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:	Lakes Nursing Home
Name of provider:	Elder Nursing Homes Ltd
Address of centre:	Hill Road, Killaloe, Clare
Type of inspection:	Announced
Date of inspection:	06 March 2024
Centre ID:	OSV-0000447
Fieldwork ID:	MON-0042761

About the designated centre

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

Lakes Nursing Home is a two-storey purpose-built centre designed to provide care for residents requiring continuing and short stay care including respite and convalescence. As a provider of high quality nursing care, we welcome the 'National Standards for Residential Care Settings for Older People in Ireland'. These standards will help to consolidate existing good practice whilst also identifying areas for development. We are committed to enhancing the quality of life of all our residents by providing inclusive, high-quality, resident-focused 24-hour nursing care, catering, service and activities. Lakes Nursing Home can accommodate a maximum of 57 residents. There are 47 single rooms available with en-suite toilet facilities as well as five double rooms with en-suite toilet facilities. A number of shared shower rooms are available. There is stairs and lift access to the first floor. It is a mixed gender facility catering for dependent persons aged 18 years and over, providing long-term residential care, respite, convalescence, dementia and palliative care. Care for persons with learning, physical and psychological needs can also be met within the unit. Care is provided for people with a range of needs: low, medium, high and maximum dependency. We employ a professional staff consisting of registered nurses, care assistants, maintenance, and laundry, housekeeping and catering staff. Prior to admission, a pre-admission assessment shall be undertaken in the resident's home or transferring facility, by a member of the residential home's nursing staff. Care plans will be established and reviewed through inclusion of families and residents supported by the community services on referral. Resident records are stored on a secure computer system and also in filing cabinets. The activities coordinator meets new residents to plan an individual activities programme. Residents are encouraged to keep up their social/leisure interests after admission, for example, gardening, painting, knitting, quiz, music, media access, beauty and hair therapy. Day trips are also organised occasionally. Arrangements can be made for residents to go shopping or attend other activities outside the nursing home; these may incur some extra costs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	54

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 6 March 2024	09:30hrs to 18:40hrs	Rachel Seoighthe	Lead
Wednesday 6 March 2024	09:30hrs to 18:40hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Overall, inspectors found that the residents were content living in the designated centre and comfortable in the company of staff, who were observed to be attentive to residents' needs. Inspectors heard mixed comments in relation to the choice of food and some residents' voiced that they would be hesitant about making complaint about the quality of the service. However, residents were generally satisfied with the service and staff were described as 'very good.'

This was an announced inspection which was carried out over one day. Following an introductory meeting with the person in charge, the inspectors walked around the centre, giving an opportunity to meet with residents and staff as they prepared for their day.

The Lakes Nursing Home provides long term and respite care for both male and female adults with a range of dependencies and needs. The centre is a purpose-built two-storey building located in the village of Killaloe, Co. Clare. The designated centre is registered to provide care for a maximum of 57 residents. There were 54 residents living in the centre on the day of the inspection. Resident bedroom accommodation was provided over both floors in single and twin bedrooms, with en-suite facilities. There was stairs and passenger lift access between floors.

The design and layout of the premises was generally suitable for its stated purpose and met the residents' individual and collective needs. The centre was found to be well-lit and warm. Inspectors noted that the provider had made some improvements to the premises since the previous inspection, including the replacement of resident equipment and the extension of an enclosed garden. Resident bedrooms were decorated with items of personal significance, such as photographs and soft furnishings and inspectors noted that they were generally clean throughout. However, some residents bedrooms were observed to have chipped paint on walls, doors and skirting and some floor surfaces were in a poor state of repair and could not be adequately cleaned. Inspectors noted that floor surfaces on circulating corridors were uneven and damaged, which was a potential safety risks for residents when mobilising. This was a repeated finding from the previous inspection.

As inspectors walked around the centre, they noted that residents moved freely, and were seen socialising with each other and staff. There were a number of accessible private and communal spaces for resident use, such as dining rooms and a sitting rooms. There was a relaxed atmosphere in the centre and inspectors observed that the majority of residents were up and about and following their normal routines. Some residents were seen to be mobilising independently, whilst others were observed using mobility aids. Hand rails were in place along all corridors of the centre and in resident bathrooms, to enable residents to mobilise safely and independently.

Inspectors spent time speaking with residents in the enclosed garden area on the ground floor of the centre. Inspectors noted that the designated smoking area had been relocated to the opposite side of the garden since the previous inspection. Residents using the smoking area had enhanced views of local scenery, however there was a lack of shelter and one resident expressed that they would feel safer if there was suitable lighting and a call bell facility. This was discussed with the management team. Inspectors noted that the garden had been extended since the previous inspection and the area was clean and well maintained. Residents told inspectors they were happy with the additional space provided.

Inspectors spoke with a number of residents in their bedrooms and communal areas throughout the day of inspection. Residents were generally complimentary of the service. Inspectors heard positive comments such about the staff who were described as 'very good.' However, feedback about the choice of food provided was mixed. Inspectors were informed by several residents that food was 'lovely' and a choice was offered daily, however some residents expressed that they would like to see a more varied menu as the choice of meals was repetitive.

Inspectors observed that visitors were coming and going throughout the inspection . Arrangements were in place to support residents to meet visitors in their bedrooms or in a variety of communal rooms.

The following sections of this report details the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

This was an announced inspection, carried out over one day by inspectors of social services, to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). During the centre's previous inspection in June 2023, a number of non-compliances had been identified in relation to fire precautions, infection control, premises and residents' rights. The compliance plan submitted by the provider to address these findings was reviewed on this inspection, to determine whether all actions had been completed within the time frames given by the provider. This inspection found that the provider had not fully implemented their own compliance plan following the previous inspection. Furthermore, significant non-compliance was found in relation to Regulation 8: Protection, and Regulation 28: Fire precautions and the provider was required to submit an urgent compliance plan to the office of the Chief Inspector following this inspection. The urgent compliance plan was accepted.

Elder Nursing Homes Limited was the registered provider for the Lakes Nursing Home. There was a clearly defined management structure in place, with identified lines of authority and accountability. Mowlam Healthcare Services are participating in the management of the service and a regional healthcare manager provided

senior management support to the person in charge, who was appointed to their role in October 2023. The person in charge was supported locally by a clinical nurse manager. A team of nurses, care assistants, activities, catering, house-keeping and maintenance staff made up the staffing complement.

On the day of the inspection, there were sufficient numbers of suitably qualified staff available to support residents' assessed needs. Staff training records evidenced that staff were facilitated to attend mandatory training relevant to their roles, such as fire safety and safeguarding. However, inspectors identified some gaps in the provision of training in the management of responsive behaviours and restrictive practices.

While there was an established governance and management structure overseeing the quality and safety of the service, and the provider had a comprehensive quality assurance system in place, this was not providing effective oversight in a number of areas. For example, a electronic system of audit for infection prevention and control was in place and was completed in line with an audit schedule for the centre. This electronic audit had been completed in November 2023. While an action plan had been developed to address deficits found in the November audit, these actions had not been completed. This resulted in a subsequent audit having a lower level of compliance.In addition, a paper-based system of auditing had also been introduced in February 2024, however, the action plan for the paper-based audit did not align with the findings and action plan of the electronic audit. This meant that issues relating to the maintenance of the premises and infection control issues were not addressed to ensure compliance with the regulations.

A review of the incidents and accidents in the centre found that, while there was a system in place to audit and monitor adverse incidents, a number of incidents recorded were not identified as potential safeguarding incidents and therefore were not managed in line with best practice guidelines.

Similarly, a review of the complaints records found that complaints were not managed in line with the requirements of Regulation 34. For example, where resident had provided feedback in relation to their dissatisfaction with parts of the service, the management of these issues had not been documented, investigated and managed as required. Residents told the inspectors that they had raised concerns with the staff but that their concerns had not been responded to. Inspectors noted that residents dissatisfaction in some areas of the service was documented within the record of a residents meeting and resident surveys, however, these issues had not been appropriately addressed to the satisfaction of the residents. Furthermore, a review of the record of a formal complaint found that the provider had not responded to the complainant in writing, as required.

Staff personnel files contained the necessary information as required by Schedule 2 of the regulations including evidence of a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

An annual report on the quality of the service was completed for 2023.

Regulation 15: Staffing

On the day of inspection, there was adequate staff available to meet the needs of the current residents taking into consideration the size and layout of the building.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors found that some staff did not have access to appropriate training. For example, a review of staff training records found that not all staff had completed training in the management of responsive behaviours and restrictive practices.

Staff knowledge in relation to the safeguarding of vulnerable adults will be discussed under Regulation 8: Protection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems in place to monitor the quality of the service did not ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored. For example;

- The system in place to monitor incidents to ensure that residents were safeguarded from abuse were not effective. This meant that, where there was an incident or a complaint relating to an allegation of abuse, this was not recognised as such, and therefore not managed in line with the national guidelines for safeguarding or the requirements of the regulations.
- An investigation report into a significant incident that had occurred two months prior to the inspection was ongoing and incomplete and therefore no areas of learning or quality improvement had been identified.
- The registered provider had failed to take adequate precaution against the risk of fire, and urgent action was required to address fire safety risks in the centre.
- There was poor oversight of the state of repair of the building. The maintenance of the premises, specific to flooring was not adequate.
- The system for maintaining the directory of residents was disjointed and incomplete as it was stored in two separate formats.
- The system of auditing in place was disjointed and was not effective in clearly identifying areas that required improvement.

- The system in place to manage risk was not effectively utilised. Known risks were documented, however, the controls in place to manage the risk were poorly detailed.

A compliance plan submitted following the previous inspection was not fully implemented, resulting in repeated non-compliance with Regulation 17: Premises, Regulation 28: Fire precautions, and Regulation 23: Governance and management.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors found that the management of complaints was not in line with the requirements of the regulations. For example, a review of a sample of complaints records demonstrated that ;

- Complaints and expressions of dissatisfaction with the service provided were not recorded and responded to. For example, residents issues with menu choice, the comfort of the beds or issues relation to heating had not been appropriately responded to.
- a written response to a formal complaint was not issued to complainants, as required under Regulation 34(2)(c).

Judgment: Substantially compliant

Regulation 19: Directory of residents

Inspectors found that the residents directory was maintained in two separate formats and records of information specified under Schedule 3 were not recorded from January 2023 to June 2023.

Judgment: Not compliant

Quality and safety

Overall, the inspectors found that residents were looked after by a caring staff team and residents were generally content with the service they received. However, inspectors found that urgent action was required to ensure that residents were safe in the event of a fire emergency. Furthermore, this inspection found that the measures in place to safe-guard residents living in the centre were not effective to

ensure the quality of life and safety of residents who lived in the centre. In the absence of satisfactory assurances regarding the protection of residents and fire safety systems, the provider was asked to submit an urgent compliance plan by 13 March 2024.

The previous inspection of the centre in June 2023 had identified deficits in fire safety systems. Further to this inspection, the registered provider commissioned the completion of a fire safety survey by a competent person. This survey was completed in January 2024, and the report was issued to the provider on the day before this inspection. The findings of the fire safety survey were that urgent action was required by the provider to address the integrity of attic compartmentation, to prevent the spread of smoke and fire in the event of a fire safety emergency in the designated centre. This resulted in an urgent compliance plan being requested from the provider to ensure residents were protected from the risk of fire.

Inspectors observed some areas of residents living environment were not maintained to a good standard. Damage to floor surfaces in resident bedrooms and along circulating corridors which had been observed on the previous inspection, had not been addressed by the provider. Damaged floor surfaces were not amenable to cleaning and some floor surfaces were uneven and this presented a trip hazard for residents. Further findings are discussed under Regulation 17, Premises.

Measures in place to safeguard residents from abuse were not robust. Staff had completed up-to-date training in the prevention, detection and response to abuse, and procedures to safeguard residents were underpinned by a safeguarding policy that provided guidance and support to staff on the appropriate actions and measures to take to protect residents should a safeguarding concern arise. However, inspectors found that the safeguarding policy and associated procedure had not been implemented in practice and appropriate action had not been taken to investigate a number of allegations of abuse. Furthermore, the review of the investigation in relation to three safeguarding concerns found that vulnerable residents did not have a safeguarding plan in place and therefore, the safety of the residents in the centre could not be assured.

Inspectors noted that some action had been taken to address the issues of non-compliance relation to infection prevention and control. Handwash basins had been installed and there were systems in place to ensure that cleaning systems were effective. Inspectors noted that management of the dirty laundry trolley required action. Laundry skip trolleys, which were stored along corridors, were uncovered and were also used to store clean personal protective equipment such as aprons, which was not line with best practice and posed a risk of cross infection.

Residents had access to medical care and records demonstrated that referral systems were in place for residents to access allied health and social care professionals, such as dietitians, tissue viability specialists, and speech and language therapists, for additional support and expertise. A physiotherapist attended the centre twice weekly.

An electronic nursing documentation system was in place. Residents care and support needs were assessed using validated assessment tools that informed the development of care plans. Care plan reviews were carried out at regular intervals.

The centre promoted a restraint-free environment and there was appropriate oversight and monitoring of the incidence of restrictive practices in the centre.

There were opportunities for residents to engage in activities in this centre, in accordance with their capacities and capabilities. An activities schedule was displayed and the programme of planned activities included live music, arts and crafts, pet therapy and beauty therapies.

Residents reported that they had choice on how they liked to spend their day and they were able to walk outside independently. Residents were supported to practice their religious faiths. Residents had access to advocacy services.

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Visitors were observed meeting with the residents in their bedrooms and communal areas.

Regulation 11: Visits

Visiting within the centre was being facilitated and inspectors saw a number of residents receiving visitors in their bedrooms or in communal rooms.

Judgment: Compliant

Regulation 17: Premises

There were areas in the interior of the building that were not kept in a good state of repair and did not meet the requirements under Schedule 6 of the regulations. For example;

- Floor covering in several bedrooms and circulating corridors room was damaged and uneven. This did not ensure these surfaces were adequately maintained, and posed a trip hazard to residents. This is a repeating finding.
- Floor covering that covered the floor and part of the wall to form skirting at the base of the wall in the first floor kitchenette was peeling away from wall surfaces. This repeated finding did not ensure that the floor surfaces were adequately maintained or that effective cleaning procedures could be completed.

- There was visible damage to wall surfaces in some resident bedrooms.
- Internal rooms such as communal shower rooms and assisted toilets were poorly ventilated, resulting in malodour.

Judgment: Not compliant

Regulation 28: Fire precautions

Following this inspection, the provider was required to submit an urgent compliance plan to address an urgent risk. A fire safety survey completed in January 2024, identified significant risk in relation to the containment of fire and that urgent action was required to mitigate the risk of the spread of fire and smoke, posed by the impaired integrity of attic compartments. The provider was required to submit an urgent compliance plan in relation to the action taken to ensure the protection of residents and others from the risk of fire. The providers response did provide assurance that the risk was adequately addressed.

Additional concerns were identified in relation to fire safety as follows;

- Two bedroom doors had visible gaps when closed. This may impact on the effectiveness of a door to contain smoke or fire in the event of a fire emergency.
- There was no call bell facility provided in the external smoking area. This may prevent residents from alerting staff in the event of a fire safety emergency in this area.
- Combustible supplies were stored in close proximity of electrical supply panels in a linen storage room and in a house-keeping room.
- Access to one activity storage room was by a key code which was not known by all staff members. This could pose a risk of a delay in evacuating all persons from the centre in the event of a fire emergency.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A sample of resident records demonstrated that care plans were developed following a comprehensive assessment of need. Care plans were reviewed at four month intervals and more frequently if required.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a general practitioner (GP) of their choice. GPs visited residents in person and were contacted and made aware if there were any changes in the resident's health or well being.

Allied health professionals such as dietitian, physiotherapist, occupational therapist, speech and language therapy, and tissue viability nurse were made available to residents, either remotely or on-site, where appropriate.

Judgment: Compliant

Regulation 8: Protection

The registered provider had failed to take reasonable measures to protect residents from abuse and to provide for appropriate and effective safeguards to prevent abuse. This was evidenced by the following;

- failure to recognise and respond appropriately to an allegation of abuse.
- A review of the investigation in relation to three safeguarding concerns found that vulnerable residents did not have a safeguarding plan in place and this did not ensure that staff had adequate knowledge to safeguard the resident from abuse.
- Following this inspection, the provider was required to submit an urgent compliance plan to in relation to the actions taken to safeguard residents living in the centre. The providers response did give assurance that reasonable measures were in place to protect residents from abuse.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider did not ensure that residents were able to exercise choice in so far as the resident's choice did not interfere with the rights of other residents. This was evidenced by;

- Several residents expressed dissatisfaction with the choice of menu available. Additionally, inspectors found that residents who required a modified consistency diet were not offered a choice of meal.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The provider had systems in place to monitor environmental restrictive practices to ensure that they were appropriate. There was evidence to show that the centre was working towards a restraint-free environment, in line with local and national policy.

Staff training in relation to restrictive practices and the management of responsive behaviours is addressed under Regulation 16: Training and staff development.

Judgment: 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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 19: Directory of residents	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant

Compliance Plan for Lakes Nursing Home OSV-0000447

Inspection ID: MON-0042761

Date of inspection: 06/03/2024

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	Substantially 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 staff training records. Since the inspection, all staff who required training in responsive behaviours and restrictive practice have received training, and refresher updates have been scheduled for staff as required. • The Healthcare Manager, Quality and Safety has conducted a Safeguarding workshop for all staff including the management team, and a further workshop is scheduled to take place on 28/05/2024. The workshop is an interactive learning opportunity for staff at all levels to recognise potential safeguarding concerns and how to report/escalate their concerns and how they will be investigated, notified and resolved. • The PIC, with the support of the CNM, will ensure that all mandatory training is scheduled for new staff and refresher updates scheduled as required. They will monitor staff attendance.	
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 be supported by the Healthcare Manager (HCM) and the Director of Care Services in the achievement of all required objectives and in ensuring that there are safe, high-quality systems of governance and management in place. Key Performance Indicators (KPIs), incidents, complaints and operational issues in the home are recorded and reviewed on a weekly basis by this senior management team to ensure sustainability	

of progress, to identify areas in need of improvement and to take corrective actions if required.
• The PIC will ensure that all new staff receive all required mandatory training as required and refresher updates will be scheduled in advance for staff.
• The PIC, supported by the HCM, will be aware of the responsibilities to recognise, report, and respond to any allegations, including escalating and notifying any concerns in line with legislative requirements and the centre's Safeguarding policies and procedures.
• The HCM will work with the PIC to ensure that recommendations and quality improvements are implemented as part of learning outcomes.
• The PIC will ensure that all incidents are reviewed weekly and will be discussed at management team meetings and monthly as part of the management team meeting within the centre.
• The PIC will ensure that all audits are recorded and that the findings are accurately reflected. Quality improvement plans will be developed, implemented and evaluated, and these will be shared with all team members as part of the monthly management meetings.
• The Facilities Manager will conduct an inspection of the flooring in the centre and identify areas that require repair or replacement, especially those areas that are not amenable to cleaning. A scheduled programme of repair/replacement will be developed following this inspection.
• A quality improvement plan will be developed and implemented following receipt of the Fire Safety Consultant's report.
• The electronic risk register will be reviewed and updated regularly to ensure that identified risks are mitigated and appropriate actions taken to minimise and manage risks.
• The Directory of Residents will be maintained and kept up to date in line with legislative requirements.
• We will monitor progress with this compliance plan to ensure that regulatory compliance is restored and maintained in the centre.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Inspectors found that the management of complaints was not in line with the requirements of the regulations. For example, a review of a sample of complaints records demonstrated that ;
• A Complaints Management workshop has been scheduled for all staff to attend, including the management team. The purpose of the workshop is to enable staff to understand the roles and responsibilities of staff at all levels to recognise when someone is making a complaint, listen to their concerns and record and escalate them appropriately. They will also be aware of how complaints are investigated, addressed and resolved with the aim of a satisfactory outcome for the complainant. Learning outcomes and service improvements will also be detailed in response to complaints with the aim of

preventing recurrence of similar concerns where possible.
• The PIC will ensure that all residents' complaints are acknowledged, recorded, investigated, addressed and resolved in accordance with the centre's Complaints Procedure and the national complaints policy.
• Complaints will be reviewed by the PIC and HCM to ensure that there are no safeguarding concerns.
• Resident meeting records will be reviewed, and any complaints recorded will be recorded as complaints and investigated in accordance with the Complaints Procedure in the centre.
• The PIC will ensure that all findings and recommendations identified from complaints will be shared at weekly and monthly management meetings.
• The PIC with support of the HCM will ensure that follow through on all complaints will be completed and a determined level of satisfaction recorded.

Regulation 19: Directory of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
• The Directory of Residents includes details of all residents as required and will be maintained in accordance with records of information under Schedule 3.
• The PIC will monitor the Directory of Residents to ensure that it is maintained in compliance with regulatory requirements.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Facilities Manager will conduct a review of the condition of all flooring in the centre which will incorporate a scheduled plan of works to address flooring repairs, renewal, and replacement.
• The PIC will ensure that uneven flooring that has been identified as posing a trip hazard will be risk assessed with interventions identified to minimise the risk and these areas will be prioritised for repair/replacement.
• The PIC, supported by the Facilities team will ensure that ongoing review of residents' living facilities will be completed and discussed at monthly management team meetings.
• The PIC will ensure that the programme of works will be completed within identified timelines and will monitor the premises and escalate any further concerns as they arise.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Works identified as a result of the fire safety survey has been carried out to restore the integrity of the attic compartments.
• We will ensure that a call bell is installed in the external smoking area so that residents can summon assistance when required.
• A universal key will be available to access the activity room and we will remove the code from the door so that staff have access to this room at any time. This will minimise the risk of a delay in evacuating all persons from the centre in the event of a fire emergency
• A review of cross corridor fire doors and bedroom doors has been undertaken to ensure that there are no significant gaps that could increase the risk of spread of fire.
• Linen cupboards will have suitable fire-retardant casing covering the open electrical fuse boxes within, to reduce the risk of fire in these storage areas. The PIC will ensure that items stored within these storage areas are non-combustible, suitable and stored appropriately.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC has scheduled a Safeguarding workshop for the management team to facilitate open discussion and provide clarity regarding roles and responsibilities in the management of safeguarding risks and each individual staff member's responsibilities in the event of a safeguarding incident in terms of immediate actions, escalation, preliminary screening, and investigation.
• Since the inspection, the safeguarding notifications discussed have been notified to the Authority.
• The PIC will ensure that all staff receive regular mandatory safeguarding training. Additional safeguarding has been completed since the inspection with further training dates booked.
• The PIC, with support of the CNM, will ensure weekly safeguarding drills will be completed. This will allow the PIC to monitor the application of theory from safeguarding training to practice. Improvement plans will be developed following safeguarding drills to illustrate best practice to all staff.
• The PIC, supported by the Healthcare Manager (HCM) will be aware of their responsibilities in recognising, reporting and responding to any allegations including escalating/notifying any concerns appropriately.
• The HCM will work with the PIC to ensure that recommendations and quality improvements are implemented.
• The HCM will review each notification to the Authority to ensure that all measures are

taken to safeguard the vulnerable person and all residents in the centre.
• The PIC will ensure that any suspicion, concern, or allegation of abuse will be thoroughly investigated (including the notification of all such suspicions or allegations to the Authority) in accordance with policies and procedures to safeguard residents including the following: Policy (PR-001) Safeguarding Vulnerable Persons at Risk of Abuse Policy (PR-002) Safeguarding Vulnerable Persons at Risk Responding to Allegations of Allegations of Abuse.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The PIC will review the menus with the Catering manager to ensure that all residents have access to a good choice of nutritionally balanced and varied foods on menus. Residents will be offered alternatives at each meal and their preferences will be respected.
• All residents who take a modified diet will have access to a choice of foods which will be documented, and this preference will be communicated to all staff. Residents on modified diets will be offered an alternative at each mealtime.
• Residents wishes and preferences will be discussed at regular resident forums and any alterations to the menu choices will be completed in consultation with the residents.

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 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 19(2)	The directory established under paragraph (1) shall be available, when requested, to the Chief Inspector.	Not Compliant	Orange	30/04/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Not Compliant	Orange	30/06/2024

	consistent and effectively monitored.			
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	30/06/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/05/2024
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.	Substantially Compliant	Yellow	31/05/2024
Regulation 34(2)(c)	The registered provider shall ensure that the complaints 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	Substantially Compliant	Yellow	31/05/2024

	improvements recommended and details of the review process.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Red	31/05/2024
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	31/05/2024
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	31/05/2024