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:	Áras Deirbhle Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Aras Deirbhle, Belmullet Community Hospital, Belmullet, Mayo
Type of inspection:	Unannounced
Date of inspection:	24 January 2023
Centre ID:	OSV-0000644
Fieldwork ID:	MON-0036384

About the designated centre

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

The following information has been submitted by the registered provider and describes the service they provide. The designated centre provides 24-hour nursing care to 18 residents over 65 years of age, male and female who require long-term and short-term care including dementia care, convalescence, palliative care and psychiatry of old age. The centre is a single story building opened in 1975. Accommodation consists of seven twin bedrooms and sixteen single bedrooms. Communal facilities include Dining/day room, an oratory, visitors' room, hairdressing salon, smoking room and a safe internal courtyard. Residents have access to three assisted showers and two bathrooms. The philosophy of care is to embrace ageing and place the older person at the centre of all decisions in relation to the provision of the residential service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	25

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 24 January 2023	09:45hrs to 17:15hrs	Catherine Rose Connolly Gargan	Lead
Tuesday 24 January 2023	09:45hrs to 17:15hrs	Lorraine Wall	Support

What residents told us and what inspectors observed

On the day of the inspection the inspectors observed that residents staff interactions were kind and caring towards residents. Many of the residents who spoke with the inspectors said they were generally happy with their life in the centre and were very well cared for by staff but that they would like more activities to do on a daily basis. The inspectors found that there was limited opportunities for residents to engage in meaningful social activities in line with the preferences and capacities. In addition, inspectors found that the environment was in need of repainting and repair and this impacted on the residents' quality of life in their lived environment. The inspectors also observed that although some staff chatted with residents, interactions between staff and residents were focused on providing care interventions and care and daily routines were not person-centred.

On arrival to the centre, the inspectors were welcomed by a staff nurse and were joined later by the person in charge.The person in charge told inspectors that she was also the director of nursing for Belmullet Community Hospital. Inspectors walked around the centre with the person in charge and this gave the inspectors an opportunity to meet with residents and staff as the residents prepared for the day. There was a relaxed and calm atmosphere in the centre. Residents were being assisted to get up from bed and were being supported by staff or walking independently to the sitting room area. The inspectors spoke with several residents and a small number of resident's visitors. Overall, feedback from residents was mostly positive but many residents expressed their dissatisfaction with not having opportunities to participate in social activities that interested them. Residents' relatives spoken with by inspectors said they were 'very happy' with the centre and the standards of care provided by staff for their loved ones. The person in charge was observed by inspectors to be well known to residents and their relatives and she spent time engaging with them throughout the day.

Aras Deirbhle Community Nursing Unit is located on the same campus as Belmullet Community Hospital and is accessible through a link corridor from the centre. The entrance door to the designated centre was not well signed and did not appear welcoming. As a result inspectors were unsure if the front door was the main entrance to the designated centre. Access was controlled between the centre premises and the Community Hospital to ensure residents' safety. Residents' accommodation was arranged on ground floor level throughout.

The inspectors observed that a number of areas in the centre were in need of repainting and repair including the floors in the reception, some corridors and the residents' dining room floor which were worn and stained. Paint was scuffed, chipped and missing on areas of the wall surfaces along corridors, in communal rooms and in some residents' bedrooms. This included bedroom and communal room doors and door frames. Paint was also chipped and missing on items of residents' assistive equipment such as bed tables and bed frames. Inspectors observed that some residents' bedrooms were personalised with their photographs

and soft furnishings. However, the corridors and communal rooms had limited decor to make the environment familiar and homely for residents. For example, apart from a collage of residents' photographs in the reception, there were few pictures hanging along the corridors or in the dining room. No residents were observed to use this dining room on the day of the inspection. Residents told the inspectors that the dining room was 'cold', 'not very inviting' and 'not a nice room to eat in'.

While, some residents were observed by inspectors to remain in their bedrooms, most of the residents spent their day in the sitting room. Although, a staff member was present with residents in the sitting room, they did not engage in facilitating residents' social activities. Inspectors observed that there was a heavy reliance on the television and radio for residents in this communal area and also for residents who remained in their bedrooms. Residents were observed to spend their time watching the television, sitting quietly watching people passing on the corridor or sleeping. Inspectors asked some residents what they did during the day and they replied that they did 'nothing'. One resident told the inspectors that they spend their day waiting on their family to visit them while, two other residents told the inspectors that their day were 'very long' and 'boring'.

The residents' dining room was viewed by inspectors and they observed that a refrigerator and a large freezer unit were stored along one wall of the dining room. The person in charge told the inspectors that the refrigerator and freezer unit were storage areas for supplies for the kitchen. These units reduced the space available in the dining room for residents. The inspectors observed that the dining room was used by staff for their meal breaks and was not used by residents. A large double door was wide open into the kitchen and there was a draught from the kitchen into the dining room. Although, the floor covering appeared relatively new, a large area of the floor covering was stained. Inspectors were told that this staining was caused by spillage of a liquid that damaged the surface of the floor covering and had not been repaired.

Although, there were store rooms available in the centre, some of these rooms were cluttered and disorganised. Inspectors observed that there was also storage of residents' assistive equipment and other items in the residents' communal bathroom/toilet and in the shower/toilet for residents' use.

Inspectors noted that residents call bells were ringing for long periods especially in the early morning and in the afternoon. Residents told the inspectors that staff 'tried their best' to get to them quickly but that they were 'busy looking after the other residents'. One resident said that they are 'always waiting' for assistance from staff. The inspectors observed that interactions between residents and staff were respectful and kind, however many of these interactions were during care interventions and there was little in the way of social interaction between residents and staff and between residents themselves.

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

Capacity and capability

This was an unannounced risk inspection completed by inspectors over one day to assess the provider's progress with completion of their compliance plan from the last inspection in November 2022 and to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 as amended. This inspection found that management and oversight by the provider of this service was not effective and the quality assurance processes in place did not ensure that this service was safe, appropriate and met the needs of the residents. As a result the inspectors found that residents' needs were not adequately met and residents were not supported to live their best lives in the designated centre.

The previous inspection in the centre had taken place in November 2021 and had identified non-compliance in relation to staff, staff training, governance and management, records, policies and procedures, premises, infection prevention and control, assessment and care planning, health care and residents' rights. On this inspection, inspectors found that actions to address the findings of the last inspection were progressed but were not sufficiently completed to bring these regulations into compliance. As a result there were repeated non compliances on this inspection and the inspectors were not assured that the provider had made the necessary resources available to bring the designated centre into compliance with the regulations and to improve residents' lived environment and quality of life. In addition, inspectors found that compliance was not sustained with Regulations 3: Statement of Purpose, 7: Managing Behaviour that is Challenging, 12: Personal Possessions and 28: Fire Precautions.

The registered provider of Aras Deirbhle Community Nursing Unit is the Health Service Executive (HSE). The designated centre is registered to accommodate up to 30 residents in 16 single and seven twin bedrooms. According to the centre's Statement of Purpose, the management structure consisted of a service manager, who represented the provider, a manager of older persons services who participates in the management of the centre, a person in charge and two clinical nurse managers. The management team had responsibility for overseeing the work of a staff team of nurses, health care assistants, multi-task attendants with responsibility for caring, cleaning and laundry, catering and administration staff. This inspection found that the management structure in place did not reflect the centre's statement of purpose. At the time of this inspection, the person in charge did not work full-time in the centre as stated in the staffing breakdown in the centre's statement of purpose and the staff duty roster and one clinical nurse manager post was vacant. The person in charge also works in the role of director of nursing in Belmullet Community Hospital and inspectors found that the governance and management systems in place were not robust and did not ensure that care and services were safe, appropriate and consistent. For example, this inspection confirmed that an effective allocation of staff to meet residents' supervision and social care needs was not in place. This was negatively impacting on residents' safety and quality of life.

Policies and procedures to guide staff were not up-to-date to ensure that they were applicable to the centre and reflected evidence-based practice. Deficits in the fire safety measures were not identified and adequate assurances regarding residents' safe and timely evacuation in the event of a fire were not available. There was gaps found in residents' care documentation and delays in residents access to occupational therapy services. In addition the environmental and infection prevention and control audits were not identifying the extent of deficits in these key areas which meant these deficits were not being communicated to the relevant staff so that improvement actions could be implemented. Although the person in charge met with members of the Community Health Organisation senior management team on a regular basis, there was limited evidence that these meetings were effective in improving the care and services for the residents and achieving compliance with the regulations.

While, the provider had a staff training programme in place, this inspection found that the majority of staff were not facilitated to access fire safety and training to ensure staff had the skills and knowledge to care for and support residents who experienced responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The person in charge told the inspectors that a staff training needs assessment was been completed by the regional staff training department. However, a date for staff training had not been scheduled.

The inspectors' observations of staff practices and discussions with staff gave assurances that staff were familiar with residents' needs. However, staff supervision in their day-to-day work was not adequate. For example, senior staff did not identify that staff were not documenting care records in line with good standards of record keeping and the centre's policies and procedures. In addition, residents with a known risk to their safety and well-being were not being appropriately supervised. Furthermore, residents were not facilitated and supported with social care activities to meet their needs.

Records of fire safety equipment checks were not recorded in sufficient detail to provide assurances that the fire alarm panel and fire doors were adequately checked. The staff duty roster was not an accurate record of all staff available and working in the centre on the day of inspection. The inspectors' findings are discussed under Regulation 21: Records.

Regulation 15: Staffing

The allocation of staff in the centre did not ensure there was adequate numbers of staff with appropriate skills to ensure that residents' individual support, choice and social activity needs were met. This was evidenced as follows;

- Staff were not allocated to meet the assessed one-to-one supervision needs of one resident. As a result, this resident was observed by inspectors to enter

other residents' bedrooms and on one occasion the sluice room. This was particularly concerning because staff told the inspectors that due to their condition there was a risk that this resident may ingest food that did not suit their diabetic dietary needs and in addition they had poor safety awareness. Furthermore, this resident was observed entering the dining room unsupervised, which gave them access to a fridge and a freezer that were being used to bulk-store milk, a variety of residents' drinks and frozen food.

- Staff were not allocated responsibility to facilitate a meaningful social activity programme for residents in the sitting room and their bedrooms to meet their social interests and capabilities. The multi task attendant (MTA) who was responsible for providing meaningful activities for the residents in the day room was also involved in providing direct care for residents and supervision of residents in the day room**.** This supervision included residents with responsive behaviours who could potentially require increased levels of support. This is a repeated finding from the last inspection in November 2021.
- Inspectors observed that some residents' call bells were ringing for prolonged periods of time before staff attended to these residents. This finding was validated by residents who told the inspectors that they often had to wait for staff to assist them.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors found that staff training did not ensure all staff had the requisite skills and knowledge to provide appropriate care and support for the residents. This was evidenced by:

- A review of the staff training records found that three staff had no record of completing mandatory training in safeguarding vulnerable adults, 17 staff had not completed refresher training in safeguarding vulnerable adults and the majority of staff had not completed up-to-date fire safety training.
- The majority of staff had not completed training in the management of responsive behaviours (How residents who are living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). This was further evidenced in the findings discussed under Regulations 5: Assessment and Care Planning and 7: Managing behaviour that is Challenging which confirmed that staff did not have the requisite knowledge and skills relevant to the needs of residents who may display responsive behaviours.This is a repeated finding from the last inspection.

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of all residents. This was evidenced by:

- Residents' assessed supervision needs were not met by staff.
- The records of daily care given and fluid intake monitoring records were not completed in a contemporaneous manner..
- Cleaning practices and waste management in the centre was not in line with recommended standards. This finding is discussed further under Regulation 27: Infection control.

Judgment: Not compliant

Regulation 21: Records

While, the records of fire safety equipment checks were available, these records were not in sufficient detail to provide assurances that key safety equipment such as the fire alarm panel and fire doors were adequately monitored and that any actions required to remedy defects found on these monitoring checks had been addressed.

The rosters did not reflect the staff on duty in the centre each day. The person in charge was recorded on the staff roster as working in the centre from 09:00 to 17:00hrs each day including on the day of this inspection. However, senior staff who spoke with the inspectors when they arrived in the designated centre were unsure if the person in charge was on-duty that morning. Furthermore, the person in charge confirmed that they was based in an office in the Community Hospital on the same campus and attended the designated centre for a part of each day and at other times they were contactable by telephone. This was not reflected on the roster.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management and oversight systems in place to ensure compliance with the Health Act 2007 (Care and Welfare of resident in Designated centers for Older People) Regulations 2013 were not effective and significant focus was now required by the provider and the management team to ensure that the quality and safety of care and services delivered to residents met their needs and that the centre was in compliance with the regulations. This was a particular concern in relation to the resources that were made available to improve the lived environment for the residents, and to bring the premises into regulatory compliance. This was a repeated finding from the last inspection in November 2021.

In addition, the inspectors found that the provider did not have effective management and oversight processes in place for key areas of the service including, appropriate allocation of staff, staff training and development, record keeping, complaints management, reviewing of policies and procedures, fire safety, infection

prevention and control, residents' rights, assessment and care planning, healthcare and managing residents responsive behaviours. This is reflected in the high number of non-compliances found on this inspection, a number of which were repeated from the last inspection in November 2021.

The centre's management structure was not clearly defined and the lines of authority, accountability and responsibility for all areas of care provision were not robust. The person in charge had a dual role as they were also based in and working as the director of nursing in Belmullet Community Hospital. Although the person in charge was known to residents, families and staff in the designated centre, there was little evidence that they were sufficiently involved in the overall governance and management of the designated centre.

Systems to ensure effective allocation of staffing resources provided were not in place and did not ensure the effective delivery of care in accordance with the centre's statement of purpose and the needs of the residents accommodated in Aras Deirbhle Community Nursing Unit. This was negatively impacting on residents' safety and their quality of life.

The provider had failed to ensure that there were sufficient resources to ensure the premises was well maintained and was a safe and pleasant environment for the residents living there.

Risks were not managed appropriately and a number of risks had not been adequately addressed and mitigated. For example:

- Fire safety risks, including risk of ineffective containment of fire/smoke posed by fire doors that were not operating as required had not been identified and addressed. These findings are addressed under Regulation 28: Fire Precautions.
- Unauthorised access to high risk areas including the kitchen and sluice areas was not being monitored especially for those residents who had poor safety awareness.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose which outlined the service provided for residents did not correspond with the findings on the inspection. For example:

- The whole time equivalent (WTE) hours worked by the person in charge in the designated centre did not reflect a full time position as described in the centre's current statement of purpose.
- The statement of purpose document had not been updated since February 2021 and the information regarding the arrangements in place for residents to meet with their visitors did not reflect current arrangements in the centre

and current public health COVID-19 precautions.
- The conditions of the centre's registration documented in the statement of purpose were not in line with the designated centre's current registration conditions.

Judgment: Not compliant

Regulation 34: Complaints procedure

While, complaints were recorded, investigated and the outcome communicated to complainants, the inspectors found that not all complaints were resolved to the satisfaction of the complainant. For example, a resident who complained about their clothes going missing from their wardrobe was given a key that secured their wardrobe. However, inspectors observed that this key also opened the other residents' wardrobes. This meant that the resident who had raised the complaint was not assured. Furthermore, the resident told the inspectors that they continued to see items of their personal clothing being worn by other residents.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The provider had not ensured that up-to-date evidence based policies and procedures were available to guide staff on their practices and procedures in the centre. This was evidenced by the following findings;

- Some of the policies and procedures available in the centre were not centre-specific to Aras Deirbhle Community Nursing Unit. For example, the complaints policy was written for another community hospital and the missing person policy was written for another designated centre.
- Some Schedule 5 policies and procedures were not available. For example, the end of life policy and the risk management policy were not available.
- The majority of the policies available had not been reviewed within the past three years as required by the regulations.

Judgment: Not compliant

Quality and safety

Many residents in this centre felt that they received a good standard of service from staff who knew them well and inspectors were assured that most residents clinical needs were met. However, inspectors observed that many residents' care was task orientated and daily routines did not always reflect residents' individual preferences and choices. While, most residents' health care needs were met, inadequate access to occupational therapy specialist expertise was negatively impacting on a number of residents' health and well being. In addition, residents' quality of life and lived experiences in the centre was impacted by their limited access to meaningful social activities and access to outdoor space in line with their preferences and abilities. The provider had not ensured that the centre was well maintained and that the residents' bedrooms met their needs and ensured their rights to privacy and choice were respected. Significant focus by the provider and person in charge is now required to ensure that residents received appropriate and safe care and that their needs and preferences regarding their care and daily routines were met.

While residents had an assessment of their needs completed on admission and their needs were regularly reviewed, some residents' care plans were incomplete and not informed by up-to-date information that reflected their current needs and preferences regarding their care. As a result some care plans did not contain up-to-date and comprehensive information to guide nursing and care staff.

On the day of the inspection, residents were not provided with opportunities for occupation or recreation. Fourteen residents spent most of their day in the sitting room listening to music on the television. While there was a number of staff supervising this area, the inspectors observed that staff made no effort to facilitate any activities or meaningful occupation for these residents. Furthermore, residents who spent their day in their bedrooms did not have access to any meaningful occupation and their interactions with staff were predominantly focused on care tasks and interventions.

Inspectors found that the current care practices did not ensure that staff provided appropriate support and care for residents who may display responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff practices observed on this inspection did not promote positive outcomes for these residents. For example, during the inspection, the inspectors observed that one resident who exhibited responsive behaviours was not receiving an appropriate level of care and supervision in line with their assessed needs. The resident was observed wandering around the designated centre without purpose or supervision and staff did not interact with the resident to offer support or distractions. This had a negative impact on other residents in the centre as this resident was entering their bedrooms uninvited.

Residents had timely access to their general practitioners (GPs), and most other specialist medical and health services. Records showed that residents were referred in a timely manner and where a specialist practitioner had prescribed a course of treatment this was implemented. However the provider had not ensured that residents had timely access to occupational therapy professional expertise to meet their needs. This was impacting on the quality of life and welbeing of residents who

needed specialist seating assessments to promote their comfort and wellbeing.

On the day of the inspection, inspectors found that visits were taking place in line with guidance from the Health Protection Surveillance Centre. (HPSC). The registered provider had ensured that visiting arrangements were in place for residents to meet with their visitors in a designated visitors' room or their own bedrooms.

Inspectors reviewed minutes of resident's committee meetings and found that the meetings were infrequent. In the meeting minutes reviewed, there was evidence that residents had made suggestions in relation to how the day to day running of the centre could be improved for them. This included requests from the residents attending the meeting for more activities to be provided for them. Other suggestions were made regarding the communal area and dining room being made more homely. Residents had also asked for the double doors to the outside courtyard area to remain unlocked so that they could access the space more easily. Feedback from the residents and staff and the observations of inspectors on the day of the inspection found that no actions had been taken to follow up on these suggestions. As a result the double doors to the courtyard remained locked and the residents did not have access to appropriate meaningful activities and recreation on the day of the inspection.

While, televisions were available in the communal sitting rooms, some residents in twin bedrooms did not have individual choice of television viewing and listening as only one television was provided in these bedrooms. In addition a number of single and twin bedrooms, residents could not easily access their wardrobes because their beds were obstructing the wardrobe doors. Furthermore, residents could not keep their personal belongings secure as one resident had a key that opened a number of other residents' wardrobes.

The provider had not ensured that all areas of the premises were in a good state of repair and were adequately maintained for the comfort and safety of residents. This was an ongoing non-compliance from the previous inspection. Inspectors found that floor coverings in a number of bedrooms, corridors and the dining room required repair. Some items of furniture were visibly scuffed and needed to be repaired or replaced. Some bedrooms, communal areas and corridors required repainting. Furthermore, the layout of a number of residents' bedrooms did not ensure that residents' privacy, dignity could be maintained when carrying out personal activities. This is a repeated finding from the last inspection and is discussed under Regulations 12: Personal Possessions and 17: Premises.

The designated centre was free of COVID-19 infection at the time of this inspection. Staff were observed to use appropriate hand hygiene techniques. However, the provider had not ensured that the environment was managed in a way that minimised the risk of transmitting a health care-associated infection. Infection prevention and control practices in the centre required review to ensure that they were in line with the national standards. This is discussed further under Regulation 27.

The inspectors found that the oversight of fire safety within the centre was not robust. The provider had failed to take adequate precautions to protect residents and action was required to bring the centre into compliance with Regulation 28, Fire precautions. The provider had failed to ensure that there was effective containment of fire and smoke, that staff had access to appropriate fire training and that fire safety equipment checks were being completed to ensure the equipment is operational at all times. These findings are discussed in further detail under Regulation 28.

Regulation 11: Visits

Visits by residents' families were encouraged and practical precautions were in place to manage any associated risks. Residents access to their visitors was encouraged and was not restricted. Facilities were available to ensure residents could meet their visitors in private if they wished and that they were protected from any risk of infection.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were unable to access their clothing in their wardrobes in three twin bedrooms and five single bedrooms as the position of one bed in each of the twin bedrooms and in the beds in five single bedrooms was obstructing the wardrobe doors and preventing them opening. This finding did not ensure that each resident could access their belongings easily and as they wished and is repeated from the last inspection in November 2021.

In addition residents could not lock their wardrobes securely as individual keys were not available for each wardrobe.

Judgment: Not compliant

Regulation 17: Premises

The design and layout of areas of the designated centre did not meet the needs of the residents and a number of areas did not conform to Schedule 6 of the regulations. These findings had also been identified in the provider's own internal audits but no action had been taken to address the deficits. This was evidenced by the following findings;

- The layout and design of two twin bedrooms did not provide sufficient space for each resident to rest in a chair by their bedside.
- Floor covering in several bedrooms, the residents' dining room and on some parts of the corridors was very worn, damaged and in need of repair/replacement. This finding did not ensure these surfaces were adequately maintained or that effective cleaning procedures could be completed.This was a repeated finding from the previous inspection.
- A number of maintenance issues were identified including items of furniture that were visibly scuffed and worn. The paint on a number of residents' beds, chairs and bed tables was worn and missing. The fabric was torn on the arm rest area of a chair that a resident was sitting in. This finding did not ensure that these surfaces could be effectively cleaned and as such posed a risk of cross infection to residents.
- Paintwork on the wall surfaces in a number of residents' bedrooms, communal rooms, along some corridors and on wooden door frames and bedroom doors was scuffed, chipped and missing and required repair and repainting to ensure these surfaces were maintained to an adequate standard and could be effectively cleaned. This was a repeated finding from previous inspection.
- There was inadequate ventilation in a sluice room and a malodour was evident.
- Although, there was some storage facilities available in the centre, the storage rooms seen by inspectors were cluttered and disorganised. There was inappropriate storage of equipment including residents' assistive equipment in a communal bathroom/toilet used by residents and in the residents' sitting/dining room area.
- A refrigerator and a ceiling height freezer unit were stored in the residents' dining room. Both were unlocked and inspectors were told that these units were in use for bulk storage of kitchen supplies and were controlled by the kitchen staff. Inspectors observed that the refrigerator contained several large cartons of milk and twelve beaker-type feeding cups containing prepared liquids were stored in the door of this refrigerator. This storage reduced the space in the dining room for residents and there was a high risk that vulnerable residents would ingest dietary products that posed a risk to their health.
- Grab rails were not fitted in some showers to support residents' independence and safety.
- The nurses office was cluttered and served as both an administrative office and the clinical room. This is a repeated finding from the last inspection.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider had not ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention

and control. The inspectors found that;

- While environmental hygiene audits were carried out, these audits were not comprehensive and the high levels of compliance found in the audit outcomes reviewed were not reflective of the findings on this inspection.

The environment and equipment was not managed in a way that minimised the risk of transmitting a health care-associated infection. This was evidenced by;

- The house keeping room did not facilitate effective infection prevention and control measures. For example, there was no hand washing and hand drying facilities in the cleaner's room to support cleaning staff with hand hygiene. There was no facility available in the cleaner's room for filling water for cleaning purposes or for disposal of waste water following cleaning. In the absence of a lockable cupboard, cleaning solutions were stored on the floor in the cleaner's room. This hindered effective floor cleaning and did not ensure that hazardous chemicals were stored securely.
- Appropriate segregation of waste was not assured. For example, a waste bin for hazardous waste disposal was the only waste disposal bin available in the communal bathroom/toilet.
- Personal protective aprons were draped over handrails on the corridors. This posed a risk of cross contamination
- The sluice room did not facilitate effective prevention and control measures. For example, cleaning equipment was stored in the sluice room and posed a risk of cross infection. There was a malodour in the sluice room and inspectors observed that a blue bucket containing discoloured water with a mop in it was stored in this sluice room. Inspectors were told that this bucket was used for cleaning spilled urine. The hand hygiene sink in the sluice room was not accessible due to storage of equipment in front of it. This finding did not support effective staff hygiene.
- There was a limited number of clinical hand wash sinks for staff use within the centre. While, a hand hygiene sink was available for staff use outside the staff office/ treatment room, this sink did not meet recommended standards for clinical hand hygiene. Clinical hand hygiene sinks were also not available convenient to the point of care. As a result sinks in residents' bedrooms, en suites and communal areas were servicing a dual purpose for resident use and staff hand washing. This practice increased the risk of cross infection.
- The area immediately around the water outlets in sinks in some residents' bedrooms, en suite facilities and in some communal toilets and shower rooms were stained. This finding did not give assurances that these areas had been thoroughly cleaned and this posed a risk of cross infection.
- There was storage of boxes on the floor in a number of rooms including the nurses' office/treatment room and this finding did not support effective cleaning of floor surfaces in these areas.
- Assistive equipment used in the centre and examined by the inspectors appeared clean, however, a system was not in place to ensure that this equipment was cleaned and decontaminated after each use.

Judgment: Not compliant

Regulation 28: Fire precautions

Action was required by the provider to ensure adequate precautions were in place to protect residents and others from the risk of fire and compliance with regulation 28, Fire precautions.

- The majority of staff working in the centre had not been facilitated to attend updated fire safety training.
- A protective apron or fire extinguishing blanket was not available in the residents' smoking room.

Assurances regarding timely evacuation of residents to a place of safety and effective containment of smoke, fumes and fire in the event of a fire emergency in the centre were not available due to;

- The simulated emergency evacuation drill records available did not provide assurances that a simulated evacuation drill had been completed of the largest compartment with the minimum number of staff on duty to ensure residents' timely and safe evacuation at all times.
- A number of cross corridor fire doors did not close to create a seal and the door to the room residents smoked in did not fully close. Some residents told inspectors that they could smell smoke from cigarette smoke entering the corridor. The person in charge informed inspectors she was working to address this.

The oversight of the fire equipment checks was not robust and did not ensure that where faults were identified, they were reported and addressed in a timely manner. For example;

- At the time of this inspection, weekly checks of fire doors were taking place. However, these weekly checks on the condition and operation of the fire doors in the centre were confirmed with a tick with no commentary as to the condition of the doors on inspection. Inspectors found that a number of fire doors were not operating as required, and as a result were not assured that a comprehensive check was completed on the operation and condition of each individual fire door and that necessary actions were taken to address any deficits to ensure their effective operation.
- Checks to ensure the fire alarm system was operational at all times and that faults were not registering on the fire alarm panel were not completed.
- Although, fire exits were free of obstruction on the day of this inspection, there was no evidence that fire evacuation routes were checked regularly to ensure evacuation was not hindered in the event of a fire in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The information in residents' care plans was incomplete and therefore did not clearly direct staff on the care interventions they must complete to ensure each residents' needs were met. For example

- The care interventions in some residents' care plans were not person-centred to reflect their individual preferences, wishes and usual routines.
- A behaviour support care plan developed to inform one resident's support needs did not reference the most effective de-escalation strategies that were being implemented by staff. Therefore, there was a risk that this pertinent information would not be communicated to all staff caring for this resident.
- There was no information in one resident's care plan to inform staff about the frequency of blood glucose level monitoring for a resident with diabetes and on insulin therapy, the parameters that this resident's blood glucose levels should be maintained within and the actions staff should take if this resident's blood glucose measurements were outside these parameters.
- Information providing assurances that each resident's social activity needs were assessed to ensure they were supported to continue to pursue their interests in line with their capabilities was available. However, a care plan was not developed to direct staff on a meaningful social programme that met their preferences and wishes.
- The procedures that were in place to monitor the amount of fluid that residents at risk of dehydration should drink in each 24 hour period were not being implemented by staff and as a result nursing staff did not have accurate information about each resident's fluid intake.
- Although, staff told the inspectors that residents' care plans were regularly reviewed and updated in consultation with residents or when appropriate with their family on their behalf, no evidence was available that these consultations were taking place.

Judgment: Substantially compliant

Regulation 6: Health care

Residents did not have adequate access to occupational therapy services in line with their needs. Referrals had been sent for five residents on 11 October 2022 for occupational therapy assessment. The person in charge had followed up on these referrals but had not been informed when these assessments would take place. The provider was aware of this delay in accessing specialist care but had not secured an assessment for these residents. Three of the five residents were assessed as needing an urgent occupational therapy assessment due to their inadequate seating and associated risk of developing pressure ulcers and to relieve levels of pain and

discomfort they experienced. One resident was needing pain medication to relieve their pain and discomfort aggravated by the chair they were seated in. This is a repeated finding from the last inspection.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

A small number of residents experienced episodes of responsive behaviours. The inspectors found that these behaviours were not adequately managed and residents with a known risk of poor safety awareness and at risk of harming themselves or others were not supported as necessary. For example, a resident with an assessed need for one-to-one staff supervision did not have their supervision needs met on the day of this inspection.

Staff had not been facilitated to access training to ensure they had appropriate knowledge and skills to manage and support residents who experienced responsive behaviours in line with best practice guidance. The person in charge told inspectors that they were in the process of organising this training for staff but there was no date scheduled. This was a repeated finding from the last inspection in November 2021.

Judgment: Not compliant

Regulation 8: Protection

The centre had policies and procedures in place to protect residents from abuse. Staff spoken with were knowledgeable regarding recognition and responding to abuse. Staff were aware of the reporting procedures and clearly articulated knowledge of their responsibility to report any concerns they may have regarding residents' safety. Residents confirmed that they felt safe in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had failed to ensure that residents were provided with adequate opportunities to participate in meaningful social activities that met their interests and capacities.

- The inspectors observed a large number of residents sitting in the sitting

room on the day of the inspection and residents who spent their day in their bedroom, who did not have any access to social activities as the provider had not identified a staff member to take responsibility for coordinating residents' social activities. Residents did not have access to voluntary groups, to go on day trips or to go out into their local community.

The provider had failed to ensure that residents could carry out personal activities in private. this was evidenced by:

- The layout of a number of twin bedrooms did not allow staff to access both sides of the beds to carry out care and to transfer residents using assistive equipment safely within the space afforded by the screen curtains whilst maintaining residents' privacy and dignity and not encroaching on the other resident's bed space. This meant that residents could not carry out personal activities such as personal care in private.
- Some residents right to privacy in their bedrooms was not assured due to residents with responsive behaviours entering their bedroom uninvited.

Residents were not supported to exercise choice in their daily routines. This was evidenced by:

- The doors from the centre to the outdoor area for residents' use were secured and this meant that residents could not choose to access this outdoor space as they wished without a member of staff being available to open the doors for them. This was of particular concern because residents had specifically requested that the doors be kept open so that they could access the outside area as they wished.
- Residents in bedrooms with two beds shared one television. Provision of one television in these bedrooms did not ensure that each resident had choice of television viewing and listening. The location of the television did not ensure that both residents could view the television comfortably or that both residents could view the television if one resident had their bed screens closed.

Residents were not adequately consulted in the day to day running of the designated centre. This was evidenced by:

- While residents were invited to make suggestions about the organisation of the centre through residents' meetings, these meetings were infrequent and residents' suggestions were not addressed or acted upon. Inspectors reviewed the minutes of the residents' meetings, the last of which took place in October 2022. These minutes evidenced a number of concerns raised by residents that had not been addressed regarding their access to activities, the facilities available to them and their choice to access the outdoors. Some of the issues raised included that residents had made management aware that they would like to participate in a wider range of social activities and this had not been addressed by the provider. Residents asked for the dining and day room décor to be brightened up, however, this had not been completed and there was no action plan in place to carry out this work. On the day of the

inspection, no residents went to the the dining room for their meals. Residents told inspectors that they found this room cold and uninviting.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not 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	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Áras Deirbhle Community Nursing Unit OSV-0000644

Inspection ID: MON-0036384

Date of inspection: 24/01/2023

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: There are adequate staff in Belmullet for the total number of beds. The number of staff available to fill the roster to standard norms is based on 0.85wte per bed. Admissions are currently on hold, in line with staff available to roster as well as current resident numbers and dependency. Permanent pool posts 2.6 wte staff nurse and 3 wte HCA are approved to cover absence of which 0.6 wte staff nurse and 2wte have accepted jobs going through clearance currently. CNM1 post is also being processed via recruitment. Three HCAs have been seconded from shortstay roster to Aras Deirbhle rostor to ensure continuity of staff. The roster at present has 2 nurses and 4 carers during day as well as 2 cleaners. At night there is 2 nurses and 2 carers for 25 residents. In addition, there is 1 additional carer on during day with 1 resident who requires close supervision for safety. This particular resident currently has close supervision in place as recommended by the Mental health specialist.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training is currently provided by Centre for Nurse Midwife Education Centre (CNME) and online via HSELand as well as onsite training. Fire training took part place on 27th and 28th February with 91% attendance. Remainder to be updated when return from absence. Positive Behaviors Management is booked for onsite training for 17th, 18th 19th and 20th April. Onsite training also booked for 25th April on how to utilize Magic table, interactive activities for residents. Staff who haven't completed Safeguarding training will be sent letter to complete training by 30th April.	

Staff will be supported to attend training
Non attendance and non compliance will be monitored, supervised and dealt with under disciplinary procedure as appropriate.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The Fire register in use is the HSE national document issued by estates for use in the unit.
Going forward the roster will reflect the actual hours worked by the PIC each day in the designated Centre.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

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

The management structure is the same management structure that has been in place since initial registration. Staff are aware when the PIC is in the building and contactable by phone. A robust audit schedule will be put in place. A tracker template will be put in place to capture the action plan from this report. The PPIM and PIC who are in regular contact by email/phone will initially arrange to meet fortnightly for 2 months to discuss issues arising from the action plan and do walkabouts through the designated centre.
Allocation of staff is done by the Nurse in Charge on the day, due to the nature of dealing with resident's needs, staff allocation may change during the day depending on what needs to be prioritized at that given time. Any complaints from residents/families re issues impacting quality of life have been dealt with to the satisfaction of the complainant
A response re staffing has also been given under regulation 15.
With regard to premises a response has been given under Regulation 17, it is noted that the provider had approved resources but contractors could not attend the site.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Statement of Purpose updated and will be reviewed annually or when required to reflect current situation in the designated centre.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Ensure resident concerns / complaints are resolved to their satisfaction and the resident signs in complaints log that they are reassured.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

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

Policies written by HSE and CHO2 / subgroups are in use in Aras Deirbhle.
Risk management and End of Life policy were in place and staff are aware where to access them. Risk management policy was in place on the day of inspection but has now been put in Schedule 5 folder.

Ensure policies are reviewed in three yearly intervals.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The layout of the rooms have not changed since initial registration, if the beds are placed in the appropriate position, a chair can be fitted and wardrobes can be accessed.

Maintenance have been contacted and requested to ensure that all keys are not master keys and to ensure each resident has lockable wardrobe with individual key.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The layout of the rooms have not changed since initial registration, if the beds are placed in the appropriate position, a chair can be fitted and wardrobes can be accessed.
PIC, PPIM and Maintenance foreman met with regards to the flooring and painting.
These issues had been identified previously but no contractor was available to come to the unit due to back log of contracts delayed as a result of Covid Pandemic. Maintenance will identify and prioritise rooms in conjunction with the PIC for new flooring and a replacement plan will be put in place.
Painting has been approved for the dining room area and quotes will be obtained for painting of the unit in stages.
Any items of furniture that are identified that cannot be effectively cleaned will be removed and replaced.
There are two windows in the sluice room that can be opened to provide adequate ventilation as necessary.
Storage rooms will be decluttered and staff will be informed by memo not to store any resident equipment in communal areas.
A revamp of the dining area will take place including painting and new flooring.
Locks have been ordered for the refrigerator and freezer, catering staff will be informed to ensure these are locked at all times to ensure that the risk of residents ingesting dietary products that posed a risk to their health is minimised.
Grab rails will be fitted in all shower areas within the Designated Centre.
The Nurses office will be decluttered to ensure a safe working area for the staff in the centre.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

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

House keeper room soap and towel dispenser in place.
Bin replaced in bathroom with general waste bin.
Personal protective aprons replaced with aprons suitable for danicentre.
Sluice room bin to be replaced with smaller option to allow access to hand hygiene sink.

The infection Control team assessed Hand hygiene sink outside Nurses office and felt it met standards. We are awaiting infection control report on the number of hand hygiene sinks required for the area.
Stained water outlets in sinks has been highlighted to cleaning staff. Spot checks carried out.
Boxes off floors to allow cleaning of floors.
I'm clean sticker on assistive equipment to give assurance to next user that it was cleaned and decontaminated.

Regulation 28: Fire precautions	Not Compliant

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

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.

Fire training took place on 27th and 28th February 91% staff updated. Remainder to be updated when return from absence.
Fire blanket insitu and Protective apron will be put in place

Simulated Fire evacuation has taken place in largest compartment with night duty staffing level, this will be carried out again and any learning will be discussed with all staff

Smoking room now has automated door in place keeping door closed stopping smell of cigarette smoke entering corridor.

Fire doors are checked as per fire register and any issues identified to maintenance dept.

Any fire checks are carried as per the Fire register issued by estates on behalf of the HSE.

Fire training took place on 27th and 28th February 91% staff updated. Remainder to be updated when return from absence.
Fire blanket insitu and Protective apron will be put in place

Simulated Fire evacuation has taken place in largest compartment with night duty staffing level, this will be carried out again and any learning will be discussed with all staff

Smoking room now has automated door in place keeping door closed stopping smell of cigarette smoke entering corridor.

Fire doors are checked as per fire register and any issues identified to maintenance dept.

Any fire checks are carried as per the Fire register issued by estates on behalf of the HSE.

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:
Residents care plans to be Individualized, person centred, taking account of residents, wishes, preferences and usual routines.
Behavior support care plans to include individualized de-escalation techniques to guide staff.
Resident with diabetes on insulin to have specific care plan to guide staff on the parameters for blood glucose monitoring and to include actions to take if blood glucose measurements were outside these parameters.
Resident Care plan to direct staff on meaningful activities that meets their wishes and preferences.
Staff to record accurate information on fluid intake on residents at risk of dehydration.
Staff to document any consultation with resident and or significant other when updating and or reviewing care plans.
This will be monitored through audit of individual care plans.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

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

This was repeated finding from previous inspection however, due to the location it is difficult to source OT to the area.
The referrals have been sent to Primary care but they don't see clients who are in nursing homes as a result approval has been given to use agency OT. The previous provider representative had submitted a business plan for therapies for all OPS sites but this was not accepted at senior CHO2 level

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Resident currently has close supervision in place as recommended by the Mental health specialist. This is being monitored and kept under review.
Staff training in positive behaviors was highlighted in last inspection but was delayed due to lack availability and location f training as well as ability to release staff due to staff absence.
Positive behavior management training is planned onsite for 17th, 18th, 19t and 20th April.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
New Activity programme in place based on residents requests.
Beds and furniture repositioned to allow access of assistive equipment without imposing on other resident's privacy.
Resident supervised to reduce risk of wandering into other resident's room.
Sensory garden has two access points, one of which had been locked but both are now open and accessible.
As per regulation 9 (3)(Cii) residents have to access to radio television, newspapers and other media.
Resident council in place and meeting to be held two monthly or sooner if at request of residents. Next meeting thurs 6th April.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Not Compliant	Orange	31/05/2023
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/04/2023
Regulation 16(1)(a)	The person in charge shall	Not Compliant	Orange	30/09/2023

	ensure that staff have access to appropriate training.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2023
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	31/10/2023
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	31/10/2023
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	31/05/2023
Regulation 23(a)	The registered provider shall ensure that the	Not Compliant	Orange	31/05/2023

	designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(b)	The registered provider shall ensure that there 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.	Not Compliant	Orange	31/05/2023
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	31/05/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by	Not Compliant	Orange	31/10/2023

	staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/04/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/04/2023
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	30/04/2023
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	Not Compliant	Orange	30/09/2023

	procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/04/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	30/04/2023
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.	Not Compliant	Orange	30/04/2023
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Not Compliant	Orange	30/04/2023
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure,	Substantially Compliant	Yellow	31/03/2023

	and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Substantially Compliant	Yellow	31/03/2023
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	31/05/2023
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review	Not Compliant	Orange	31/05/2023

	and update them in accordance with best practice.			
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	30/06/2023
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.	Substantially Compliant	Yellow	30/05/2023
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.	Not Compliant	Orange	30/06/2023
Regulation 7(1)	The person in charge shall	Not Compliant	Orange	31/10/2023

	ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	25/01/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	05/03/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/03/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably	Not Compliant	Orange	31/05/2023

	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.	Substantially Compliant	Yellow	30/04/2023