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:	Cahercalla Community Care
Name of provider:	Cahercalla Community Hospital Company Limited By Guarantee
Address of centre:	Cahercalla Road, Ennis, Clare
Type of inspection:	Unannounced
Date of inspection:	20 March 2024
Centre ID:	OSV-0000444
Fieldwork ID:	MON-0043163

About the designated centre

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

Cahercalla Community Care is located on the outskirts of the town of Ennis. It provides care to long-term, respite, and convalescence residents and also has five designated hospice beds. The centre was originally opened as a hospital in 1951, and while there had been significant extensions and renovations since then, the overall the design and layout of the premises was largely reflective of a hospital from this period. The original building consists of a three storey units, Ground floor, St. Joseph's and Sacred Heart. An unused clinical unit beside the ground floor unit has recently been refurbished. This new unit consists of three twin rooms, two single rooms, a large day room and a large dining room. The centre also has a two storey building with two units, Garden wing ground floor and Garden wing first floor. The centre is registered to accommodate 112 residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	103

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 20 March 2024	10:00hrs to 19:00hrs	Una Fitzgerald	Lead
Wednesday 20 March 2024	10:00hrs to 19:00hrs	Rachel Seoighthe	Support

What residents told us and what inspectors observed

Overall, the residents living in the centre were content and expressed satisfaction with the service provided. Residents spoken with expressed satisfaction with the direct provision of care. Residents had positive feedback when speaking about the staff. One repeated source of dissatisfaction voiced by the residents to the inspectors was in relation to the call bell system and the response times from staff. Inspectors observed that call bells were not always placed within resident reach, this meant that residents who had the ability to utilise the call bell could not always call for routine assistance or support from the care staff.

Following an introductory meeting, inspectors walked around the centre and found that the overall standard of cleanliness was poor. While the inspectors observed that the centre was spacious and generally well laid out to meet the needs of the current residents, multiple resident bedrooms were observed to be in a poor state of repair. This observation was a repeated finding from the last inspection completed in June 2023. For example, inspectors noted that wall surfaces were damaged and some floor covering that was continued to form skirting at the base of the walls in a number of residents' bedrooms, was peeling away from wall surfaces. This meant that the area could not be effectively cleaned.

The centre was divided into five separate units. Inspectors found that the standard of cleanliness in communal bathrooms, some kitchenettes and sluice rooms was inadequate. Multiple bathrooms, that had been signed as having been cleaned, were visibly unclean. Each unit had a separate kitchenette where food was served from. Inspectors observed layers of dust along windowsills, fly screens that had embedded layers of dirt, and unclean kitchen equipment. Inspectors observed mops, that were in use to clean catering areas were food was served, were observed to be unclean and sticky to touch.

Resident bedroom accommodation comprised of shared and single bedrooms. Residents' bedrooms were personalised with items of personal significance such as photographs and ornaments. Many resident bedrooms were noted to be spacious and in the main, there was sufficient storage space for resident personal possessions. However, inspectors noted that residents in one shared room could not access their own wardrobe without entering another residents bed space. This was a repeated observation from inspections in May 2022, October 2022 and June 2023.

Resident had access to a variety of communal rooms including dining rooms, sitting rooms, a coffee shop and a spacious chapel. Refurbishment works along the main corridor were underway to one unit on the ground floor. While there was a secure enclosed garden, inspectors noted that the garden was not easily accessible to residents, as it was secured with key code access. This code was not displayed which meant that residents could not go outside independently, as they required a member of staff to unlock the door for them.

Inspectors observed the residents dining experience in two units of the centre. Staff were observed providing assistance and support to residents in the dining rooms and to those residents who remained in their bedroom. Inspectors noted that pictorial menus were displayed and background music was playing softly, to enhance the resident experience. Residents were complimentary of the quality of the food they received and inspectors noted that residents were offered snacks throughout the day.

There was sufficient private and communal space for residents to meet with visitors. Inspectors observed a number of residents receiving visitors during the inspection.

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

Capacity and capability

Overall, the findings of this inspection were that residents were receiving good quality service in a caring environment that met residents assessed health and social care needs. Inspectors found that the direct provision of care was of a good standard. However, this inspection found that the provider had failed to ensure that the premises were in a good state of repair, impacting both the quality of the care environment and the ability to ensure appropriate infection prevention and control.

This was an unannounced inspection conducted by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulation 2013 (as amended). The inspection findings were that the provider had failed to implement the compliance plan in relation to the premises, infection control and the supervision of staff that was submitted to the Chief Inspector following the last inspection of the centre in October 2022 and June 2023.

Cahercalla Community Hospital Company Limited By Guarantee is the registered provider of Cahercalla Community Care. There was a clearly defined management structure in place, with identified lines of authority and accountability. Mowlam Healthcare Services Unlimited Company is participating in the management of the centre and provides additional senior management support to the director of nursing. Within the centre, the director of nursing was supported in the role by a full-time assistant director of nursing, with a team of clinical nurse managers. On the day of inspection there were 103 residents living in the centre with nine vacancies. There were sufficient numbers of suitably qualified staff available to support residents' assessed needs. The team providing direct care to residents consisted of at least five registered nurses on duty at all times, supported by a team of health care assistants.

Staff had access to training. This included infection prevention and control training,

manual handling, fire safety and safeguarding training. In the main, staff responses to questions asked displayed a good level of knowledge. On the day of inspection, the training records in relation to the management of responsive behaviours were incomplete. The inspectors were informed that training sessions had been scheduled.

The provider had implemented an auditing schedule as part of the system in place to monitor the service. The person in charge, supported by the assistant director of nursing were completing the audits. The system included monitoring of care plan documentation and infection prevention and control practices. The inspectors found that the audit system in place was not fully effective to support identification of risk and deficits in the quality and safety of the service. For example;

- some audits used in the centre were not reflecting known areas of dissatisfaction. For example; at the January 2024 resident meeting the residents had voiced dissatisfaction at the availability of call bells and with the call bell response times. Despite this, the call bell audit was checking the mechanics of the bell and did not look at the timing of call bell response times or if residents had access to their call bell. Therefore, a quality improvement plan that addressed the issue impacting residents was not developed.
- the audit system in place was not fully effective to support identification of environmental risk and non compliance with the overall state of repair of the premises. For example, a hygiene and infection control audit completed in February 2024, had identified that resident equipment was not clean, however appropriate action to address the finding was not completed.

The provide had failed to ensure that the recruitment process in place met with Schedule 2 requirements. For example; the details and documentary evidence of qualifications obtained by staff.

Inspectors reviewed a sample of complaints that had been received since the previous inspection. Inspectors found that complaints management was not in line with regulatory requirements or the centre's own complaints policy. For example, several individual concerns raised at residents meetings were not recorded as complaints. In addition, recorded complaints did not detail any actions taken to address the issues raised by the complainants.

Regulation 15: Staffing

A review of the rosters found that there was adequate staffing levels in place to meet the needs of the residents and for the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff did not receive appropriate training. A review of the staff training record found that six staff had not completed yearly mandatory fire safety training. Additionally, 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) as required by the regulations.

The supervision arrangements in place to ensure that the centre was adequately cleaned were not effective. While training in cleaning and infection prevention and control had been completed by staff, there was poor supervision in place to ensure that learning was implemented. The result of this was a poor standard of cleanliness within the centre. This was evidenced by;

- Multiple rooms which were signed off as clean on the morning of the inspection were visibly unclean. Communal bathrooms, identified as clean, had layers of dust on windowsills, and sinks were unclean.
- Cobwebs had formed on the window sills of the kitchenettes in use where food was prepared.
- Items of resident continence equipment that were marked as ready for resident use were not clean. This was a repeated finding.

Furthermore, some areas of care delivery were not appropriately supervised. For example, while all residents were provided with a call bell, it was not always within reach. Supervising staff did not ensure that residents were enabled to call for assistance when required.

Judgment: Not compliant

Regulation 23: Governance and management

The systems in place to ensure a safe, monitored and consistent service was provided were not fully effective. This was evidenced by;

- An ineffective system of infection and environmental audit. For example, in house audits and external provider audits had identified that parts of the premises were in need of cleaning. Insufficient progress had been made on the standard of cleaning. This repeated finding presented a risk to residents.
- Areas identified as having been cleaned were not checked or verified. Staff were not supervised to ensure that the cleanliness of the environment was maintained at an appropriate standard.
- Ineffective record management systems were in place to ensure compliance with the regulations. There was poor oversight of records pertaining to staff personal files.

- Ineffective communication systems to ensure complaints were recognised and appropriate follow up action taken. This poor oversight of the complaints management system did not ensure the quality of care of residents was monitored, reviewed and improved on an ongoing basis.

The provider had not taken action to address the non-compliance identified in the previous inspection. Repeated non-compliance was found in the following regulations:

- Regulation 16: Training and staff development,
- Regulation 23: Governance and management,
- Regulation 27: Infection prevention and control,
- Regulation 17: Premises
- Regulation 9: Residents' rights.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors found that complaints management was not in line with regulatory requirements or the centres' own complaints policy. A review of the complaints log found that complaints were not managed in line with the requirements of Regulation 34: Complaints procedure. This was evidenced by;

- a resident who reported a complaint in relation to access to activities did not have this complaint documented, investigated or resolved.
- the resident meetings recorded that residents voiced dissatisfaction with the time delay for call bells to be answered. In addition, a resident had voiced that their bell was not left within their reach at night time. This information had not been logged as a complaint and at the time of inspection was not under review.
- There were multiple examples whereby complaints had been documented, but no investigation or follow up review had been completed.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that residents received a good standard of evidenced-based care in response to their assessed needs, and residents were content with the service they received. However, the provider had failed to address non-compliance in relation to residents rights, premises and infection control following the previous

inspection, which were impacting on the quality of life and safety of residents who lived in the centre. Furthermore, action was required to bring fire precautions into compliance with the regulations.

The design and layout of the premises was suitable for its stated purpose and the centre was found to be well-lit and warm. However, inspectors found that progress in relation to actions proposed to address the findings in relation to the premises from the previous inspection were not completed on this inspection. Repeated non-compliance were identified in relation to the overall state of repair of the designated centre. For example, inspectors noted damage to wall and floor surfaces which was a finding of the previous inspection.

Inspectors found that the provider had not taken action to ensure a satisfactory standard of environmental hygiene was maintained to minimise the risk of infection in the designated centre. For example, multiple hand wash sinks were visibly unclean and inspectors observed resident equipment, which was stored and marked as ready for use, were not clean. This posed a risk of cross contamination and infection. This is a repeated finding.

The provider had systems in place to mitigate the risk of fire, including a fire alarm system, emergency lighting and fire-fighting equipment. Inspectors found that there was inadequate arrangements in place for the containment of fire and smoke. A number of fire doors did not close fully when released. Furthermore, several doors had visible gaps between the floor and bottom of the door when in a closed position which did not ensure the containment of fire and smoke in the event of a fire in the designated centre.

Residents had access to radio, television and internet. Residents' views on the quality of the service provided were sought through satisfaction surveys, feedback events and through resident meetings. Records demonstrated that resident meetings were held three monthly and agenda items included food, activities and staffing. However, a review of records evidenced that individual concerns and complaints raised by residents at meetings were not managed in line with the centres own complaints procedure.

While residents rights were generally found to be upheld, the provider had failed to ensure that the privacy and dignity of residents was maintained in some shared bedrooms. For example, the privacy curtains did not provide sufficient cover. Some residents did not have appropriate access to activities, that suited their interest and needs. The communal sitting rooms were supervised by a member of staff. Inspectors were informed that activities were provided daily. There was an activity schedule in place. On the day of inspection, inspectors observed residents spending long periods of time without any activity occurring.

A review of a sample of resident's records showed that residents had timely access to a general practitioner (GP) and out-of-hours services. There were referral arrangements in place for services such as speech and language therapy, dietetics, occupational therapy and physiotherapy. Resident care documentation was maintained on an electronic system. Records demonstrated that care plans were

developed following completion of validated assessment tool. Care plans were individualised and could effectively direct resident care.

The registered provider had ensured that there were arrangements in place for residents to receive visitors. Inspectors observed visits to residents were not restricted and there was sufficient private and communal space available.

Regulation 17: Premises

A review of the premises confirmed that the following areas were not kept in a good state of repair as required under Schedule 6 of the regulations:

- There were a number of damaged wall surfaces in resident bedrooms, paint was missing and plaster was exposed. This meant that these surfaces could not be effectively cleaned.
- Floor covering, that was continued to form skirting at the base of the walls in a number of residents' bedrooms was peeling away from wall surfaces. This is a repeated finding which did not ensure that the floor surfaces were adequately maintained or that effective cleaning procedures could be completed.

Judgment: Not compliant

Regulation 27: Infection control

The designated centre did not fully met the requirements of Regulation 27: Infection Control and the National Standards for Infection Prevention and Control in Community Services (2018). For example:

- There were areas of the centre that were not cleaned to an acceptable standard on inspection. This included kitchenette units on all floors in the centre. For example, there was heavy dust on doors and equipment surfaces, fly screen traps had cobwebs, and sweeping brushes and mops, which were visibly dirty, were stored beside crockery and utensil trays on open shelves. This posed a risk of cross contamination.
- The area around the water outlets in a number of sinks used by staff for hand hygiene was visibly unclean and overflow openings were layered with dirt. This posed a risk of cross infection.
- There was a tagging system in place to show which equipment was decontaminated after use between residents, however the efficacy of this system was not effective. For example, inspectors observed a shower chair labelled as clean was visibly unclean.
- Resident continence equipment which was ready for use, was not clean.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had failed to take adequate precautions to ensure compliance with Regulation 28, Fire precautions. This was evidenced by;

- A number of corridor fire doors, when released, had gaps which may not contain smoke in the event of a fire.
- there were large spaces between the door and the floor under a number of fire doors and this posed a risk that fire and smoke would not be contained in the event of a fire safety emergency.
- A set of cross corridors fire doors had holes bored through the top of both doors; this could compromise the integrity of the door and allow fire and smoke to enter a compartment.
- The configuration of furniture in one dining room meant that access to one fire exit door was obstructed. This could pose a delay in the event of an evacuation.
- Emergency lighting that is required to illuminate the route of escape in the event of a fire evacuation at night time was not operating in one area.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of resident care documentation found that each resident had a comprehensive assessment in place that guided the development of a care plan. Assessments were completed using validated assessment tools to identify residents clinical and social needs. Care plans were effective in guiding staff to deliver person-centred care. Records demonstrated that care plans were reviewed at intervals not exceeding four months, and more frequently, if required.

Judgment: Compliant

Regulation 6: Health care

Residents had access to allied health and social care professionals and access to a general practitioner (GP), as required or requested. There was clear evidence that advice received was acted upon. For example, inspectors reviewed a sample of wound care records in the centre and found that evidenced-based wound care was

provided to residents. Wound prevention measures were in place and nursing staff had access to tissue viability expertise to support the management of residents wounds.

Judgment: Compliant

Regulation 8: Protection

Measures were in place to safeguard residents from abuse. Staff had completed up-to-date training in the prevention, detection and response to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had not ensured that some residents could carry out personal activities in private. Residents' in a number of twin rooms could not undertake activities, such as dressing, in private. For example;

- The privacy curtain in one shared bedroom did not provide sufficient coverage to ensure the privacy and dignity of both residents occupying the bedroom.
- Residents in one shared room could not access their wardrobe space, without entering their neighbouring residents private space. This is a repeated finding from inspections in May 2022, October 2022 and June 2023.

Access to the enclosed courtyard garden on the ground floor was restricted by use of key coded locked, and alarmed doors. This arrangement placed restrictions on residents' freedom of movement and their choice to access the outside space without the support of staff to open the door for them.

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	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cahercalla Community Care OSV-0000444

Inspection ID: MON-0043163

Date of inspection: 20/03/2024

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person in Charge (PIC) has completed a review of all mandatory staff training and since the inspection, training and refresher updates have been scheduled and completed with additional sessions scheduled for Fire training and Responsive Behaviours to ensure that all staff are up to date on mandatory training requirements. • The PIC, with the support of the HCM will monitor all training needs at the weekly Management meeting to ensure that all staff receive mandatory training as required. • The PIC and General Services Manager (GSM) will review the housekeeping service, cleaning schedules and practices in the home and will ensure that there is sufficient supervision of household staff to monitor the effective cleaning of all departments to the expected high standard. • The GSM will arrange for a deep clean of the centre to be undertaken and this will set a baseline which will be maintained by the housekeeping team. • Since the inspection, the PIC and GSM have increased the hours for housekeeping to ensure that staff have sufficient hours to maintain cleaning standards in all departments in accordance with the centre's policies. • The PIC will continue to conduct spot-checks, and compliance with cleaning standards will be regularly monitored by the PIC and GSM as part of their daily rounds. • The GSM will oversee the development and implementation of quality improvement plans for housekeeping standards, and these will be reviewed at monthly quality and safety meetings. • The PIC, supported by the ADON/CNMs will ensure that all staff are aware and appropriately utilise the cleaning tagging system. Items of equipment awaiting cleaning will be identified with a red sticker label until such time as they have been cleaned. • The PIC and the IPC lead nurse will ensure that the cleaning system is monitored, and all staff are reminded of the need to ensure compliance with cleaning and decontamination of clinical equipment. • The PIC walkabouts will include the visible checking of equipment in the sluice rooms to ensure they are clean and available for use when required.	

• Weekly Call bell audits will be completed to idenifiy any deficits with the call bell system and to ensure that response times are satisfactory. We will monitor the positioning and the operation of the call bells. The call bell response audit is reviewed weekly and if there are delays identified, these will be investigated, addressed with staff and a quality improvement plan will be developed by the ADON or designated member of the management team. Audit findings will be discussed daily at safety pause, weekly at the management meeting and monthly at the Quality and Safety meeting and all quality improvements identified from the call bell audits will be shared among the team.

Regulation 23: Governance and management	Not Compliant

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

• The PIC will ensure that the management team and the IPC lead nurse actively monitor IPC standards and adherence to IPC protocols in the centre.
• The PIC will ensure that there is an effective system of IPC and environmental audits in the centre. Audit findings will be accurately reflected and will lead to appropriate quality improvement plans to address any deficits identified. Quality improvement plans will be reviewed at monthly management meetings to ensure that they are being adhered to.
• The GSM will review cleaning schedules with the housekeeping supervisor and identify priority areas.
• The housekeeping supervisor will provide effective oversight of the housekeeping team, ensuring that expected standards of cleaning are consistently maintained.
• Compliance with cleaning standards will be regularly monitored by the PIC and GSM as part of their daily rounds.
• The PIC has completed a review of all staff files and will ensure that all staff records are maintained in line with Schedule 2 requirements.
• Complaints training has been scheduled for all staff in the centre, including the management team.
• Records of resident meetings will be reviewed and any issues or concerns will be recorded as complaints and investigated in accordance with the Complaints Procedure.
• The PIC, with the support of the Healthcare Manager (HCM) will undertake a weekly review of all complaints to ensure they are recorded, investigated, addressed and resolved in accordance with the Complaints Policy.
• The PIC and HCM will analyse complaints to identify trends and to ascertain whether there are any safeguarding concerns. They will ensure that learning outcomes are identified and that recommended improvements are implemented.
• The PIC will discuss learning outomes from complaints at the weekly management team and at the monthly Quality and Safety Meetings.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Complaints management training has been scheduled within the home for all staff including the management team.
• The PIC will ensure that all residents' complaints are acknowledged, recorded, investigated and responded to in accordance with the Complaints Policy. The satisfaction of the complainant will be recorded and learning outcomes will be identified. The learning outcomes and recommended quality improvements will be discussed at the weekly management team meetings and monthly Quality & Safety meetings to ensure that interventions identified and closed off in line with Regulations.
• The PIC and HCM will ensure that all complaints received within the home will be managed in line with regulatory requirements and in accordance with the centre's Complaints Procedure. They will analyse complaints to identify trends and determine whether complaints include any safeguarding concerns.
• Resident meetings records will be reviewed, and any issues or concerns raised by residents will be recorded as complaints and investigated in accordance with the centre's Complaints Procedure.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The centre will be reviewed by the Facilities Manager and a programme of works will be identified to repair or replace damaged flooring and walls and to ensure that all surfaces can be cleaned.
• The PIC will review the plan of painting works to ensure that walls, skirting, and scruff marks are cleaned, painted and kept in a good state of repair.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Since the inspection, a deep cleaning of the centre has commenced, and the kitchenettes have been deep cleaned. This will create a baseline standard which will be maintained by the housekeeping team, overseen by the GSM.
• The PIC and GSM will monitor standards and systems of cleaning throughout the centre

on their daily walkabouts. Any deficits in cleaning standards will be brought to the attention of the housekeeping supervisor who will be required to address them.
• Housekeeping staff have been reminded that checklists are to be completed accurately and kept up to date.
• All water outlets have been cleaned since the inspection. The cleaning of water outlets has been added to daily cleaning schedules and will be monitored by the GSM.
• The PIC and IPC lead nurse will ensure that the tagging system utilized for the cleaning of equipment will be monitored daily.
• The ADON and CNMs will supervise IPC practices to ensure that staff are vigilant and provide a high standard of infection control.
• The GSM will ensure that all kitchenettes, including fixtures, fittings and equipment will be always maintained in a clean and hygienic condition and will monitor compliance with the schedule and standard of cleaning.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Since the inspection the gaps in the fire doors have been addressed, doors have been realigned. The holes in the fire doors have been repaired.
• The newly fitted fire doors will be connected to the fire alarm system.
• A review of all emergency lighting has been undertaken. The PIC, with support of the GSM, will ensure that consistent checking of the emergency lighting is carried out and any deficits will be addressed immediately.
• The furniture in the dining room has been rearranged to ensure that there is clear and unobstructed access to the fire exit door.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The privacy curtain in the identified shared room will be adjusted to provide sufficient coverage, ensuring the privacy & dignity of both residents

• The twin room identified where a resident was unable to access their wardrobe space without entering the neighbouring resident's private space will be re-configured to ensure that both residents' privacy will be assured.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/06/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/05/2024
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	31/07/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and	Not Compliant	Orange	30/06/2024

	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.	Not Compliant	Orange	31/05/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/05/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/05/2024
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Not Compliant	Orange	30/06/2024
Regulation 34(2)(c)	The registered provider shall ensure that the complaints	Not Compliant	Orange	31/05/2024

	procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.			
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	31/05/2024
Regulation 34(7)(b)	The registered provider shall ensure that all staff are aware of the designated centre's complaints procedures, including how to identify a complaint.	Not Compliant	Orange	30/06/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is	Substantially Compliant	Yellow	31/07/2024

	reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.			
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.	Not Compliant	Orange	31/07/2024