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre concerned.	Substantially Compliant	Yellow	31/03/2024
Regulation 34(1)(b)	The registered provider shall	Substantially Compliant	Yellow	31/03/2024

	provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.			
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	31/03/2024
Regulation 34(2)(g)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant when the complainant will receive a written response in accordance with paragraph (b) or (e), as	Substantially Compliant	Yellow	31/03/2024

	appropriate, in the event that the timelines set out in those paragraphs cannot be complied with and the reason for any delay in complying with the applicable timeline.			
Regulation 34(5)(b)	The registered provider may, where appropriate assist a person making or seeking to make a complaint, subject to his or her agreement, to identify another person or independent advocacy service who could assist with the making of the complaint.	Substantially Compliant	Yellow	31/03/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/04/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	30/04/2024
Regulation 9(3)(b)	A registered	Not Compliant	Orange	30/04/2024

	provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.			