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:	College View Nursing Home
Name of provider:	Aspen Green Limited
Address of centre:	Clones Road, Cavan, Cavan
Type of inspection:	Unannounced
Date of inspection:	16 July 2024
Centre ID:	OSV-0000128
Fieldwork ID:	MON-0043116

About the designated centre

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

College View Nursing home is a purpose built nursing home located in landscaped gardens on an elevated site within the Cavan town opposite St Patrick's College on the Clones Road. The centre is registered to accommodate a maximum of 69 residents, both males and females, over the age of 18 years on a long term and short stay, respite and convalescence basis. The centre provides care for a wide range of age related conditions such as general nursing care for elderly residents, Old Age Psychiatry, dementia specific care, respite care, post operative care and palliative care. The town can be accessed by wide footpaths which have been extended to meet the drive into the nursing home. There are extensive gardens over an acre which include raised flower beds, extensive lawns and secluded sun and patio areas for those residents who like to sit outside.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	69

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 16 July 2024	09:45hrs to 18:30hrs	Nikhil Sureshkumar	Lead
Tuesday 16 July 2024	09:45hrs to 18:30hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

This inspection found that residents received appropriate care and services in line with their assessed needs however some immediate and longer term actions are now required to ensure residents are protected in the event of a fire emergency.

This unannounced inspection was carried out over one day. There were 69 residents accommodated in the centre.

The inspectors were met by the person in charge who facilitated the inspection. Following an introductory meeting, the inspectors completed a walk around of the centre. This gave the inspectors an opportunity to meet with staff and residents and observe life in the centre.

Staff were observed to be very kind and respectful to residents who were mobilising around the centre. Staff were familiar with the residents' needs and preferences for daily routines and were seen to facilitate residents' choices such as menu options, drinks and snacks and what activities to participate in during the day. Residents were seen using the communal areas for meal times and activities as well as to sit and watch television or read the newspaper.

The centre had a varied weekly menu that included vegetable, meat, and fish dishes. From speaking with residents and observations, inspectors found that residents were in the most part satisfied with the service provided. However, from a review of residents' meeting records, a resident requested to have a particular food item which had not been provided. This was brought to the attention of the provider who immediately addressed this issue and staff confirmed that the resident's choice of food item was now on the menu.

College View Nursing Home is a purpose built facility. The building for the most part is single storey with a small first floor area for staff use only located over the main reception. There is a central corridor running the length of the building with individual residential or staff wings branching off this corridor. The building is divided into 8 compartments with a number of communal and garden areas. Television, radio and newspapers were available for all residents in the communal areas.

While the centre was comfortable and nicely decorated, some areas were not in a good state of repair. For example, a number of doors and door frames had signs of damage and gaps were found in ceiling areas around service penetrations. In addition several areas of the corridors and communal rooms required repainting. Main corridors were spacious and the centre was provided with a number of fire exits. However, some corridors were found to absent of emergency directional signage and one fire exit was difficult to open due to vegetation. From a selection of fire doors reviewed by the inspectors, a number of doors had gaps, did not close

fully when tested and smoke seals were absent leaving them ineffective to contain the spread of smoke and fire. .

The next two sections of this report presents the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

Overall, the provider had governance and oversight systems in place to manage the service and ensure that residents received care and support in line with their assessed needs and the statement of purpose. However this inspection found that the provider had not ensured resources were made available to comprehensively address fire safety deficits and ensure residents were protected in the event of a fire emergency. Furthermore the oversight of fire safety processes in the centre did not ensure that these were consistently implemented and the provider was issued with immediate actions on the day and an urgent compliance plan to be completed within a defined time frame. These findings are discussed under Regulations 23 and 28.

The registered provider of College View Nursing Home is Aspen Green Limited and the company Chief Executive Office (CEO) represents the provider. The person in charge has been in the role since 2023 and works full-time in the centre. A newly appointed assistant director of nursing supports the person in charge and provides deputising arrangements for when the person in charge is not available. The management team in this is also supported by a group-level quality manager.

The provider had a comprehensive range of quality assurance processes in place including regular audits, governance and management meetings and feedback from residents through resident meetings. Complaints and accidents and incidents were reviewed as part of the governance and management meetings and reports. In contrast the oversight of the fire precautions was not robust. Inspectors found that the provider had been made aware of a number of red-rated fire safety risks identified in their own Fire Safety Risk Assessment report dated February 2024; however, there were no assurances in place that the provider had a time bound action plan in place to address the identified risks in a timely manner. As a result an urgent action plan was issued to the provider, requiring them to take the necessary actions to come into compliance with the regulation in order to keep residents safe in the event of a fire in the designated centre.

The inspectors found that there were enough staff on duty on the day of the inspection. Call bells were answered promptly and residents told the inspectors that staff were usually prompt in responding to their requests for support. However inspectors found that the provider had not reviewed their staffing levels to ensure that there were enough staff on duty at all times to keep residents safe in light of the known fire safety risks taking into account the size and layout of the building.

Regulation 14: Persons in charge

The person in charge is a registered nurse with several years of experience nursing older people and has management experience. The person in charge works full-time in the centre.

Judgment: Compliant

Regulation 15: Staffing

Inspectors found that there was a sufficient number and skill mix of staff on the day of the inspection to meet the assessed needs of the residents in accordance with Regulation 5; however the provider's oversight of the staffing resource did not provide assurance that the staffing levels had been reviewed in line with fire safety deficits identified in February 2024. This is addressed under Regulation 23.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a selection of online and in-house training activities. Staff had completed their mandatory moving and handling, fire safety, and safeguarding training.

Judgment: Compliant

Regulation 23: Governance and management

The inspectors were not assured that the provider had kept their staffing resources of the centre under review as the staffing strategies to respond to a fire emergency had not been reviewed in line with the fire safety risks identified in February 2024.

Even though there were management systems in place, they had failed to ensure that the service provided in the centre was safe and effective. For example, the provider's management and oversight of the fire precautions in this centre were not robust and did not adequately protect residents. For example,

- The provider had not addressed the fire safety risks identified by their competent person in a timely manner to ensure the safety of residents and staff in this centre.
- The provider had failed to provide the resources that were required to address the significant fire safety risks identified in their own fire safety risk assessment dated February 2024.
- The day to day management of fire risk in the centre did not ensure that risks were identified and managed effectively. These findings are set out under Regulation 28.
- Immediate actions and an urgent compliance plan in regard to fire risks had to be issued to the provider as outlined under Regulation 28.

Judgment: Not compliant

Quality and safety

Overall, the care provided to the residents on a day-to-day basis was of a good standard; however, the oversight of care planning required improvement to ensure that the residents who were at risk of pressure ulcers had an appropriate plan in place. In addition, significant improvements were required to improve the physical environment of the centre to ensure that residents were adequately protected in the event of a fire emergency.

The centre provided the residents with a variety of activities and ensured that they were well-supported in engaging in social care activities that were in line with their preferences and capabilities. Staff spoken with the inspectors had up-to-date knowledge appropriate to their roles to positively react to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment).

Television, radio and newspapers were available for all residents in communal areas.

Residents' meetings were held regularly, and the centre maintained detailed records of these meetings, which demonstrated that resident suggestions and feedback were taken into account and addressed.

The centre had a varied weekly menu that included vegetable, meat, and fish dishes. Residents at risk of weight loss were monitored closely and referred to a dietitian, and nutritional supplements were provided when recommended by dietitians.

Non compliant findings in relation to Regulation 28 identified significant fire safety risks such as; inappropriate storage practices in relation to flammable items in a number of areas, a personal emergency evacuation plan (PEEP) for one resident did not accurately record their support needs in the event of an evacuation. In addition, assurances were required in relation to the adequacy of the fire compartmentation

currently in place throughout the building for both horizontal and vertical evacuation and to all high risk rooms.

While the Provider had a fire safety risk assessment (FSRA) carried out in February 2024, a significant number of red-rated fire risks had been identified and at the time of this inspection in July 2024, five months after the report was made available to the provider , there were no assurances in place that these risks would be addressed within a three to six-month time frame in line with their fire safety risk assessment recommendations. In addition to this, the FSRA was not a fulsome or comprehensive assessment of fire safety and recommended that further investigation was required to key structures in the building such as as; ceilings throughout the centre, fire rating of access hatches and ventilation ducts and the compartmentation of the attic spaces throughout the building.

An urgent compliance plan was issued to the provider, requiring them to take the necessary actions to come into compliance with the regulation in order to keep residents safe in the event of a fire in this building. Additional assessments completed by the providers' competent person were subsequently submitted. The assessments identified significant deficiencies with all of the above areas in relation to fire safety. These and other fire safety concerns are detailed further under Regulation 28: Fire Precautions.

Regulation 10: Communication difficulties

Residents who had communication difficulties and special communication requirements had these recorded in their care plans and were observed to be supported in communicating freely.

Judgment: Compliant

Regulation 11: Visits

The provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 17: Premises

The centre's premises did not conform to the matters set out in Schedule 6 of the Care and Welfare Regulations 2013. For example:

- A number of bedroom door frames and doors had scuff marks, which had not been repaired in a timely manner.
- Several areas of the corridors and communal rooms required repainting.
- The floor covering of a communal bathroom was damaged and did not support effective cleaning.
- Holes were found around service penetrations that required sealing.

Judgment: Substantially compliant

Regulation 27: Infection control

The centre's infection prevention and control processes required improvement to ensure compliance with the national standards for infection prevention and control in community health services and other national guidance. For example:

- The laundry room did not support the functional separation of the clean and dirty phases of the laundering process and posed a risk of cross-contamination. This was a repeated finding from the previous inspection in April 2023.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The provider was non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

The provider was issued with immediate actions and urgent compliance plan due to inadequate fire precautions in regards to;

- Inappropriate storage practices of flammable items found in an internal electrical switch room.
- Inappropriate storage practices of flammable items, paint buckets, paint tins and cardboard boxes found in an internal store room that contained an electrical panel. Furthermore, holes were noted on the ceiling around several service penetrations and the fire door was compromised.

- Inappropriate storage of flammable items were observed in a generator outbuilding.

The provider had de-cluttered and removed all items from these rooms by the end of the inspection.

In addition to the above, the following fire risks were identified.

- A number of fire doors were found to be wedged open. This would result in the unhindered spread of smoke and fire if a fire were to develop. This was a repeated finding from previous inspections.
- The main fire exit door was fitted with a slide bolt which could delay instant egress in the event of a fire.
- The inspectors observed that hoists were being charged along a corridor. This created a potential fire risk and could potentially compromise a protected means of escape in the event of an evacuation.

The provider did not provide adequate means of escape including emergency lighting. For example:

- The inspectors identified an area under a staircase being used as a storage area for combustible items, which compromised the vertical means of escape. This had previously been identified in the providers own fire safety risk assessment (FSRA) dated February 2024 and again on this inspection.
- Some external gates were found to be fitted with bicycle locks. Staff when asked for the code to release the lock were not familiar with the code. A Key locking mechanism was found to be fitted to the escape side of the main door. This created a risk of delaying an evacuation in the event of an emergency.
- Internally, emergency directional signage was observed to be lacking in areas of the centre to indicate all escape routes in the event of a fire emergency. Externally, there was a lack of emergency lighting to the front, rear and side areas of external evacuation routes leading to fire assembly points and above some of the fire exits.

The provider did not adequately maintain all fire equipment, means of escape and building fabric. For example:

- The quarterly maintenance certification records were available on the day of the inspection for the emergency lighting system and the fire detection alarm system. However, the annual maintenance certificate for the emergency lighting system was not available. Instead the inspectors reviewed the annual report that highlighted a number of failings and defects of emergency lighting on the system.
- An external Fire exit was difficult to open due to a build-up of vegetation around the door. The surface of some external paths appeared rough and may prove difficult for some evacuation equipment in the event of an evacuation. Some paths required maintenance, and appeared to be narrow. This could delay or hinder residents to evacuate in the event of a fire.

- Areas in the centre were noted to have utility pipes or ducting that penetrated through the fire-rated walls and ceilings and required appropriate fire sealing measures. This was evident in a boiler room, an electrical room, store rooms and an electrical switch room. This created a risk of fire and smoke to spread from these areas due to numerous penetrations.
- In regards to fire doors, excessive gaps were found at the bottom/side/top and where double fire doors met. Smoke seals were absent throughout the centre. Screws were found to be missing to fire door hinges and non-fire rated ironmongery were found throughout. Furthermore, some fire doors would not close fully when tested and did not align.

The registered provider had failed to adequately review fire precautions throughout the centre. For example:

- A fire safety risk assessment (FSRA) dated February 2024 was reviewed during the inspection. A significant number of deficiencies were identified in regards to; fire doors throughout the centre, fire stopping, attic hatches, ventilation ducting, directional signage, fire rating of high risk rooms and compartment fire doors. A high number of red rated risks were associated with the findings contained within the assessment.
- The provider did not have a time-bound action plan in place to address the fire risks**.** Furthermore the inspectors were not assured that the provider had reviewed their fire safety procedures in line with the additional risks identified and as such had not implemented appropriate mitigating measures to reduce the risk to residents until such time that all fire safety works were completed. An urgent compliance plan was issued to the provider in regards to the above.
- In addition to this, in house fire safety checks had identified deficiencies in regards to fire doors in May 2022. However, the works to address these deficits and ensure fire doors were repaired and fit for purpose had not been carried out at the time of this inspection in July 2024.

Furthermore, the inspectors noted the FSRA stated further investigation was required to ascertain:

- If the ceiling throughout the centre was fire rated
- If the access hatches were fire rated
- If the attic spaces had been compartmentalised
- If the ventilation ductwork system has been provided with appropriate fire safety measures.

The recommended further investigations had not been completed at the time of this inspection and an urgent compliance plan was issued to the provider requiring them to complete the additional assessments by their competent person. These investigations were subsequently completed and submitted to the Chief Inspector. The report identified significant deficiencies with all of the above areas in relation to fire safety.

Arrangements for staff of the designated centre to receive suitable fire training required improvement;

- While staff were up-to-date with fire safety training and familiar with the fire procedures, some staff when spoken with were not familiar with the location of the fire compartments used for progressive horizontal evacuation in the event of a fire. Furthermore, some staff stated they did not refer to the repeater fire panels located across the centre in the event of an emergency. As a result, additional fire training is required for staff to receive further aid and support in regards to this.

The registered provider did not make adequate arrangements for containing fires. For example:

- Arrangements for containment of fire in the event of a fire emergency in the centre required significant action by the provider. The inspectors were not assured there were adequate compartmentation provided in the centre to facilitate progressive horizontal evacuation. This was evidenced from what the inspectors identified on the day of the inspection and from a review of the fire safety risk assessment.
- Fire doors located on the assumed compartment boundaries and to high risk rooms were not of the required fire rating, had excessive gaps and were missing cold smoke seals. The inspectors noted a significant number of timber panel doors fitted throughout the centre did not appear to meet the criteria of a fire door, were missing cold smoke seals and some fire doors were missing door closing devices. Furthermore, attic access hatches located in corridors and a boiler room did not appear to be fire rated.
- As noted in the FSRA further investigation was required in regards to the attic compartmentation, compartmentation of high risk rooms such as the boiler, kitchen and laundry rooms within the centre, the fire rating of ceilings throughout the centre and the ventilation ductwork system. An urgent compliance plan was issued to the provider in regards to the above and a review by a competent fire safety professional is required to provide assurances.
- Subsequent to this inspection, documentation submitted by the provider identified significant deficiencies between compartments and an absence of compartmentation in the attic spaces. This resulted in residents being accommodated in one large 16 bedded compartment instead of two smaller compartments. This created a significant risk to the safety of the residents.

Arrangements for evacuating all persons in the designated centre and safe placement of residents in the event of a fire emergency in the centre were not adequate. For example:

- The inspectors were informed that the minimum number of staff required to aid in the evacuation of a resident with additional needs for support in a fire emergency would be three staff members. However, from a review of the resident's personal evacuation plan (PEEP) only two staff were identified for assistance in an evacuation using a ski-sheet as the required evacuation aid.

The records did not accurately reflect this residents' evacuation requirements and an urgent review of their PEEP was required both to ensure there was enough staff available at all times to safely evacuate the resident and also to ensure staff were clear about the evacuation equipment and procedure the resident required.

The displayed procedures to be followed in the event of a fire required a review by the provider. For example:

- Floor plans on display were annotated in a way with colour to identify the areas of the building but did not set out clearly the fire compartments for phased evacuation.
- Floor plans were annotated in a way with colour to identify the areas of the building zones but did not decipher or match the location of fire compartments for phased evacuation. Furthermore, floor plans did not indicate the direction of escape, the location of fire exits or fire extinguishers. This could cause confusion and delay the evacuation of residents in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

An appropriate system of reviewing residents' care plans was not in place in the centre to support the residents in meeting their care needs. For example, the inspectors reviewed the care files of five residents who were at high risk of pressure ulcers, and they did not have an appropriate care plan in place to guide staff in providing the most appropriate care to prevent pressure ulcers from developing.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were generally well supported to have access to general practitioners (GPs) from local practices, health and social care professionals, and specialist medical and nursing services.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The use of restrictive practices in this centre was kept under review. Each resident had a risk assessment completed prior to any use of restrictive practices.

Judgment: Compliant

Regulation 8: Protection

The provider had systems in place to ensure that residents were protected from the risk of abuse. Residents reported that they felt safe living in the centre. Staff were knowledgeable regarding safeguarding residents and were aware of their responsibility to report any allegations, disclosures or suspicions of abuse. Staff were familiar with the reporting structures in place.

Judgment: Compliant

Regulation 9: Residents' rights

One communal bathroom was located along a corridor adjacent to a twin-bedded room. The communal bathroom could be accessed from the corridor and from the twin bedroom. The inspectors found that if one of the residents accommodated in the twin bedroom was using the bathroom they would lock the door that was accessed from the corridor to ensure their privacy. If the resident did not unlock the corridor door when they left the bathroom then other residents trying to access the bathroom from the corridor would not be able to do so without either that resident or a member of staff entering the twin bedroom and unlocking the door. This arrangement did not ensure the privacy of residents accommodated in the twin bedroom and did not ensure that other residents could access their bathroom facilities when they wished to do so.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for College View Nursing Home OSV-0000128

Inspection ID: MON-0043116

Date of inspection: 16/07/2024

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: • A fire competent person has been appointed to complete the fire risk assessment and to review all fireworks completed on behalf of the provider. • Contractors have been appointed to complete works, with high-risk areas being prioritized. Work has commenced and is in progress. • A Regional Operations Manager has been appointed in conjunction with existing Group Maintenance Manager to support the PIC in ensuring that there are effective management systems in place going forward -September 2024 • In additional the action plan around fire management will be reviewed monthly in the Local Management team meeting to ensure timely completion of agreed actions. - Ongoing • A full review of issues identified has been completed and plan has been implemented to address these issues as detailed under Regulation 28.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • A review of the facility is underway to devleop a 12 month upgrade plan to address wear and tear issues idenfited in the report –November 2024 • A plan is in place to repair the flooring in this communal bathroom - September 2024 • Holes were found around service penetrations were resealed. –- Completed July 2024	

These actions have been added to homes action plan and will be reviewed monthly as part of the Local Management team meeting.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Upgrade of current laundry room to allow for clear segregate of laundry into clean and dirty area. This will be achieved by adding and additional door and adjusting the current layout. The works will require input from multiple trade persons, and we estimate works will take around 4 weeks to complete once commenced. We expect to complete works by February 2025.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• All Flammable items stored in the internal switch room and storeroom with electrical panel and generator outbuilding have been removed – Completed July 2024
• Holes noted in the ceiling around several service penetrations of the above stores have been sealed – Completed July 2024
• Wedges used to hold open fire doors were immediately removed on the day of inspection and staff have been advised that this can not be used. – Completed July 2024
• The side bolt from the main fire exit door has been removed – Completed July 2024
• Hoists charging were removed from the corridors on the day of inspection – Completed July 2024
• Access control has been fitted to external gates and linked with the fire alarm and nurse call system. – Completed July 2024
• Additional storage area will be identified, and current items being stored in under the staircase will be removed – September 2024
• Additional directional signage will be added to the center to support safe evacuation – 31 November 2024
• A review of the external lighting will be completed in 31st November 2024 by a competent person and necessary actions identified to enhance the visibility at exit points.
• The quatertly maintenance certificates were provided on the day of inspection, annual maintenance certificate for the emergency lighting system was issued on the 12th of September 2024 and any actions on the report will be completed by October 2024
• Vegetation located around the emergency fire door has been cleared and the area tidied up. We are currenlty sourcing quotes to complete repair works to the external pathway which we plan to complete by latest 31st January 2025

• The boiler room, an electrical room, store rooms and an electrical switch room have been reviewed and areas where fire rated walls were penetrated have been re-sealed.- Completed September 2024

Review fire precautions throughout the centre.
An inital fire safety risk assessment (FSRA) was completed in February 2024 and it identified the need for further investigations . A follow up inspection had been compelted prior to the date inspection however the updated report was only received after the date of inspection and subsequently provided to the inspector.
The following actions have been agreed:
• Competent person completed a through review of every fire door and identify any corrective actions, an action plan will be developed from this with based on prioritising higher risk items – September 2024
• Obtain tender quotes for the proposed works identified in the FRSA inspection completed in July 2024 and subsequent inspection report completed on fire doors – Commenced July
• Timelines for works of quotes received have already been agreed with initial works already commenced. Any subsequent quotes will be reviewed added to the timeline of works.
• Have competent fire expert inspect benchmark details.
• Have competent fire expert carry out several site visits during the upgrade works to ensure works are in line with those identified in their report.
• Have competent fire expert review all relevant material/product data sheets.
• Have individual contractors/sub-contractors provide sign off of their works upon completion.
• Have competent fire expert give an overall sign off once works are completed.

The above works will be applied on a phased basis:
Phase 1: Necessary works to bring the compartments and attic spaces into compliance and other high-risk areas will be completed by 31/01/2025.
Phases 2: Actions around fire doors for higher risk areas including main kitchen, laundry and electrical rooms will be completed – 31/01/ 2025.
Phases 3: All remaining works relating to the fire doors as per the above report, not completed by the onsite maintenance team will be completed (orange risks)– 30th June 2025
All reports, inspections and quotes provided on the above will be reviewed and actioned at the monthly local management team meeting.
• All staff onsite have received fire training, additional signage will be added to the doors to support the staff in the clear identification of compartments in line with agreed works above. Onsite training to be provided to staff by PIC to support formal training and ensure staff are aware of need to refer to the repeater panels and feedback has been provided to the company providing fire training to enhance this area of training. – September 2024
• It has been identified due to larger compartment of 16 residents given compartmentation deficiencies , this area has been planned for Phase 1 which includes works on compartment doors and attic spaces to bring these areas into compliance and an additional staff member will be assigned to night duty roster while works are being completed – October 2024.

Arrangements for evacuating all persons in the designated centre:
PEEPS record for one resident on the day of inspection incorrectly advised that the resident was assistance of two , this has now been correct to reflect that resident is assistance of three in the event of an evacuation.Completed
All staff have now been trained in the use of Ski Mat currnelty being identifed as needed for this particular resident.Copmleted
The displayed procedures :
We have requested our fire competetent person to review the displayed information with a view to adding the additional information needed including direction of escape as well as location of fire exits and extinguishers and clearly definable compartments – 31st January 2024

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:
Care plans had included preventative measures taken, including use of pressure relieving mattresses and cushions. While there were no pressure ulcers at the time of inspection the care plans for all residents deemed a high risk of pressure ulcers have been updated to also include SSKIN Care Bundle – September 2024

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Access from resident’s bedroom to bathroom will be closed off leaving access only from the main corridor. A Sink will be added into resident’s bedroom for resident use. – September 2024

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2025
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	30/10/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Not Compliant	Orange	30/10/2024

	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	28/02/2025
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	Red	31/01/2025
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/11/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/01/2025
Regulation 28(1)(c)(ii)	The registered provider shall	Not Compliant	Red	31/12/2024

	make adequate arrangements for reviewing fire precautions.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/09/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	31/12/2024
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	Red	31/12/2024
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in	Substantially Compliant	Yellow	30/11/2024

	the designated centre.			
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	31/07/2024
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	30/09/2024