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:	Alzheimer's Care Centre
Name of provider:	Sparantus Limited
Address of centre:	Highfield Healthcare, Swords Road, Whitehall, Dublin 9
Type of inspection:	Announced
Date of inspection:	13 March 2024
Centre ID:	OSV-0000113
Fieldwork ID:	MON-0042178

About the designated centre

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

Alzheimer Care Centre is a 119 bed centre providing residential services to males and females with a formal diagnosis of dementia over the age of 18 years. The centre also contains a unit specific to meeting the needs of people with a diagnosis of enduring mental illness. The centre is located on the Swords Road at Whitehall in Dublin within easy reach of local amenities including shopping centres, restaurants, libraries and coffee shops. The centre comprises of an original single storey building and a large extension over three floors which was opened in 2012. Accommodation for residents is across five units. With the exception of the Grattan unit, the remaining units consist of single bedrooms with fully accessible shower and toilet en suites, dining and sitting rooms and access to safe outdoor garden areas. The centre also contains a large oratory for prayers and religious services, activity rooms, hairdressing salons, coffee dock, several private visitors rooms and designated smoking areas.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	93

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 13 March 2024	08:35hrs to 18:05hrs	Niamh Moore	Lead
Wednesday 13 March 2024	08:35hrs to 18:05hrs	Karen McMahon	Support

What residents told us and what inspectors observed

From the inspectors' observations and from what residents told them, it was clear that the residents living in Alzheimer's Care Centre received a high standard of quality and personalised care. Feedback from residents and visitors, who the inspectors spoke with, were that the staff were "great", the food was lovely, the environment was "like a hotel" and there was always activities going on.

When the inspectors arrived at the centre, they were met by the receptionist who conducted a signing-in process. Following an introductory meeting with the person in charge and two members of senior management, the inspectors were accompanied by the person in charge on a walk around the centre.

The designated centre is located in Whitehall, Dublin 9. The centre comprises three storeys with five different units set out across the ground, first and second floors, which are accessible by stairs and lifts. Each unit functions as a self-contained unit with resident bedrooms, dining and sitting room facilities in all. Shared facilities such as a coffee shop, visiting rooms and a chapel are located on the ground floor. Units were referred to as Grattan, Delville/ Lindsey, Drishogue, Coghill/Daneswell and Clonturk. All units except for Grattan have single bedrooms with en-suite facilities. The Grattan unit has single bedrooms with access to shared bathrooms. A number of residents' bedrooms were viewed and were seen to have been personalised with flowers, family photographs and decorative items, including throws. Residents reported to be happy with their bedroom accommodation. Inspectors observed that some windows into resident bedrooms did not have appropriate privacy measures in place which is further discussed within this report.

Inspectors reviewed the questionnaires completed by residents or their family members as part of this announced inspection. A total of 15 questionnaires were completed. Overall the feedback was overwhelmingly positive. Some comments stated "staff are hardworking", "lovely", "patient", "willing to listen" and "understanding". However themes of dissatisfaction included laundry services, portions of meals, being unhappy with access to a garden, to go outside the centre and participation in the wider community. Management informed inspectors that there recently had been issues with the laundry service and they were in the process of discussing these arrangements with the external provider.

The premises was warm and appeared to be clean. There were efforts to create a homely environment evident, with areas within the nursing home decorated in seasonal decoration such as balloons to celebrate the upcoming St Patrick's Day. However, the wear and tear to the premises in some places had the potential to impact on the effective cleaning of these areas.

Activities on offer were displayed on noticeboards which showed opportunities for recreation were available from Monday to Sunday. Activities were facilitated by activity therapists and volunteers. Activities were seen to take place on the day of

the inspection including mass, poetry, and a sing along. Residents reported to be happy with the activities on offer.

Residents had access to televisions, telephones and newspapers. Residents appeared to be well-cared for and neatly dressed according to their preferences. Residents' views on the running of the centre were sought through residents' meetings and surveys. The inspectors reviewed residents' surveys and the minutes of residents' meetings and saw that the provider had taken action to respond to resident feedback.

Inspectors observed the dining experience at lunch time and saw that the meals provided were of a high quality and well presented. Assistance was provided by staff for residents who required additional support and these interactions were observed to be kind and respectful. Feedback from residents was positive, with residents reporting that they enjoyed the meals on offer.

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

Capacity and capability

This was an announced inspection carried out to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centres for older people) Regulation 2013 (as amended). Overall inspectors found that compliance had improved within the designated centre. However, some improvements were required in the management systems in place to ensure that there was effective oversight and the necessary resources were in place within the designated centre.

The registered provider for Alzheimer's Care Centre is Sparantus Limited. The registered provider had changed since the last inspection of 2023. However, the management structure and personnel had remained the same. One of the eight company directors, who is also the Medical Director, attended the feedback meeting at the end of the inspection. The person in charge reports to the Chief Operating Officer, who in turn reports to the Chief Executive. The person in charge was supported in the role by, clinical nurse managers (CNMs) assigned to each unit, staff nurses, team lead care assistants, healthcare assistants, catering, household, activity therapists, laundry, administration and maintenance staff. Inspectors found that there was sufficient staff available on the day of the inspection to ensure residents received assistance, interventions and care in a respectful, timely and safe manner.

The registered provider had prepared a statement of purpose for Alzheimer's Care Centre which had recently been reviewed in March 2024 and contained the

information set out in Schedule 1 of the regulations.

Schedule 5 policies were available to guide staff and were seen to be specific to the centre.

The registered provider had developed a policy on Education and Training which stipulates arrangements in place for staff to access training and the timeframe for how long the training is valid. For example, infection control lapses after two years. The training matrix indicated that there were high levels of staff attending mandatory training with additional dates available to ensure that levels of compliance remained high. Overall, there were good levels of supervision seen. However, there was one occasion where inspectors had to inform staff that supervision of a volunteer required review.

The registered provider was in the process of reviewing their annual review of the quality and safety of care completed for 2023 with an expected completion date of April 2024. Management systems in place included meetings, committees, service reports and auditing. Key data was seen to be discussed during meetings attended by senior management in areas such as occupancy, staffing, clinical care, incidents, complaints, risk management, infection control and quality. From a sample of auditing, inspectors found that while some audits identified issues, action plans to respond to all required improvements were outstanding.

Inspectors were told that there were no staff vacancies on the day of the inspection as the registered provider had reviewed staffing levels following the closure of one unit in December 2023. Management had informed inspectors that they had omitted to amend the staffing levels submitted within the application to vary the centre's registration which had been approved by the Chief Inspector in December 2023. Thus inspectors found that the registered provider was not operating in line with Condition 1 of their registration. This is further discussed under Regulation 23: Governance and Management.

There was an accessible complaints policy and procedure in place to facilitate residents and or their family members to lodge a formal complaint should they wish to do so. This policy also identified details of the complaints officer, timescales for a complaint to be investigated and details on the appeal process should the complainant be unhappy with the investigation conclusion. The complaints log was made available to the inspectors for review. The inspectors observed that complaints were appropriately logged and adhered to the registered provider's complaints procedure.

Regulation 15: Staffing

On the day of the inspection, the registered provider had ensured that the number and skill-mix of staff was appropriate having regards to the needs of the 93 residents, assessed in accordance with regulation 5, and the size and layout of the

designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

The registered provider had a policy and committee in place on training and development. Staff had access to and had completed training that was up to date and appropriate to the service provided, their role and the needs of residents.

Inspectors observed many occasions where appropriate supervision arrangements were in place. This included review of additional support available to staff through refresher training and performance improvement plans.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider was in breach of Condition 1 of their registration. Inspectors found that the staffing resources had been reduced within the statement of purpose dated March 2024 and were not in line with the statement of purpose dated December 2023 which the registered provider was registered for. The Chief Inspector had not been informed of or agreed these changes. For example, the following staffing reductions were evident following a comparison of both documents:

- The Medical Director was registered as 0.3 whole time equivalent (WTE) this was reduced to 0.2 WTE
- A CNM3 was no longer in place
- The CNM2 posts were 3 WTE and this was reduced to 2.5 WTE
- Staff nurse posts were reduced by 11 to 26 WTE
- Health care assistant posts were reduced by 11 to 65 WTE

While it is acknowledged that the registered provider had a number of assurance systems in place regarding the oversight of the service, a number of areas were identified that required further action for full compliance with the regulations:

- The oversight of fire safety required review. Fire closures had been added to bedrooms within the Drishogue unit. However, it was noted that this resulted in some doors being heavy to operate. The risk register had not been updated to reflect this risk and therefore while identified, there was no controls in place to respond to this risk. In addition, there was a gap in the weekly fire safety checks which had not been identified by the registered provider.

- Environmental audits had not recorded flooring which required repair and gaps in sluicing facilities.

Judgment: Not compliant

Regulation 3: Statement of purpose

Inspectors reviewed the recently revised statement of purpose for Alzheimer's Care Centre and found that it clearly describes the service and the provider's aims, objectives and ethos.

Judgment: Compliant

Regulation 34: Complaints procedure

Evidence was seen by inspectors that procedures were in place to ensure any complaints received were promptly investigated and managed in line with the centre's complaints policy.

Judgment: Compliant

Regulation 4: Written policies and procedures

All Schedule 5 written policies and procedures were available and reviewed in line with the regulations at intervals not exceeding three years.

Judgment: Compliant

Quality and safety

The inspectors found that the residents of Alzheimer's Care Centre were receiving a good standard of care that supported and encouraged them to actively enjoy a good quality of life. Staff working in the centre were committed to providing quality care to residents. The inspectors observed that the staff treated residents with respect and kindness throughout the inspection. However, further improvements were required in a number of regulations including; care planning, residents' rights, the premises, infection control and fire precautions. These will be discussed under their

respective regulations.

A selection of care plans were reviewed on the day of inspection. A pre assessment was carried out prior to admission to the designated centre and a comprehensive assessment was carried out within 48 hours of admission to the centre. Care plans were generally individualised and many clearly reflected the health and social needs of the residents. However, inspectors found that a number of care plans had not been updated to reflect current care practises. This is further discussed under Regulation 5: Individual assessment and care plan.

Residents had good access to medical and health and social care professionals. A local general practitioner (GP) practice provided GP services to the centre with on call services at weekends. Alzheimer's Care Centre also had access to other services including physiotherapy tissue viability nurses, dietitians and speech and language therapists, which were responsive when referrals were sent in.

Residents reported to feel safe within the centre. Reasonable measures were seen to protect residents from abuse such as a safeguarding policy to guide staff, staff training in relation to the detection, prevention of and response to abuse. The registered provider had designated officers appointed to ensure all reporting obligations were met including referrals to the Health Service Executive's safeguarding teams. Improvement was required in the development of safeguarding plans which has been noted under Regulation 5: Individual Assessment and Care Plan.

Residents had access to television, newspapers and radios. Residents were supported to exercise their civil, political and religious rights. The registered provider ensured that residents has access to facilities for occupation and recreation. There was a varied activities programme available for residents to attend. These activities included, but were not limited too, hairdressing, pet theraphy, religious services, excersice sessions and live music.There were minutes of residents meetings reviewed by the inspectors, where their voice could be heard and their opinion provided. However, inspectors were not assured that the privacy and dignity of residents was maintained. This is further discussed under Regulation 9 Resident's Rights.

Overall the premises conformed to the matters set out in Schedule 6 of the regulations. Improvements were seen in communal areas of the Grattan unit. However, some areas of wear and tear which required repair were not seen recorded on the maintenance schedule and therefore time bound actions were not seen to be put in place to resolve these items. This is further outlined under Regulation 17: Premises.

The risk management policy was requested prior to the onsite inspection and was reviewed. This policy had been recently renewed in March 2024 and was seen to meet the criteria stipulated by the regulations. For example, it detailed the measures and actions in place to control the five specified risks. This policy also referred to separate individual policies on each of these risks. The Major Emergency plan was reviewed which was also recently renewed in March 2024. This contained details on

how to respond to events such as a fire, flood, severe weather and power outages.

Overall the centre was clean. However, cleaning practises needed to be improved to promote good infection control measures. Not all units had access to bedpan washers and this required staff members to wash used healthcare items by hand or to travel to other units. Furthermore, cleaning schedules reviewed during the inspection found that net curtains hanging in many units were not included on the cleaning schedule. Further gaps are identified under Regulation 27: Infection Control.

The fire safety risk assessment available within the centre was dated 2022. Management told inspectors this was due for review in April 2024 and would be submitted to the inspectors. While the registered provider had made significant improvements to the overall fire safety of the centre there were still some areas that required improved oversight. A routine test of the fire alarm took place during the inspection. The inspectors observed on the Drishouge unit that one door did not automatically close and another door could not close due to the position of a chair upon the activation of the fire alarm. This meant issues with fire doors were not being reported or attended to.

Regulation 17: Premises

Inspectors saw that the premises was designed and laid out to meet the needs of residents, however, some action was required to the premises, included ensuring that all areas of wear and tear were recorded on the maintenance log to ensure timely action was taken. For example:

- Wall paper outside the Drishogue unit was seen to be torn.
- An assisted shower room on the Drishogue unit was locked. Inspectors were told that this was for safety as some residents on this unit walked with purpose. A bath had been removed within this room and replaced with a shower trolley. However a wooden unit had not been repaired with three holes remaining visible in this structure. Inappropriate storage was also seen within this room including the storage chemicals.
- Furniture on the Drishogue unit such as two dressers were seen to be chipped and stained.
- Linen trolleys used on two units were not suitable for use as, plastic bags were used and tied around the trolley to prevent the items on the trolley from falling.
- The grab rail in a toilet in the Drishogue unit and a shower chair in the Grattan unit were rusted.
- Flooring was badly marked in two areas on the Drishogue unit, in the corridor by the sluice room and in the large communal area.
- The wall was damaged in the hairdressing room within the Coghill/Daneswell unit.

- A ceiling tile was missing in the Delville/Lindsey sluice room.

Judgment: Substantially compliant

Regulation 26: Risk management

The risk management policy included all the required information in line with the regulations and there was a system in place for responding to emergencies.

Judgment: Compliant

Regulation 27: Infection control

Equipment and the environment was generally managed in a way that minimised the risk of transmitting a healthcare-associated infection, however further action is required to be fully compliant. For example:

- Staff on all units did not have access to an automated bedpan washer to empty and decontaminate urinals or commode basins after every use. Inspectors were told that staff would use the bedpan washer from another unit when required which was located a distance from some of the other units. Inadequate disinfection of urinals increases the risk of environmental contamination and Multi-Drug Resistant Organisms (MDROs) transmission.
- Hand hygiene facilities were not provided in line with best practice. There were some areas in the centre that had a limited amount of hand hygiene sinks or wall mounted hand sanitisers, within easy access for staff. This included multiple areas in the centre where sluice and laundry facilities were located.
- Cleaning schedules did not include the routine cleaning of net curtains and inspectors observed net curtains that were visibly dirty on the day of inspection. In addition, the vent in a store room, previously used as a smoking room was very dusty.
- Storage of some resident items posed a risk of cross contamination. For example, inspectors observed unused incontinence wear stored outside their packets and some resident items such as talcum powder and a razor were unlabelled and stored in a communal bathroom and therefore staff could not be assured who these items belonged to and it created a risk of cross-contamination.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Inspectors found that the management systems in place for the oversight of fire safety in the building needed improvement. For example:

- While the registered provider carried out routine testing of the fire alarm on a weekly basis, there was no oversight for the identification of issues during this test.
- The registered provider did not have sufficiently reliable arrangements in place to monitor fire doors. Deficits to fire doors meant that fire doors are not capable of restricting the spread of smoke and fire in the event of a fire. For example, inspectors observed:
    - The fire seal on one door was noted to be torn.
    - A number of doors were observed to have issues when closed, such as not been flush or having visible gaps in them.

Furthermore, a freestanding hob and oven, located in one activity room, had tea towels and a small wooden shelf located directly over it and posed a significant fire risk. This room was not supervised at all times and there was a risk of a resident inadvertently turning on the hob providing a heat source to these flammable items.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The registered provider had failed to ensure all care plans were reflective of the resident's current care needs. For example:

- Two residents' care plans had not been updated following a comprehensive assessment by a member of the inter-disciplinary team and therefore did not reflect all the recommendations made.
- A number of residents' care plans regarding safeguarding did not accurately reflect the residents' individual care needs.
- A number of care plans had not been updated within the 4 month intervals as outlined under the regulation.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider had ensured that all residents had access to appropriate

medical and healthcare.

Judgment: Compliant

Regulation 8: Protection

There was a safeguarding policy in place. Staff had completed safeguarding training and were aware of what to do if they suspected any form of abuse. Any incidents that had occurred in the centre were appropriately investigated.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had not ensured that all residents in the centre had their privacy and dignity maintained. There were windows in resident's bedroom doors that were controlled by a mechanism on the outside of the door. This allowed for the view into a resident's room to be obscured. However, due to its location on the outside of the door the resident's had no control over it and anyone on the corridor could open or close this mechanism at any time. As a result residents' right to privacy and dignity was not upheld at all times.

Judgment: Substantially 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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Alzheimer's Care Centre OSV-0000113

Inspection ID: MON-0042178

Date of inspection: 13/03/2024

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: We have fully reviewed our staffing in light of reconfiguration of the service. We noted some clerical errors in previous numbers listed in our Statement of Purpose. With the phased reduction of beds, the number of staff nurses reduced by two and the number of HCA's reduced by 10 between December and March however care hours remain constant for all existing residents. The current WTE is Nurses: 27 and WTE HCAs: 66. We have increased overall medical input and temporarily reallocated one CNM2 to a Family Liaison role while reconfiguring the service. An issue was raised at the Fire committee meeting on 11th March about a possible concern arising from the recent addition of door closers to bedroom doors on Drishogue unit. Our Fire Consultant reviewed the doors on 9th April identified four out of 32-bedroom doors with possible weight issues, making it difficult for some doors to be opened easily by residents These doors will be rectified in the coming weeks and we have included on our risk register. Actions are being taken to address weekly fire safety checks as identified under Regulation 28 The flooring on Drishogue unit had been listed on the PPM for upgrade this year. A third bedpan washer is being procured for the centre.	
Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Wall paper outside the Drishogue unit will be remedied by the end of April.

• The wooden unit in the assisted shower room on the Drishogue unit will be repairedby the end of May.

• Chemical storage was discussed at the last H&S meeting and chemicals have been moved to the cleaners store.

• Furniture on the Drishogue unit such as two dressers were seen to be chipped and stained will be fixed by the end of May

• New linen trolleys for two units are being procured by the end of June.

• The grab rail in a toilet in the Drishogue unit and a shower chair in the Grattan unit will be replaced by the end of June.

• The flooring on the Drishogue unit, in the corridor by the sluice room and in the large communal area are on the facilities improvement plan for this year and will be completed by 30th September.

• The wall in the hairdressing room within the Coghill/Daneswell unit will be repaired by end of May.

• A ceiling tile missing in the Delville/Lindsey sluice room has been replaced.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• An additional automated bedpan washer is on the facilities improvement plan for this year and will be in place by the end of September.

• Our IPC Nurse is reviewing hand hygiene facilities in the designated centre including in the sluice and laundry areas. Additonal hand hygiene facilities will be installed based on identified needs within 3 months.

• Curtains are on the cleaning schedule and are cleaned every 6 months. Spotchecks are being carried out and staff reminded to log any issues on the housekeeping portal.

• A vent in a store room, previously used as a smoking room was observed to very dusty and was rectifed on the day of inspection.

• Staff have been reminded about correct storage of resident property and possessions

to avoid cross contamination. CNM's are carrying ou constant spotchecks and reminding staff of appropriate storage. Our IPC Nurse will include in IPC audits.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A process is being put in place to document any issues arising from the weekly fire alarm testing to ensure any issues identified are recorded and logged on maintenance portal. A staff member are being allocated on daily allocations to assess same. Maintenance staff will also check with all units to ensure no issues arising from weekly testing. The process will be audited going forward.

All fire doors have recently been fixed on Drishogue unit based on an original fire audit. Following the findings of the inspection, a further review is being completed by our Fire Consultant and remedial works will be carried out on any deficiencies identified within three months.

The fire door closers (identified at a Fire Safety meeting on 11th March following the completion of the project to fit door closers) are under review and four bedroom doors on Drishogue unit have been identified as having potential weight issues. Remedial works will be carried out by the end of May. This issue has been added to the risk register.

The power to all cookers is on a time clock to align to daily activities. The Activities staff have been advised to ensure the fuse is switched off when the oven/hobs are not in use. This will be kept under review and further controls put in place as required to mitigate any additional risks arising. The small wooden shelf above the hob has been removed.

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:
All care plans have been audited in March. Action plans were drawn up based on issues found and all issues have been rectified and care plans updated.

A full review of safeguarding care plans has been completed. The PIC is working with staff to remind them to follow our safeguarding policy and procedures and ensure safeguarding plans accurately reflect resident needs. The Safeguarding Lead will issue guidance on developing safeguarding plans and run further education and training with

CNM’s in the next three months.	
Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The issue of privacy screens on doors is being assessed and manufacturers contacted for possible solutions. In the meantime, staff will consult with residents on dignity and privacy and actively seek their preferences with regards to privacy screens being open or closed on their bedroom door. Solutions will be agreed at the NH Forum and Support Services committee.

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	30/09/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	15/04/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Substantially Compliant	Yellow	30/09/2024

	consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/09/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	31/05/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/05/2024
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	Substantially Compliant	Yellow	30/06/2024

	family.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/07/2024