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:	St Colman's Residential Care Centre
Name of provider:	Health Service Executive
Address of centre:	Ballinderry Road, Rathdrum, Wicklow
Type of inspection:	Unannounced
Date of inspection:	01 October 2024
Centre ID:	OSV-0000492
Fieldwork ID:	MON-0043892

About the designated centre

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

St. Colman's Residential Care Centre is a community facility providing a variety of services to the elderly population of Wicklow. St. Colman's Residential Care Centre provides residential care, respite and palliative care for a total of 92 residents both male and female, over the age of 18 years. Accommodation is provided on three units, Primrose Place, Clover Meadow and Lavender Vale. Four beds are dedicated for respite admissions and the remainder are long term care. Bedroom accommodation is mostly multi-occupancy three and four-bedded rooms. There are two twin-rooms and four single-bedrooms - two of which are allocated to palliative care. There is a designated smoking area for residents on Primrose Place, Clover Meadow and Lavender Vale.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	82

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 1 October 2024	09:45hrs to 17:45hrs	Catherine Furey	Lead

What residents told us and what inspectors observed

This unannounced inspection took place over one day. The inspector greeted many residents during the day and spoke in more detail to some, to gain an insight into their lived experience in St. Colman's Residential Care Centre. Feedback gathered from residents was generally positive, and residents expressed feeling content in the centre. One resident said "I am here years, they are like family to me". Another commented that staff were "fantastic in every way". Feedback from visitors was also positive, with family members saying they had "no doubts about the care".

Following an introductory meeting, the inspector completed a tour of the building with the assistant director of nursing, who was deputising in the absence of the person in charge. The inspector observed that the majority of residents were having their care needs attended to by staff. At different times throughout the day, residents were observed in the communal areas watching TV, listening to music and participating in activities with staff. Friendly conversations were overheard between residents and staff and there was relaxed atmosphere in the centre. Staff stated that they had sufficient time to ensure the residents' personal care needs were met and the inspector observed that residents' dressing and grooming needs were attended to at a high standard.

The centre is a single-storey building providing accommodation for 92 residents located in Rathdrum, Co. Wicklow. The centre is divided into three separate units; Lavender Vale, Primrose Place and Clover Meadow, which are connected via shared corridors and are each staffed by teams of clinical nurse managers, nurses and care assistants. There is one central dining room, and each unit has a separate communal area which are used for a combination of activities, relaxation and dining. The newly-refurbished conservatory area was generally designated for the residents of Primrose Place as an alternative dining room to the main dining area. It was noted that the conservatory was completed to a high level, with new, comfortable chairs and bright and clean décor and flooring. The glass roof meant that the room could become warm at times, and it was very warm on the morning of the inspection, however there were newly-installed air conditioning units, which when operating provided an appropriate temperature in this room.

The inspector observed some of the centre's bedrooms. The two twin rooms on Lavender Vale had been reduced to single occupancy, and this provided these residents with sufficient storage and privacy. Some work was required where areas of chipped paint and plaster remained following the removal of the curtain tracking. Work was progressing in the four-bedded rooms on Clover Meadow to ensure that each resident had sufficient privacy. This generally required the reconfiguration of curtain tracking. Management showed the inspector where this had been completed, however some rooms remained configured in a way that did not maximise resident privacy. Additionally, the lighting arrangements in some rooms were insufficient, due to rearranging the curtain tracking, but not the overbed lighting. Some of the fitted wardrobes were original wardrobes from when the centre was previously a hospital.

These provided very little hanging space. Additionally, the inspector saw some rooms where stocks of linen were kept in residents wardrobes, further minimising the space available for residents belongings. Residents were provided with a secure locked facility within their storage spaces. Residents' clothing was laundered daily and the system in place was efficient. Residents' confirmed that their clothes were returned to them without delay.

A large number of residents living in the centre had a diagnosis of dementia or cognitive impairment. Residents who spoke with the inspector were happy to chat about how they spent their day. When asked what it was like to live in the centre, one resident told the inspector that 'you couldn't find better'. Another resident outlined how they liked to spend their day and told the inspector that everything was 'very good' and that they got everything they needed. One resident was not happy with the privacy arrangements in their room, and they stated that they had informed management of this but they were still unhappy. A resident told the inspector that they would love a private room instead. There were a number of residents who sat quietly observing their surroundings, and who were unable to speak or express their wishes to the inspector. These residents were observed to be comfortable and relaxed.

Residents were provided with opportunities to participate in recreational activities of their choice and ability. There was a schedule of activities in place and residents were encouraged to go out with families and maintain connections with their own communities. On the day of inspection, the activities coordinator had arranged for an external person to start a course of flower arranging which would last six weeks. A number of residents attended this session. In the afternoon, another activity staff member went to the communal rooms on each unit and played guitar and sang well-known songs, and there was good resident involvement observed. A range of activities were included in the weekly schedule including exercise, Bingo and dementia-specific therapy. Friends and families were facilitated to visit residents, and the inspector observed many visitors coming and going throughout the day.

Residents were generally complimentary about the quality of food on offer. The dining experience was observed to be a social, relaxed occasion, and the inspector saw that the food appeared appetising. There was one main separate dining area, however prior to meals, the tables were rearranged in the sitting rooms and place settings were laid. Food was served from the bainmarie and plated up as per the resident's order. Residents were assisted by staff, where required, in a sensitive and discreet manner. Other residents were supported to enjoy their meals independently. Throughout the day, staff supervised the sitting rooms, and those residents who chose to remain in their rooms, or who were unable to join the communal areas were monitored by staff. Staff who spoke with the inspector were knowledgeable about the residents and their needs.

To summarise, residents were in receipt of a good service from a dedicated team of staff who ensured that clinical and social needs were met to best of their ability. However, deficits in the premises and environment contributed to a service that could not fully support the rights of the residents.

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. The levels of compliance are detailed under the individual regulations.

Capacity and capability

This was an unannounced inspection to monitor compliance with the regulations and standards. The inspector found that while governance and management systems were in place, further oversight was required, to ensure a consistently safe level of care and service provision to residents.

The registered provider of St. Coleman's Residential Care Centre is the Health Service Executive (HSE). The centre is registered to provide accommodation for 92 residents, and there was 82 residents living in the centre on the day of inspection. The registered provider had submitted an application to the Chief inspector to vary conditions of their registration, in relation to the change of purpose of some rooms and the reduction in occupancy of two twin rooms to single rooms. This application was made following the findings of previous inspections in January and April 2024, which identified that the two twin rooms on Lavender Vale unit did not meet the space and layout requirements of the regulations, and two rooms had changed purpose from a store room to an office, and an office to a private room. The rooms in question were reviewed by the inspector and the changes as outlined in the application were verified.

The centre has a recent history of repeated non-compliance with some regulations, in particular related to the premises and fire precautions. This inspection assessed the provider's compliance plans from both the January and April 2024 inspections, and found that a number of actions had been implemented to improve the quality and safety of care provided to residents. Despite these improvements, the overall management systems in place continued to require strengthening, to ensure that all aspects of residents' safety and the care provided were consistently monitored, and actions put in place to drive continuous quality improvement.

On the previous inspection, there was no person in charge assigned, which is required by the regulations. A new person in charge had commenced in April 2024 and she was very familiar with the centre, having previously been the assistant director of nursing. There was a clear management structure in place and staff were aware of the reporting mechanisms, and their own responsibilities. Staff meetings were occurring where different aspects of the service were discussed. This was strengthened by regular daily handovers and safety huddles where pertinent daily concerns were discussed and staff were made aware of any specific plans for the day.

Audits were carried out by the management team and a sample of these were reviewed by the inspector, including audits of infection prevention and control,

residents' records and incidents. For the most part, the audits were a collection of data and did not have associated time-bound action plans to evidence improvements made. Some of the audits did not identify evident issues, for example, gaps in assessments and care planning.

Improvements were seen in the provision of staff training. A system was in place to ensure that as new staff were recruited, they were assigned to complete appropriate online training which, where required, was followed up with in-person training courses. Staff had access to a programme of training that was appropriate to the service.

The system of rostering and allocating staff to specific units provided assurance that staff were appropriately supervised by senior staff in their respective roles. The provider had good procedures in place for the recruitment and retention of suitable staff. Staff files reviewed contained all the requirements under Schedule 2 of the regulations. An Garda Síochána (police) vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available in the designated centre for each member of staff.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The registered provider had made the appropriate application to vary conditions of registration, in relation to the change of purpose of a small number of rooms in the centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge commenced the role in April 2024. She had the required management and nursing experience to fulfil the regulatory requirements of the role.

Judgment: Compliant

Regulation 16: Training and staff development

A review of the centre's training records provided evidence that important training, for example, safeguarding of vulnerable persons, fire safety and medication management was completed by staff. There was a plan in place to provide refresher

training in moving and handling for some staff in the coming weeks, which would ensure that all staff were up-to-date and appropriately trained in this area.

A review of staff files identified that there was a documented, tailored induction process in place to ensure that staff were knowledgeable about their individual roles and responsibilities.

Judgment: Compliant

Regulation 21: Records

While overall record-keeping practices in the centre were very good, the inspector identified one area in relation to residents' records which did not meet the requirements of Schedule 3 of the regulations; a signed and dated daily nursing record of resident's health, conditions and treatment given was not always made. Management informed the inspector that daily nursing notes were only made when there was a change to a resident's condition, or a notable incident.

Judgment: Substantially compliant

Regulation 23: Governance and management

At the time of inspection, assurances were not fully provided that the systems in place to ensure oversight of key areas of the service were safe, appropriate, consistent and effectively managed. For example;

Incidents were appropriately documented as they occurred, with the majority being falls-related. The data in relation to the incidents was recorded, however, there was no analysis of the incidents. For example, the data collection showed that the majority of incidents each month were occurring on Lavender Vale unit, however there was no documented plan to address this. This is a missed opportunity to share learning from incidents and implement quality improvement plans to address any findings from the analysis of the data.

The management of fire safety in the centre continued to require strengthening. While many areas outlined in the compliance plan from the previous inspection had been addressed, the systems in place to oversee the evacuation requirements of the residents continued to require further oversight. This is evidenced under Regulation 28: Fire precautions

The oversight systems for individual resident and care planning did not capture many errors and omissions, which were identified by the inspector on the day, and are detailed under Regulation 5: Individual assessment and care plan.

The person in charge had prepared an annual review of the quality of care provided to residents in 2023, however this review was not prepared in consultation with residents and their families, and offered no analysis of satisfaction surveys or feedback completed by residents or their families.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose had been update in July 2024 to reflect the changes made to the purpose of some rooms. The statement of purpose accurately reflected the services and facilities provided, the management and staffing complements, and the arrangements to ensure residents' wellbeing and safety.

Judgment: Compliant

Quality and safety

Overall, the residents were supported by kind and compassionate staff to have a good quality of life in this centre. Improvements were evident in the provision of activities and the use of all communal spaces, which had a positive impact on residents' wellbeing. Further oversight of fire safety procedures, aspects of the premises, and individual care planning was required, to ensure that all risks to residents' safety and wellbeing were identified and actioned.

Since the previous inspection, there had been incremental improvements in the state of repair of parts of the premises. For example,

- the conservatory was completely refurbished and upgraded with replacement of windows, new flooring, and repair of the ceiling and roof. This provided a bright and pleasant room for residents' use
- on Lavender Vale unit, new wardrobes were provided for residents who previously had to access fitted wardrobes outside of their personal bedspace. This provided a larger personal space area allowing for access to personal belongings.

However, the premises continued to have multiple areas of wear and tear and damage. Work to progress these issues was slow, and as a result, detracted from the overall appearance of some rooms. Findings in this regard are detailed under Regulation 17: Premises.

Following the previous inspection, the registered provider has made a number of improvements in relation to overall fire safety in the centre, and had completed many of the actions set out in their compliance plan response. For example;

- means of escape were kept clear, including the main corridors where bed evacuations may would be required in the event of an emergency
- an improved system was in place to ensure that keys of locked emergency exits were available at all times
- staff training in fire procedures was up-to-date for staff
- storage of oxygen and the charging of hoist batteries was improved and the new systems in place reduced the risk of fire spreading
- containment measures on the corridor known as the N11 corridor has been improved by the removal of the old louver type windows to traditional windows which would more appropriately contain fire smoke or fumes in the event of a fire.

On the day of inspection, an external contractor was onsite, carrying out work to repair and replace fire doors. This was as a result of a fire safety risk assessment which was carried out in July 2024, which identified a significant amount of deficits to the fire doors throughout the building. Evidence was provided that the work had been carried out progressively, and was planned to be complete in the coming weeks.

Notwithstanding the work completed to date to improve fire safety measures in the centre, assurance was not provided that staff were familiar with evacuation procedures. There continued to be confusion amongst staff in relation to the methods and manner of evacuation from different areas, and conflicting documentation in residents' personal emergency evacuation plans (PEEP's) and records of simulated fire drills. This is discussed in more detail under Regulation 28: Fire precautions.

The inspector reviewed a sample of residents' records throughout the inspection which identified inconsistencies related to individualised care planning. The new electronic documentation system was not fully operational, leading to inconsistencies, errors and omissions in the documentation of, for example, residents' clinical assessments, care plans and weights. Staff were able to provide evidence in the residents old paper-based notes of previous care plans which were detailed and person-centred, however this information had for the most part not been transferred over to the electronic system. This meant that two systems were in use, which made it difficult to identify the specific plans of care for some residents.

A restraint-free environment was promoted in the centre. Alternative measures to bed rails, such as low profile beds and sensor alarms were trialled before applying bed rails. Consent was obtained when restraint was in use. Records confirmed that there was a system in place to monitor the safety and response of the resident when bed rails were applied.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of their

safeguarding training and detailed their responsibility in recognising and responding to allegations of different types of abuse. Residents who spoke with the inspector, reported that they felt safe living in the centre.

There had been improvements in the provision of activities within the centre since the previous inspection. This included an improved system of documenting resident participation in activities, with the aim of identifying what worked well and what residents enjoyed. There were a minimum of two staff on duty to provide activities each day, and these were a combination of group and individual therapies. Following a resident survey, a review of residents' preferences for activities had been completed, and a plan to implement new and varied activities was in progress. The inspector identified that this was the only area of the recent survey that had documented follow up. For example, residents' concerns related to privacy had no documented plan to address these concerns. Privacy within multi-occupancy rooms remained a concern, as detailed under Regulation 9: Residents' rights.

Since the previous inspection, WiFi had been installed throughout the centre, which provided good service for residents who wished to use their individual phones and devices to access the Internet. One resident was completing an online course and attended virtual lectures every week.

Regulation 10: Communication difficulties

Residents who had communication difficulties related to their diagnosis or condition were enabled to communicate freely. Residents had an assessment of their communication needs made on admission to the centre and this was reflected in the individual plan of care for each resident.

Judgment: Compliant

Regulation 17: Premises

Aspects of the premises did not conform to all the matters as set out in Schedule 6. For example;

- Wear and tear issues continued to persist at the centre. Damage was noted to doors, walls and flooring. Areas where reconfiguring of beds had occurred continued to have damage from removal of curtain tracking which required replastering and repainting. This was also a repeat finding from previous inspections.
- the layout of some rooms continued to be unsuitable for residents' needs. Rooms that previously contained six beds and which had reduced to four beds, still had the overbed lighting configured for six residents. This meant

that in some rooms, when the privacy curtains were closed, there was no overbed lighting

The additional impact of the lack of lighting on residents' rights is discussed further under Regulation 9.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider did not ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and, in so far as is reasonably practicable, residents are aware of the procedure to be followed in the case of a fire. For example:

- Resident PEEP's did not clearly reflect the needs of the residents. The template in use was not in a suitable format and contained irrelevant information related to areas such as allergies, continence and dietary requirements. The specific evacuation information was difficult to find. Furthermore, the PEEPs were not grouped by building compartment, and instead all were contained in one folder in an office, which was not readily available for staff if an emergency evacuation was required.
- The sample of PEEP's reviewed did not include any information on the ability of the resident to understand the sound of the fire alarm system going off, the ability of the resident to evacuate out of the building, or a clear description of the staff assistance they will need, including the number of and skills of staff for both daytime and night-time evacuation, or the supervision requirements after the evacuation.
- The PEEP's indicated that ski-sheets were the method of evacuation for all residents. This directly conflicted with staff statements, who indicated that the beds themselves would be evacuated. Additionally, this conflicted with the drill records, which identified a number of residents who were evacuated by wheelchair or by independently mobilising.
- Despite staff regularly practising drills of different scenarios, the procedure for the evacuation of all residents, in particular within the large compartment of 25 residents remained unclear. The previous inspection identified that a final exit route through the physiotherapy room, which was an evacuation route from Lavender Vale unit, did not have a ramp installed and the evacuation of beds through the exit door would prove difficult if required in the event of a fire. The provider's compliance plan indicated that this exit was not suitable for bed evacuation due to the width allowance of a wheelchair at most, however, due to the conflicting information in PEEP's, and confusion amongst staff, it remained unclear if beds would still be required to be evacuated via this door.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A sample of seven residents' individual assessment and care planning documentation was reviewed. This review identified some issues with the current system of care planning, which required addressing, to ensure that residents' care plans are comprehensive, individualised and regularly reviewed. Examples of the findings include;

- one resident did not have important clinical risk assessments including risks associated with mobility, oral care and malnutrition completed since November 2023. This is excessively beyond the minimum four-month timeframe for assessment specified in the regulations. Regular reassessment of individual needs is important to ensure that care is delivered appropriately.
- in one residents' record, the validated risk assessment tool to measure risk of malnutrition was incorrectly calculated on numerous occasions. This meant that the risk of malnutrition was incorrectly classified as medium risk when the correct classification was high risk. This led to a missed opportunity to make a referral to a dietitian for further specialised assessment.
- a resident who had recently sustained a fall necessitating a hospital transfer, had no updates or changes made to their falls care plan following this event. This is important, to determine if further actions are necessary to minimise falls occurring.
- some of the newly-completed care plans on the electronic systems were based on a generic template that provided no individualised or specific steps to meet residents' needs in a person-centred way.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Restraint use in the centre was well-managed and residents had a full risk assessment completed prior to any use of restrictive practices. Assessments were completed in consultation with the residents and the multi-disciplinary team and were reviewed regularly to ensure appropriate usage in line with national guidance.

Judgment: Compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date safeguarding policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns. Any allegations of abuse were investigated and referred to the appropriate external agencies, for example the safeguarding and protection team and advocacy services.

The provider was acting as a pension agent for a small number of residents. Records of client account statements and balances provided assurance that there were strong systems in place to safeguard residents' finances.

Judgment: Compliant

Regulation 9: Residents' rights

Despite the evident improvements in relation to activities in the centre, further action was required to ensure that residents rights' to privacy and dignity were consistently maintained in multi-occupancy rooms.

- the inspector observed staff entering a residents bedspace in a multi-occupancy room, to retrieve linen from a cupboard labelled "stock items". The cupboard was part of fitted furniture in the room, designed for residents' personal belongings and not as a multi-purpose storage area.
- the position and placement of the television within some multi-occupancy rooms did not provide all residents with access to the television. For example, in some four-bedded rooms, the television was within one of the residents bedspaces and therefore, if that resident's privacy curtain was closed, no other resident could see the television.
- there was insufficient electrical sockets at some bedspaces.The registered provider had started to provide additional electrical trunking in some rooms to alleviate this problem. In one room on Clover Meadow there were only two sockets available in one resident’s bedspace. Both were used for the bed and the mattress, meaning that the overbed light could not be plugged in. Another resident was required to charge their mobile phone outside of their private bedspace.
- the availability of overbed lighting was further compromised by the poor configuration of bedspaces, with no overbed light in some bedspaces. This meant that some residents did not have sufficient lighting, impacting on their ability to conduct activities in private. For example, one resident said it was difficult to read in her bed with no light.

While consultation with residents had improved, further action was required to ensure that the findings of this consultation was acted upon in a timely manner to address residents' concerns;

- while satisfaction surveys had been carried out, there was no evidence that findings in relation to privacy in multi-occupancy rooms, had been individually

addressed. There was no documented plan to follow up on the identified issues.
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	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Colman's Residential Care Centre OSV-0000492

Inspection ID: MON-0043892

Date of inspection: 01/10/2024

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: • A signed, dated and daily record of resident's health, conditions and treatment is active through Epic care system and was implemented throughout the Centre post inspection on 7th October 2024.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A documented incident review template, accompanied by an action plan for potential shared learning, has been implemented. All learning outcomes have been previously disseminated through the weekly MDT meetings and during handover/safety hub sessions. • Individual care plans are systematically reviewed for metrics, ensuring continuous quality improvement in person-centred care. Resident satisfaction surveys are currently underway and will inform the annual quality and safety review. • An invitation has been extended to family members, nominated care representatives, and decision-making representatives for an open meeting on November 11th 2024. This meeting will provide an opportunity for consultation in the compilation of the annual report.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The ongoing refurbishment program aims to enhance the quality of residents' personal space, privacy, and dignity through the extension and reconfiguration of curtain rails in Clover meadow and Primrose Place, with completion expected by 31st December 2024.
• The upgrade to provide additional electrical points at residents' bed spaces, which began in July, is progressing. This includes bed space lighting and electrical supply for appliances. Painting will follow the curtain upgrades to minimize disruption to residents.
• The upgrades to fitted wardrobes in Lavender Vale is also scheduled for completion by 31st December 2024, along with necessary plaster and paintwork replacements in the centre.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Centre now utilizes the Epic care format for residents' PEEPS (Personal Emergency Evacuation Plans), which details residents' awareness of the fire alarm, the required number and skill mix of staff for evacuation, the mode of evacuation, and the specific level of supervision needed post-evacuation. All PEEPS are stored in folders corresponding to the appropriate compartments on each unit.
• Staff are trained to use the safest and most efficient evacuation methods. Fire education and drills are conducted weekly on all units, supplemented by random safety hub scenarios involving all staff. This process is thoroughly documented to ensure all staff have participated and demonstrated safe practices with complete and safe awareness of fire evacuation procedures
• Staff participate in weekly fire drills throughout the Centre. The primary focus is on horizontal internal evacuation where feasible. External evacuation is reserved for extreme circumstances only. Lavendar Vale, the largest compartment area with a capacity of 23 residents, is a key focus during fire drills. Staff are trained to understand and practice horizontal internal evacuation to the nearest safe adjacent compartment. The route for evacuation from this area are to the Older Persons Day Centre compartment (Big Room) and also into Heather Rest Dementia day Care Service. The direction of evacuation is determined by the location of the fire and the nearest and safest compartment.
• All compartments are visually indicated with a fluorescent red tape over each compartment doorway entrance. This visual aid for compartment identification reinforces both verbal and active educational support through repeated demonstration with staff on the correct and most efficiently safe method of evacuation in the event of a fire.
• The Physiotherapy department, although a separate compartment to Lavender Vale has no suitable external fire exit to facilitate a bed evacuation. The compartment entrance leading to the Physiotherapy Department from Lavender Vale has the capacity to allow bed access with a limited number in accommodation. There is however no means for external evacuation should it be necessary. Fire education on site with staff emphasizes

the preferred and safer evacuation practice to the Big Room/Heather Rest or main corridor compartments.
• Fire education/drill simulation with staff also emphasizes the need for full understanding and awareness of the importance of a safe, operational, easily accessible alternative method of equipment other than a bed for evacuation should it be necessary. I.e. wheelchair with footplates.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• Clinical risk assessments are now reviewed within the appropriate timeframes using the Epicare system, which enables comprehensive review and audit by the CNM, ADON and DON at both unit and central management levels. MUST calculations are now performed on the Epicare system also, ensuring accuracy at all times.
• The Centre's policy mandates a review of residents' care plans following their return to the centre after an acute incident, treatment, or admission. Nursing Administration conducts a weekly audit and review pathway for all residents who have returned from acute care, ensuring compliance with person-centred care delivery, including all post-fall care plans.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• All linen will no longer be stored in residents' bed spaces. Cupboards within a resident's personal space will be reserved for their use only.
• A centre wide review and upgrade of television placement is being conducted to better meets residents' access and individual needs.
• The electrical upgrade, which includes the provision of electrical sockets, began in July 2024 and has a scheduled completion date of 31st December 2024.
• Resident satisfaction surveys are currently in progress. These surveys will be followed by a reviewed system of action plans, including follow-up, review, and feedback to residents on any issues identified. This process will also contribute to the structure of the Annual Review.

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2024
Regulation 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	05/11/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Not Compliant	Orange	30/11/2024

	consistent and effectively monitored.			
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Orange	31/12/2024
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.	Not Compliant	Orange	30/11/2024
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 the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/11/2024
Regulation 9(3)(b)	A registered provider shall, in	Not Compliant	Orange	31/12/2024

	so far as is reasonably practical, ensure that a resident may undertake personal activities in private.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	31/12/2024