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:	Milford Nursing Home
Name of provider:	Milford Care Centre
Address of centre:	Milford Care Centre, Plassey Park Road, Castletroy, Limerick
Type of inspection:	Unannounced
Date of inspection:	26 June 2024
Centre ID:	OSV-0000418
Fieldwork ID:	MON-0044105

About the designated centre

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

Milford Nursing Home was established in 1928 by the Little Company of Mary Sisters. There is 24 hour nursing care within the home. The accommodation consists of 69 single full en-suite bedrooms located over two floors. There are two assisted bathrooms, two sitting rooms, a large conservatory, dining rooms on each floor, a restaurant on site and a chapel at the entrance to the Nursing Home. We can accommodate both male and female residents/ patients who are predominantly over 65 years of age. The residents have a broad range of physical and psychological needs with varying degrees of cognitive ability. We provide multidisciplinary services in the specialties of gerontology and specialist palliative care. Our service is person centred with an emphasis on providing best practice in infection control and improving clinical care standards and treating residents with dignity and respect. The following allied health services are available at Milford Nursing Home: physiotherapy, complementary therapy and occupational therapy. The following creative arts therapies are available within Milford Nursing Home: music therapy and art therapy. Mass is celebrated six days a week, and Eucharistic Ministers bring Holy Communion to those who cannot attend mass. The organisation respects and embraces the spiritual needs of each resident with compassion and care, while accepting different beliefs, cultures and values.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	64

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 26 June 2024	09:30hrs to 17:45hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Residents living in Milford Nursing Home received a high standard of care and were supported to live a good quality of life, by a dedicated team of staff who knew their individual needs and preferences. Residents told the inspector that Milford Nursing Home was a very good place to live, and that staff were kind, caring and attentive to their needs. Staff were observed to deliver care and support to residents which was kind, respectful and person-centred.

Following an introductory meeting with the person in charge, and a person participating in the management of the centre, the inspector walked through the centre, reviewed the premises and met with residents and staff.

On the morning of inspection, there was a relaxed and calm atmosphere in the centre. Some residents were observed enjoying breakfast in bed, while others chose to have breakfast at a later time. Staff were overheard greeting residents as they entered their room, and this was followed by polite conversation discussing topics such as the activities plan for the day and the residents preferred choice of clothing. The care provided to residents was observed to be unhurried and allowed staff to engage with residents socially during morning care.

The inspector spoke with a number of residents, in their bedrooms and communal rooms, who expressed their satisfaction with the quality of care they received. Some residents described themselves as 'lucky to live here' referring to the centre as their home. One resident told the inspector that they enjoyed living in the centre because 'staff treat you like a person', while another resident described the overall service they received as being 'exemplary'. Residents told the inspector that they felt part of a community.

The inspector observed that the centre was bright, visibly clean, spacious and laid-out to meet the needs of the residents. The centre provided accommodation over two floors and comprised of single bedroom accommodation. The centre was well-lit, warm and comfortable for residents. Residents could independently access secure enclosed gardens which were observed to be appropriately maintained and furnished. Residents were observed enjoying the gardens throughout the day.

The inspector noted some fire safety concerns on the walk around of the centre. A number of fire doors did not appear to close effectively, with gaps observed around the doors evident when the doors were in a closed position. This may reduce the effectiveness of a fire door in the event of a fire emergency.

Residents told the inspector they were satisfied with their bedroom accommodation, furnishings and storage facilities for their personal belongings. Residents explained that they were encouraged to personalise their bedroom. Residents had pictures of their family and friends, and ornaments on display. Residents personal clothing was laundered on-site they were satisfied with this service. Residents said that their

room was cleaned daily.

Residents were served their lunch in the dining room and in their bedrooms. Residents stated that they were offered choice at mealtimes and were very complimentary regarding the quality of food provided. Meals were observed to be appetising and well-presented. Residents who required assistance were attended to by staff in a dignified, relaxed and respectful manner.

A dedicated member of the staff was allocated to activities, morning and evening. A daily schedule of activities was displayed on a notice board in the main foyer of each floor. The notice board also displayed information about a variety of social groups such as knitting and baking groups for residents to attend. A live music event was observed in the afternoon and residents were actively engaged in the event and appeared to enjoy it.

Residents stated that they were consulted about the quality of the service frequently and told the inspector that they 'felt listened to' by the staff and management. Residents were also provided with information on the services available to support them. This included independent advocacy, and safeguarding services.

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

Visiting was not restricted, and a number of visitors were observed attending the centre on the day of inspection. Visitors expressed a high level of satisfaction with the quality of care provided to their relatives, and described the management and staff as approachable.

The following sections of this report details the findings with regard to the capacity and capability of the centre, and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

This was an unannounced inspection, carried out over one day by an inspector of social services, to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Notifications submitted by the provider in relation to adverse incidents involving residents were also reviewed on this inspection.

The findings of this inspection were that the provider had an established management structure that was responsible and accountable for the provision of safe and quality care to the residents. This inspection found that there were aspects of the management systems that were not fully robust and did not ensure that the management of records across a number of regulations were maintained in line with

the regulations. In addition, residents individual assessment and care plans and fire precautions were found not to be in full compliance with the regulations.

Milford Care Centre is the registered provider of this centre, and is a company comprised of nine directors. One of the directors represented the registered provider in engagement with the Chief Inspector. The roles and responsibilities of some of the management personnel within the organisational structure had changed since the previous inspection. An assistant director of nursing had been appointed as the person in charge, and they reported directly to the director of nursing, therapy and social care, who was now a person participating in the management of the centre. The governance and management structure was clearly defined and effective to maintain oversight of the quality and safety of the service provided to residents.

Within the centre, the person in charge was supported by a team of clinical nurse managers. An assistant director of nursing was on planned extended leave, and the centre was awaiting the commencement of an interim assistant director of nursing to provide additional nursing oversight and support to the person in charge.

The centre had established management systems in place to monitor the quality and safety of the service provided to residents. Key aspects of the service that included resident falls, antimicrobial usage, wounds, medication management, restrictive practices and infection prevention and control, were monitored and subject to frequent auditing to identify areas for continuous quality improvement. However, a review of completed audits found that some audits were not effectively used to identity risks and deficits in the service. For example, recent fire safety audits of the integrity of fire doors reflected high levels of compliance. While weekly fire safety audits identified that fire doors were not wedged open and free from obstruction, the audits did not identify that some fire doors were impaired due to the presence of significant gaps between doors that could potentially compromise fire containment. In addition, there was an absence of a robust auditing system to monitor, evaluate and improve the quality of records, particularly clinical care records. This impacted on the providers ability to appropriately identify, monitor and improve this aspect of the service.

The management of some records did not ensure that they were always available for inspection or maintained in line with the requirements of the regulations. For example, on the day of inspection, records of adverse incidents involving residents, fire safety, and risk management records were accessible only to a limited number of staff. In their absence, those records could not be retrieved in a timely manner. Some documents such as maintenance records of the fire safety systems were presented as incomplete and disorganised records. In addition, documents in relation to some residents' clinical care and records of resident transfers from the designated centre could not be retrieved on the day of inspection.

A review of the records of adverse incidents involving residents showed that incidents were appropriate documented, investigated, and learning identified to improve the quality and safety of the service provided to residents. However, notifiable incidents, as detailed under Schedule 4 of the regulations, were not always notified to the Chief Inspector of Social Services within the required time-

frame.

A review of the centre's staffing roster on the day of inspection found that the staffing levels and skill-mix were appropriate to meet the assessed health and social care needs of the residents, given the size and layout of the building. There were sufficient numbers of house-keeping, catering and maintenance staff in place.

There was a system in place to ensure clear and effective communication between the management and staff, and arrangements were in place to induct, orientate and support staff.

There was a training and development programme in place for all grades of staff. Staff were facilitated to attend training pertinent to the provision of safe and quality care to residents. This included training in relation to safeguarding of vulnerable people, fire safety, medication management, and complaints management.

Regulation 14: Persons in charge

The person in charge was a registered nurse with the required experience in the care of older persons, and worked full-time in the centre. The person in charge had the overall clinical responsibility for the delivery of health and social care to the residents.

Judgment: Compliant

Regulation 15: Staffing

There was adequate staff available to meet the needs of the current residents taking into consideration the size and layout of the building. There were satisfactory levels of health care staff on duty to support nursing staff. The staffing compliment included cleaning, catering, activities and administration staff.

Judgment: Compliant

Regulation 16: Training and staff development

Training records reviewed evidenced that all staff were facilitated to attend training such as safeguarding of vulnerable people, fire safety, and manual handling.

Judgment: Compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements.

Records set out in Schedule 3 and 4 of the regulations were not appropriately maintained in the centre and were therefore not available for inspection by the Chief Inspector. For example;

- Records of some complaints made by residents about the operation of the designated centre were not appropriately maintained. While action had been taken by the registered provider in response to complaints about medicines and pharmaceutical services, a record of the complaints made by residents was not maintained, as required by Schedule 4(6) of the regulations.
- Records of any plan relating to residents nutritional monitoring such as weight monitoring were poorly maintained. For example, records of weights for some residents assessed as being at risk of malnutrition were not maintained, in line with the requirements of Schedule 3(4)(b) of the regulations.

Records were not maintained in a manner that was accessible. For example;

- A full and complete record of any incident in which a residents suffered abuse or harm was not provided for review. The records of adverse incidents involving residents provided for review were a summary document. The records did not contain the details required by Schedule 3(4)(j) of the regulations. This included information pertaining to the names of the person(s) in charge of the centre, supervising the residents, and names and contact details of any witnesses, and results of investigations and action taken.
- A full record of staff training in respect of each person working is the designated centre was not provided for review as required by Schedule 4(8)(c) of the regulations.
- Records required under Schedule 4 were not made available for review. This included records of testing and maintenance of fire equipment.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider had an up-to-date contract of insurance in place against injury to residents, and loss or damage to residents' property.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place to monitor the quality of the service were not fully effective to ensure the service provided to residents to residents was safe and effectively monitored. For example;

- The systems in place to manage and access records was not robust. For example, in the absence of nominated staff members, access to some key records was not possible, and the systems to monitor records to ensure full compliance with the regulations was poor. There was no clear policy, procedure and robust system to underpin an effective record management system.
- Some of the systems used to evaluate and improve aspects of the service were not effective. For example, audits of fire safety were not effective to identify areas of the service that required quality improvement.
- Management oversight and monitoring of adverse incidents involving residents required action to ensure they were appropriately notified to the Chief Inspector, as required.

Judgment: Substantially compliant

Quality and safety

Resident's health and social care needs were maintained by a satisfactory standard of evidenced-based care and support from a team of staff who knew their individual needs and preferences. Residents were satisfied with their access to health care and reported feeling safe and content living in the centre. However, the inspector found that action was required to ensure residents received care and support in an environment that protected them from the risk of fire, and to ensure that residents individual assessments and care plan accurately reflected their current care needs.

The inspector reviewed the arrangements in place in relation to fire safety. Regular fire safety checks in the centre were completed and recorded. There were daily, weekly and monthly checklists which included testing of fire equipment, fire alarm testing, emergency lighting, means of escape and fire exit doors, all of which were up-to-date. However, a number of corridor doors contained significant gaps between the bottom of the door and the floor. This could potentially impact on fire containment measures in the event of a fire. In addition, day-to-day fire precautions and drill practices were not effectively completed. These are further described under Regulation 28, Fire precautions.

A sample of assessments and care plans were reviewed and found that while each resident had a care plan in place, care plans were not always informed by an accurate and up-to-date assessment of the residents needs, following an adverse incident such as a fall. Therefore, some care plans did not always reflect the current care needs of the residents. Furthermore, some care plans were not reviewed following a change in the residents condition.

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

The needs of residents who had difficulty communicating were identified by staff to support residents to communicate their views and needs directly. Residents who required supportive equipment to communicate were provided with such equipment. Residents care plans reflected their communication needs and preferences.

Residents had easy access to their clothing and personal possessions. Laundry was well looked after and their laundry returned in a timely manner. There was adequate space for personal storage that included secure storage for the safe-keeping of valuables.

Residents stated that they felt at home in the centre and that their privacy and dignity was protected, and that they were free to exercise choice about how to spend their day.

Residents had access to advocacy services and information regarding their rights, and were supported to engage in activities that aligned with their interests and capabilities. There was a number of information notice boards strategically placed along corridors.

Satisfaction surveys were carried out with residents and relatives and reflected that residents were satisfied with the service provided. Arrangements were in place for residents to receive visitors. There was no restrictions placed on visiting to the centre.

Regulation 10: Communication difficulties

The registered provider had arrangements in place to ensure residents who experienced communications difficulties were appropriately assessed. Staff demonstrated an appropriate knowledge of each residents communications needs, and the aids and appliances required by some residents to support their needs, in line with the residents individual care plan.

Judgment: Compliant

Regulation 11: Visits

The registered provider had arrangements in place to facilitate residents to receive visitors in either their private accommodation, or in a designated visiting area. Visits to residents were not restricted.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were supported to have access to, and retain control over, their personal property, possessions and finances. Residents had adequate space to store their clothing and other personal possessions.

Staff ensured that residents wore their own clothes, and that residents' clothes were laundered and returned to them in a timely manner.

Judgment: Compliant

Regulation 28: Fire precautions

Arrangements for reviewing fire precautions in the designated centre were not in line with the requirements of the regulations. For example;

- There was inadequate management of the keys to locked storage and service areas that contained sources of ignition, or flammable materials.The keys for locked doors were not managed appropriately, creating a high risk that those areas were not accessible in the event of a fire emergency.

Arrangements for containing fire in the designated centre was not adequate. This was evidenced by;

- Some corridor fire doors had large gaps where the doors meet at the top and the bottom. Gaps were also observed where the doors align in the centre. This had the potential to impacted on fire containment measures in the centre.

Arrangements for the evacuation of residents in a timely manner were not line with the requirements of the regulation. This was evidenced by;

- fire drill reports did not contain sufficient information to demonstrate the effectiveness of the evacuation procedure. This included evidence of the

evacuation strategy, details of the compartment used as the place of safety, or an analysis of the deficits and improvement actions required.

Although staff were documented as having up-to-date fire safety training, the lack of awareness by some staff of the centres fire evacuation procedures, did not provide assurance that the fire safety training provided, captured the full extent of the requirements of the regulations. For example, staff demonstrated a poor awareness of the procedure to commence should the fire alarm sound, and the evacuation strategy.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Care plans were not guided by a comprehensive assessment of the residents' care needs. Residents assessed as being at risk of falls were not identified as such within their care plans. Consequently, care plans did not contain person-centred guidance to support appropriate care of the residents.
- Residents did not have an appropriate assessment of their needs completed following a falls incident. Consequently, the care plan did not detail the interventions necessary to support residents who required close supervision and support with their mobility care needs.
- Care plans were not consistently reviewed or updated when a resident's condition changed. For example, the care plan of a resident whose general condition had deteriorated had not been updated to reflect a significant increase in their nutritional care needs. Consequently, the care plan did not reflect the nursing and care interventions required to support their needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP), and the person in charge confirmed that GPs were visiting the centre as required.

Residents also had access to a range of allied health care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of old age, and palliative care.

Judgment: Compliant

Regulation 9: Residents' rights

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

Residents were provided with the opportunity to be consulted about and participate in the organisation of the designated centre by participating in residents meetings and taking part in resident surveys. Residents told the inspector that they could exercise choice about how they spend their day, and that they were treated with dignify and respect.

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	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Milford Nursing Home OSV-0000418

Inspection ID: MON-0044105

Date of inspection: 26/06/2024

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 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1.With regard to incident reporting, all incident details can now be accessed at night or at weekends by all Centre Cover managers and night CNM3s. The updated link will be emailed each Friday to reflect all incidents for the previous week, and the centre cover folder updated accordingly. This is an interim measure until the on-line incident management project team implement electronic point of entry at Milford Care Centre so all staff will have access to the on-line electronic record system.

2.All residents transferred from the designated centre will be recorded on the on-line electronic record system. This change in practice has been communicated to all staff at the nursing documentation days and at all handovers and Safety Pause.

3.All notifiable incidents as detailed under Schedule 4 of the regulations will always be notified to the Chief Inspector of Social Services within the required timeframe. This has been repeatedly communicated to staff at all handovers, Safety Pause and Fast Fact Sessions.

4.All complaints made by residents about the operation of the centre will be appropriately maintained as required by Schedule 4(6).The complaints folder Point of Contact Resolution Log is accessible to all staff on PC desktops in the Nursing Home. This has been repeatedly communicated to staff at all handovers, Safety Pause and Mandatory Training days.

5. A checklist has been developed for CNM's to ensure accurate and timely recording of residents clinical care and updating of care plans to reflect any changes in resident clinical status. The checklist is returned weekly to the ADON & is reviewed with the CNM's weekly. All KPI's are discussed at this meeting and actions reviewed.
Audit of 2 care plans per Unit will be carried out weekly by the CPC and CNM.
6.Recording of weights and review of residents status will include a comparison with the last recorded weight of the resident. Referral to dietitian and speech and language therapist is actioned as required, in line with the requirements of schedule 3(4)(b) of the

regulations.

7.A full and complete record of any incident in which a resident suffers abuse or harm will always contain the detials required by schedule 3 (4)(j) of the regulations. Safeguarding Training for 20 nursing home staff will be facilitated by the HSE on September 18th 2024, and will continue to be rolled out by Milford Care Centre Education Department staff.

8. A full record of staff training in respect of each person working in the designated centre will be available for review as required by schedule 4 (8) (c) of the regulations.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1.With regard to incident reporting, all incident details can now be accessed at night or at weekends by all Centre Cover managers and night CNM3s. The link will be emailed each Friday, to reflect all incidents for the previous week , and the centre cover folder updated accordingly. This is an interim measure until the on-line electronic record system project team implement electronic point of entry at Milford Care Centre, so all staff will have access to the on-line electronic record system.
2.We are in the process of developing a guideline to underpin an effective record management system to ensure easy access to all records, ensuring full compliance with the regulations.
3.Fire safety audits are conducted in respect of fire registers weekly for safety checklists and annually overall. Fire doors are audited biannually. All staff are encouraged in the intervening period to report any defects noted to fire doors. Reception staff to be requested to add the quarterly fire alarm and emergency lighting certs to their audit checks and fire contractor to be instructed to ensure certs are received immediately post inspection, and that quarterly inspections are no more than 3 months apart.
4. All notifiable incidents as detailed under Schedule 4 of the regulations will always be notified to the Chief Inspector of Social Services within the required timeframe. This has been repeatedly communicated to staff at all handovers and Safety Pause to ensure timely updates for the ADON and DONTSC.

Regulation 28: Fire precautions	Substantially Compliant

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

DONTSC, ADON, CNMs, Centre Cover Manager and Maintenance Manager hold keys to the locked storage areas in the Nursing Home which may contain sources of ignition. All staff aware that they can access the keys from all of the persons above.The Nursing Home CNM or her designate will always hold this key as does the night CNM.
Fire doors are audited every 6 months. All staff are requested to report any defects in the intervening period for remedial works. Following the inspection, all doors were reviewed and adjusted to ensure no gaps existed.

Fire drill reports will be reviewed; these contain attendees, the type of drill and evacuation strategy, compartment evacuation, stage of evacuation, time taken, revised time taken and fire prevention discussion.

Currently, staff attend fire training online, in class fire extinguisher training and attend fire drills. Fire marshals also attend in-class training, including fire extinguishers, fire drill and fire panel training. New staff members are inducted as to the fire evacuation plan for the Nursing home. Staff are required to acknowledge the fire policy, strategy and Nursing home fire plan. Additional fire drills will be run monthly in the Nursing home to address any deficit in knowledge.

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:
Bespoke documentation study day developed by the Education Department in MCC, Practice Development Co-Ordinator and Clinical Nurse Managers. Special emphasis has been placed on resident care plans and groups are limited to six participants to ensure maximum engagement in an environment conducive to learning which will enhance quality of care for the residents.The agenda covers care planning, falls , nutrition, pressure area care, and the importance of updating the care plan to reflect individualised person centred care. These study days commenced in July 2024, further dates are set for September & October 2024.Continuous weekly audits of care plans in place in the nursing home.

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 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/09/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	23/08/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/09/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate	Substantially Compliant	Yellow	27/06/2024

	arrangements for reviewing fire precautions.			
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	26/07/2024
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	26/07/2024
Regulation 28(2)(i)	The registered	Substantially	Yellow	27/06/2024

	provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Compliant		
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	30/09/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/09/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with	Substantially Compliant	Yellow	30/09/2024

	the resident concerned and where appropriate that resident's family.			