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:	Aperee Living Churchtown
Name of provider:	Aperee Living Churchtown
Address of centre:	Churchtown, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	07 February 2024
Centre ID:	OSV-0000266
Fieldwork ID:	MON-0042442

About the designated centre

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

Aperee Living Churchtown is a purpose built nursing home and is located close to the village of Churchtown in Co. Cork. The centre is built on large landscaped grounds with adequate parking for visitors and staff. The centre is registered to accommodate fifty residents in forty four single bedrooms and three twin bedrooms. All bedrooms are en suite with toilet, shower and wash hand basin. The centre provides long-term nursing care, predominately to people over the age of 65, but can also provide convalescent and respite care. The centre caters for residents with varying degrees of dependency from low to maximum. The person in charge is responsible for the day-to-day operation of the centre with the support of an assistant director of nursing and a clinical nurse manager. Care is provided by a team of nurses, healthcare care assistants, activity staff, catering staff, and housekeeping staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	30

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 7 February 2024	09:00hrs to 17:00hrs	Robert Hennessy	Lead
Wednesday 7 February 2024	09:00hrs to 17:00hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

This inspection took place over one day by two inspectors of social services and was unannounced. The purpose of this inspection was to monitor the care and welfare of residents in this centre, and to follow up on serious concerns regarding the registered provider's ability to provide a safe service and ensure fire safety risks were addressed. Inspectors met with many residents during the inspection and spoke to eight residents in more detail all of whom spoke positively about the centre, the staff and the care they received. Residents gave positive feedback about living in the centre and the care they received. However, on this inspection inspectors continued to have concerns about the governance of the centre particularly in relation to fire safety.

The inspectors were guided through infection control procedures that were in place in the centre on the day by the person in charge and an opening meeting was held with them. The inspectors were informed that some residents were currently in isolation following an outbreak of influenza. There were 30 residents living in the centre on the day of the inspection and the centre was legally restricted from admitting any new residents for the last two months.

The centre was purpose built in 1996 and is situated on the outskirts of the village of Churchtown in North Cork. Resident's bedroom accommodation consists of forty four single bedrooms and three twin bedrooms. All bedrooms had en suite facilities including toilet, shower and wash hand basin. Communal areas comprised of three separate sitting rooms, a lounge and a dining room. Inspectors noted that the premises was decorated with many attractive features, such as a shop front appearance for the hairdressers rooms, an antiques shop which had an inbuilt glass cabinet containing interesting artefacts. There was also an area which was home to two budgies and an open fish pond which contained four large goldfish. Corridor walls were adorned with photographs, paintings and caricatures which added colour and life to the corridors. An antique piano was available for residents in one of the day rooms. Artwork was on display extensively throughout the building. A number of bedroom doors had been painted a specific colour at the request of the resident and also assisted them to identify their own bedroom. The inspectors saw that there were two garden areas which allowed easy access for residents to the outdoors.

The residents were engaging in activities with the activities co-ordinator and were having a quiz during the morning. The centre's hairdresser was in attendance on the day of inspection. The hairdressing room was well equipped and residents were seen enjoying this as a social occasion. The residence was being decorated on the day of inspection for Valentine's day that was in the week following the inspection.

Overall inspectors saw that many aspects of the upkeep of premises required attention. In the hallways and corridors the carpet was and difficult to clean. Some of the bedroom furniture was dated and worn, certain bedrooms had staining on the ceiling and some rooms had holes in the walls and ceilings which needed

addressing. Appropriate storage in the centre was lacking, the communal room which had an antique piano was used for storage, which made the room unattractive for the residents to use. Linen trolleys, laundry trolleys and hoists were inappropriately stored in the corridors of the centre, which would impede residents and staff if the area needed to be evacuated. Storerooms in the centre were seen to be fully packed and one of these storerooms did not have any smoke detecting device in it. The sluice room (a room used for the safe disposal of human waste and disinfection of associated equipment) was seen to be full of equipment which was not suitable for sluicing. The outdoor storage areas were also full to capacity and many of the items were old broken and in need of disposal rather than storage. Residents' bedrooms had items such as pressure relieving cushions stored on top of wardrobes and many of the rooms were generally cluttered which took from the homely atmosphere of the bedrooms. Inspectors saw that privacy curtains were also lacking in twin bedrooms.

During the walk around of the centre inspectors saw that fire doors along the corridors continued to have large gaps which would not contain the spread of smoke. Although the inspectors were informed that new fire doors had been ordered these had not been delivered to the centre at the time of inspection so there was no definitive date of works commencing. This will be further detailed under Regulation 28: Fire safety

The inspectors observed that a number of areas of the centre were visibly unclean during the inspection especially a number of bedrooms that were vacant. Inspectors saw inappropriate items stored in empty bedrooms, toilets not flushed and strong odours in rooms that were not cleaned. Inspectors also identified that there was a limited number of dedicated clinical hand wash sinks in the centre. It was observed that space had been made in three of the corridors to install sinks in these areas but these sinks were not in place. These and other aspects of infection control issues will be addressed further in the report.

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

Capacity and capability

This was a risk inspection to monitor the care and welfare of residents as the centre was currently in escalation. The previous three inspections of Aperee Living Churchtown undertaken on the 18th of May 2022, 25th of May 2023 and 10th of August 2023 identified significant areas of concern relating to the governance and management of the centre, fire safety and the protection of residents' finances. Following the registered provider's failure to address serious fire risks identified in their fire own external fire safety risk assessment undertaken on the 20th of January

2022 and issues identified during the inspection of the centre 10th of August 2023, a restrictive condition was attached to the registration of the centre allowing no more admissions until the safety of residents was assured. This restrictive condition came into affect on the 21st of December 2023. The Chief Inspector had issued a notice of proposed decision to cancel the centre's registration on 09th of November 2023 due to serious concerns about the registered providers fitness to operate the centre and their lack of action in addressing fire safety risks and protection of residents finances.

Following receipt of the notice proposing to cancel the registration of the centre the provider submitted representation to the Chief Inspector on 08th of December 2023, outlining actions the provider was taking to address the serious regulatory non compliance identified and requesting that the Chief Inspector reconsider the decision. The representation submitted outlined a revised organisational structure and detail of the action underway to bring the centre into compliance with fire precautions and the safeguarding of residents finances. On this inspection inspectors inspected against this representation and found that as the representation outlined, three new directors were appointed to Aperee Living Churchtown Ltd., and the previous person nominated to represent the provider was no longer a director of the company. The inspectors were informed that remedial works relating to the fire safety had not commenced at the time of inspection. The representation received on the 08th of December stated that the fire doors were ordered and the fire works would begin on the 8th of January 2024 and works would be completed by the 28th of February 2024. However the inspectors saw that no fire works had commenced and that the doors had not been ordered as stated in the representation. An email was shown to the inspectors stated that the fire doors had only been ordered on the 01st of February following a query made by the person in charge. This demonstrated a lack of oversight by the provider into the required programme of works, therefore these fire doors had yet to be delivered to the centre so no work had commenced. The registered provider had also committed in their representation that they would provide a weekly update to the chief inspector on the progress of the fire works and that also had not taken place. A separate bank account for residents' finances to separate residents monies from that of the registered provider and day to day finances of the centre was in place and and this became active on 21st of January 2024

The inspectors found during the inspection that the organisational structure within the centre did not reflect that outlined in the representation submitted and staff on the ground in the centre were not made aware of the proposed changes. For example, at the time of the inspection a number of the posts outlined in the representation had not been filled including that of a director of clinical care and a human resource lead, nor were there definitive dates for these roles to commence. There was no notification sent to the Chief inspector in relation to the appointment of a regional manager and no supporting documentation for the role of the person participating in management.

Inspectors continued to be concerned about the registered provider's ability to safely operate and sustain the business of the centre. The provider had committed in their representation to the completion of the fire works, however the provider

failed to plan and prepare for these fireworks. The fire works had not begun and red rated fire risks along with other fire safety actions identified on the 10th of August 2023 were yet to be addressed.

Aperee Living Churchtown is operated by Aperee Living Churchtown Limited, the registered provider. The centre was part of the Aperee Living Group, which operates a number of centres around the country. The Chief Inspector had been notified of changes to the company directors in November. Within the centre care is directed by a suitably qualified person in charge who was just returning from an extended period of leave. They are supported by an assistant director of nursing and a team of nursing, healthcare, domestic, activity, maintenance, administration and catering staff. However, the inspectors found that the providers governance structure remained weak and did not reflect the commitments given to strengthen it as identified in the legal representation. In particular there was not as of yet a director of care quality and a regional manager to provide additional oversight as committed to in the representation submitted. Notwithstanding this, the person in charge reported that they had access to a director of the company that is the registered provider informally. In addition all of directors had been on site, and formal governance meetings had commenced and were scheduled on a monthly basis however there minutes of these meetings lacked detail.

Incidents that occurred were recorded and monitored by the person in charge. One incident that was required to be reported to the Chief Inspector had not been done in line with regulatory requirements. The complaints procedure had been updated in response to the changes in legislation in March 2023, however, some further amendments were required to ensure that the policy clearly outlined the procedure to be followed, in response to a complaint.

Although staff had access to training in accordance with their role and responsibility, there were ten staff overdue fire safety training and a smaller number due other mandatory training.

Regulation 14: Persons in charge

The person in charge was a registered nurse with the relevant experience and qualifications as specified in the regulations. They had just returned from a period of leave and had good knowledge of their responsibility under the regulations.

Judgment: Compliant

Regulation 15: Staffing

There was appropriate staffing levels in the centre to meet the needs of the 30 residents and also appropriate to the size and layout of the centre. There was a staff nurse on duty in the centre at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Assurance was not provided to the inspectors that all staff had access to appropriate training in there roles:

- there were ten staff due fire precaution training which was very concerning in a centre that had serious fire risks
- some staff requiring training in safeguarding and responsive behaviour was also evident.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider established and maintained a Directory of Residents which contained the information required under Schedule 3 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

Significant concerns remained with regards the governance and management of the service and the registered providers ability to ensure that the service provided was safe. This was evidenced by the following:

- the provider had arranged for an external consultant to conduct a fire safety risk assessment of the premises on the 20th of January 2022 which identified five red (high) 12 orange (medium) fire safety risks in the centre. The findings of this inspection were that none of these risks had been addressed some two years after they were first identified and that these red (high) and orange fire safety risks continued to pose a risk to residents safety. Despite assurances set out in their representation to the proposal to cancel the registration of the centre the registered provider had failed to adhere to the commitment that works to address these fire risks would commence on the 8th of January 2024.

- the management structure of the provider was not clearly defined to identify the lines of authority and accountability and to specify roles and detail responsibilities for all areas of care provision. Senior management roles within the organisation remained vacant such as the director of quality and HR lead. The provider had committed in their representation to strengthening the management structure , however, this had not been actioned to date and staff in the centre had not been informed of the any new governance arrangements at the time of the inspection.
- the provider had failed to submit the correct documentation for a proposed person to participate in the management of the centre
- although the provider had committed in their representation to submit weekly updates to the chief inspector in relation to the progress of the fire works these reports had not been received at the time of the inspection.
- there was a lack of oversight of staff training as outlined under Regulation: 16.

Significant concerns remained with regards to the designated centre having sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose:

- works in relation to fire safety had yet to commence
- the provider had not made resources available to address the premises issues identified on the previous inspection
- there was a lack of physiotherapy and occupational therapy for residents
- there continued to be outstanding bills for services including agency services and other services raising concerns about the resources available to the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The following action was required in relation to the statement of purpose:

- the statement of purpose required updating as the information regarding staffing and the governance of the centre was out of date
- the complaints section of the statement of purpose required updating to include the information required following changes to the regulations which came into effect in March 2023.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The following action in relation to notifications was required to be addressed:

- a three day notification was not submitted for a resident that required hospital treatment following an incident in the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints policy and procedure required review to meet the requirements of the latest regulations.

Judgment: Substantially compliant

Quality and safety

Overall the inspectors were assured that residents were supported and encouraged to have a good quality of life in Aperee Living Churchtown. There was evidence of residents needs were being met through good access to GP services and opportunities for social engagement. However, the providers history of poor governance and failure to implement effective fire management systems, impacted on the quality and safety of care and continued to put residents at risk.

Residents had good access to general practitioner (GP) services and medical notes showed regular reviews by their GPs to ensure best outcomes for residents. Timely referrals were requested to specialist services such as deititian, speech and language therapy and tissue viability nurse, however, residents did not have access to a physiotherapist or occupational therapist.

A separate bank account for residents' finances to separate residents monies from that of the registered provider and day to day finances of the centre was in place and and this became active on 21st of January 2024. Regarding other finances relating to service provision, evidence demonstrated that bills for some services such as physiotherapy and occupational therapy had not been paid leading to the withdrawal of these services.

Regular drills, evacuations and fire alarm checks were taking place. Records showed that drills were timed and the number of staff and residents involved in the evacuation detailed, evacuation aids required and used, analysis and actions taken following simulations to enable learning for all staff. A pictorial summary of the personal emergency evacuation plans (PEEPs) were available to the staff at the residents' door as a quick guide for staff in an emergency. Records to show work

had been completed for quarterly fire checks for lighting, equipment and appliances were available but, certifications for these works were not available. Fire safety works to address all the fire safety risks as previously outlined had yet to commence in the centre. Actions required for fire safety in the centre are outlined under Regulation 28.

The premises had adequate communal space and outdoor areas for the residents. However the provider had not provided resources for the premises and there was no upgrade works had taken place since the last inspection and the premises was poorly maintained. Action required for the premises is discussed under Regulation 17.

The person in charge knew the residents well and was seen to be interacting with all the residents on the day of inspection. There was an appropriate activity schedule in place that was observed while the inspectors were present. Residents had a choice when it came to food and dining experience. Resident had a full activity schedule which was implemented by a staff member assigned to managing activities.

Regulation 10: Communication difficulties

The registered provider ensured that residents with communication difficulties were assisted to communicate freely. Communication aids and devices were made available as required and communication plans were available for residents.

Judgment: Compliant

Regulation 17: Premises

Further deterioration in relation the premises was noted in this inspection. The following needed to be addressed by the registered provider and were repeat findings from the previous inspections:

- areas throughout the centre required painting, including residents' rooms and bedroom doors
- storage areas in the centre were full and items were inappropriately stored in residents bedrooms
- hoists and laundry trolleys were stored inappropriately on corridors in the centre
- twin rooms not in use on the day of inspection were not suitable for two residents and some of these twin rooms had had no privacy between the beds
- some bedrooms that were not in use on the day of inspection were not clean
- carpets throughout the centre were worn and stained

- lockers and wardrobes in a number of bedrooms were not in good condition and impacted effective cleaning
- there was a lot of unused and broken furniture and equipment in the centre and storage areas that required disposal
- seperate to the investment required to address the fire safety issues the premises also required investment to ensure that it was kept in a good state of repair internally and externally and that it was suitably clean and decorated.

Judgment: Not compliant

Regulation 26: Risk management

The risk management policy was in place and the measures and actions were in place to control the risks specified in the regulation. However the risk identified with fire safety are actioned under Regulation 28 and Regulation 23

Judgment: Compliant

Regulation 27: Infection control

The following items needed to be addressed to ensure that procedures consistent with the standards for the prevention and control of health care associated infections were implemented:

- bedrooms and bathrooms in the centre were visibly unclean
- there were no clinical hand washing sinks available to staff
- storage areas had items stored on the floor which impeded effective cleaning
- there was excessive equipment in some bedrooms which prevented proper cleaning of these rooms
- items of furniture in bedrooms were worn which again would impede effective cleaning.

Judgment: Not compliant

Regulation 28: Fire precautions

The following actions were required in relation to fire precautions these were the same actions repeatedly identified in the previous inspection reports had not been actioned by the registered provider.

Improvements were required by the provider to ensure adequate precautions against the risk of fire and for reviewing fire precautions:

- a store room contained electrical panels. Assurance and risk assessment was required, to assess the risk and determine any required control measures, including any operational controls and nature of items (if any) that can be safely stored.
- while there were no residents who smoke at the time of inspection, the smoking area for potential residents that smoke was not adequate. There was no call bell at the area identified to the inspector as the resident smoking area.

The arrangements for providing adequate means of escape including emergency lighting were not effective:

- the threshold to some exits was high. This meant that egress may be hindered where mobility aids and evacuation aids were used
- the gate providing escape from the garden, had a padlock and the key was not available to open the lock. Some exits from the building led to this garden.
- external escape routes were not adequate. They consisted of a concrete pathway following the line of the building and there were corners and pinch points which would not be conducive for mobility aids or evacuation aids.
- the shorter external route from one exit was obstructed by a fence across the path, resulting in residents being assisted along a protracted escape path to the assembly point
- at some final exits, there was insufficient space to manoeuvre around the door when it was in the open position
- escape corridors did not provide a fire protected means of escape
- the provision of emergency lighting along external escape routes was not adequate to safely guide occupants from the exits to a place of safety
- the provision of exit signage was not adequate. St. Bridget's corridor did not have an exit sign at one end of the corridor
- one fire exit door had glass that was broken and another had glass that had condensation throughout.

The arrangements for evacuating residents required improvement:

- a number of staff in the centre lacked fire safety training.

The measures in place to contain fire were not effective, for example

- fire doors to rooms were not adequate and would not all be effective to contain the uncontrolled spread of fire and smoke. While some fire compartment and cross corridor doors were in good condition, deficits were

observed to some such as gaps where the doors meet, and the door leaf not fully closing.

The measures in place to detect fire were not adequate:

- the store room which opens from the quiet room did not have fire detection
- the small staff changing rooms were not fitted with fire detection
- the manner of storage in the small storage presses along corridors meant that there was not enough free space around the smoke detector head to ensure it would function correctly.

The arrangements for maintaining fire equipment were not effective:

- certification for the annual and quarterly servicing of fire equipment was not available on the day of inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While care plans were in the main person centred, action was required to address the following:

- recording of information in relation to wound care for the residents was not completed in a consistent manner
- ABC charts (behaviour recording charts) were not completed in a manner that provided sufficient information of the incident that had occurred and to assist in preventing further incidents.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner, tissue viability nurse, dietitian and speech and language therapy. However, at the time of inspection, the residents did not have access to physiotherapy or occupational therapy.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Further action was required to ensure the service used restraint in accordance with the national policy.

The inspectors saw a gate in front of a residents door which prevented the resident from leaving their room without the assistance of staff and was therefore an undue restraint and required action to ensure the least restrictive form of restraint was used if required.

Judgment: Substantially compliant

Regulation 8: Protection

Following from the findings of the last inspections, the registered provider had set up a separate resident/client account. The registered provider was not currently a pension agent for any resident and all monies owed to residents estates had now returned to their estate. Relevant staff were aware of their legal obligations regarding return of monies to estate of any deceased residents, and every effort was made to liaise with the relevant authorities to enable monies to be returned in a timely manner.

In addition, a robust system was implemented regarding the management of monies and valuables held in safe keeping for residents, to protect residents and staff. Items handed in for safekeeping were securely maintained in individual containers with security tags applied with each transaction, along with individual comprehensive logs maintained of the items handed in and each transaction. In general, double signatures were in place for all transactions.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
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	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Aperee Living Churchtown OSV-0000266

Inspection ID: MON-0042442

Date of inspection: 07/02/2024

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: Fire Training was held on the 4th of March and all outstanding staff attended this training session. The Director of Nursing will monitor the training Matrix in place and schedule training promptly. The Director of Nursing has scheduled training sessions for safeguarding and responsive behavior – completion date no later than 30th April 2024.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Fire Rectification works were due to commence in Q1 2024, unfortunately that didn't happen. We have now engaged a new contractor and he will be onsite on 29th April 2024, with an anticipated completion timeframe for all Fire compliance matters of 3 months. Detailed forthnightly updates will be provided to the Inspector. A new head of Care Quality and Compliance has commenced on April 22nd 2024. Currently we have 2 very experience Regional Managers and from the comments in all the reports, their oversight and support of the Director of Nursing is reflected in the level of care of our residents, that is acknowledged in the report. We have currently outsourced our HR function and our Director of Nursing and Administrator has this support on a needs basis.	

All necessary documentation for the PPIM has been submitted.

A misunderstanding in relation to the weekly updates has occurred, it was our understanding that this update was to happen once works commenced. A contractor has been retained and commence on site on Monday 29th April 2024 with forthnightly updates being provided to the Inspector.

Fire Training was held on the 4th of March and all outstanding staff attended this training session

Resources for premises issues –
• Paint works – In conjunction with Maintenance a paint schedule has been established to paint hallways / communal areas and bedrooms. Maintenance has begun painting the last week.
• Power washing footpaths in the gardens has also begun.
• 10 new armchairs have been sourced.
• 5 new lockers have been sourced.
• 6 new beds have been sourced.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of Purpose is now up to date regards staffing and the governance of the center

In conjunction with the Regional Manager the Complaint policy has now been reviewed and updated in accordance with the regulation which came into effect in March 2023. A copy of the up-to-date policy has been given to all staff and a copy is also available to view at reception.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

The Director of Nursing shall ensure all required notifications will be submitted within the required regulatory time frame.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
In conjunction with the regional manager the Complaint policy has now been reviewed and updated in accordance with the regulation which came into effect in March 2023. A copy of the up to date policy has been given to all staff and a copy is also available to view at reception.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A maintenance schedule is in place and in progress to address areas mentioned in the report relating to bedrooms and communal areas. Maintenance has made great progress on same following last inspection February 2024 and will continue to work through all identified areas which need addressing with ongoing oversight of the DON.

Resident bedrooms have been de-cluttered of in appropriate items and a weekly resident bedroom check is in place.

Laundry trolleys will only remain in the hallways when in use. In the interim, a newly designated storage area for the laundry trollies has been identified, until a more suitable long term storage area is established. The Director of Nursing has made all staff have been made aware of this change.

Hoists – will only remain in the hallways when in use. In the interim, a newly designated storage area for the hoists has been identified, until a more suitable long term storage area is established. The Director of Nursing has made all staff have been made aware of this change.

Twin rooms remain vacant since the inspection. In conjunction with the Registered Provider, the Director of nursing will conduct a review of the twin rooms to establish suitability for two residents.

The Director of Nursing in conjunction with the Head of Housekeeping have developed a new daily room check for all vacant rooms. This check began on the 12.02.24.

Housekeeping staff now check all vacant rooms twice a day and a log of this check is kept. All vacant rooms are deep cleaned once a week.

Carpets will be replaced as part of the long-term refurbishment plan for the home.

Replacement of lockers and wardrobes has begun with 6 being replaced so far.

Unused / broken furniture – A skip was delivered to the centre on the 19th of February and unused or broken furniture/equipment was disposed of.

A refurbishment plan is currently being developed and will commence once all other works are fully completed.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Bedrooms & Bathrooms - The Director of Nursing in conjunction with the Head of Housekeeping have developed a new daily room and bathroom check. This check began on the 12.02.24. Housekeeping staff now check all vacant rooms and bathrooms twice a day and a log of this check is kept.

Three designated hand wash station have been identified within the home and we are currently awaiting for them to be fitted.

The Director of Nursing has informed all staff about not storing items on the floor in storerooms. The Director of Nursing conducts a weekly walk about to monitor same.

Bedrooms have been de-cluttered of inappropriate items and a weekly bedroom check is in place.

Regulation 28: Fire precautions	Not Compliant

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

Risk assessment in relation to the electrical panel is in place and the door of the electrical panel is now fixed.

A new designated smoking area has been identified and a plan is in place to install a new shelter.

A new lock and key system in place for gates in the enclosed garden. The nurse appointed to be the Fire Marshalls by day and night will now carry the key to the gates in the enclosed garden. The lock and key system have been a topic of discussion during the weekly fire safety brief's, so all staff are informed.

The fence obstructing an external escape route has been removed.

An exit sign at one end of the corridor in St Bridget's wing has now been installed.
The broken glass on an exit door has now been fixed.

New glass for the fire exit door with condensation throughout has been ordered.

Fire Training was held on the 4th of March and all outstanding staff attended this training session.

All necessary Fire works will be commencing in April 2024 with an expected completion timeframe for all internal and external Fire compliance matters being 3 months from commencement.

The top shelves in the small storage presses are now free from clutter.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance 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:
The length, dept and width of wounds are now recorded on the Epiccare system.

A Nurse education session has been provided by the Director of Nursing in relation to accurately completing the ABC charts. A review of all ABC charts will be done monthly as part of the KPI's by the Director of Nursing.

Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: Residents now have access to Physiotherapy and occupational therapy.	
Regulation 7: Managing behaviour that is challenging	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: A review of restrictive practices in the center was carried out by the Director of Nursing. The gate has been removed from outside the resident's room door. A motion sensor has been implemented on the resident's door. The motion sensor is less restrictive, and the resident can freely leave the bedroom if so wishes. Restrictive practices are reviewed monthly as part of the KPI's by the Director of Nursing. The resident is satisfied with the removal of the gate. The residents care plan has been updated to reflect this change.	

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.	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	30/09/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/07/2024
Regulation 23(b)	The registered provider shall ensure that there	Not Compliant	Orange	30/04/2024

	is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
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	31/05/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/04/2024
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	Not Compliant	Orange	31/07/2024

	suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/07/2024
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	31/07/2024
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	30/04/2024
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.	Substantially Compliant	Yellow	30/04/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/07/2024

Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/04/2024
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.	Substantially Compliant	Yellow	30/04/2024
Regulation 34(5)(a)(i)	The registered provider shall offer or otherwise arrange for such practical assistance to a complainant, as is necessary, for the complainant to understand the complaints process.	Substantially Compliant	Yellow	30/04/2024
Regulation 34(5)(a)(ii)	The registered provider shall offer or otherwise arrange for such practical assistance to a complainant, as is necessary, for the complainant to (ii) make a complaint in accordance with the designated centre's complaints procedure.	Substantially Compliant	Yellow	30/04/2024
Regulation 5(4)	The person in charge shall	Substantially Compliant	Yellow	30/06/2024

	formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	30/04/2024
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.	Substantially Compliant	Yellow	30/04/2024