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:	Unannounced
Date of inspection:	25 September 2024
Centre ID:	OSV-0000447
Fieldwork ID:	MON-0043903

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:	57

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 25 September 2024	10:00hrs to 18:00hrs	Rachel Seoighthe	Lead
Wednesday 25 September 2024	10:00hrs to 18:00hrs	Una Fitzgerald	Support

What residents told us and what inspectors observed

On the day of inspection, inspectors observed that residents were supported by a team of staff who were kind and caring and staff were described by residents' as 'very good'. The overall feedback from residents was that they were happy with the care they received. However, several residents described their concerns, regarding certain aspects of the care environment, which impacted on the quality of their lives in the centre.

This was an unannounced inspection which was carried out over one day. Inspectors were met by the person in charge upon arrival to the centre. Following an introductory meeting, inspectors walked through the centre giving an opportunity to meet with residents in their home environment.

Located in Killaloe, Co. Clare, Lakes Nursing Home is registered to provide respite and long term care to a maximum of 57 residents. The centre was a purpose built two-storey facility, with stairs and passenger lift access between floors. Resident bedroom and communal accommodation was provided over both floors of the designated centre. There were 57 residents living in the centre on the day of inspection.

Inspectors spent time walking through the centre and they noted that the atmosphere was bustling. Inspectors observed that staff were busy supporting residents with their personal care needs and several residents were mobilising independently throughout the centre. There were a variety of communal spaces available for resident use and several residents spent time relaxing in seating areas adjacent to the nurses stations' on both floors. Inspectors observed that the dining room was clean, bright and well-furnished to accommodate residents. There was a spacious communal sitting room on the ground floor and inspectors noted that there was constant activity in this room. Residents were seen spending time here, attending activities and watching television. There was a secure enclosed garden area which was accessible through a door on the ground floor. Inspectors noted that outside lighting and a call bell facility had been provided here, in response to resident feedback at the previous inspection. Inspectors observed residents spending most of their day in communal areas, or in their bedrooms.

Resident bedroom accommodation consisted of 47 single and five twin bedrooms bedrooms, laid out over both floors of the designated centre. Inspectors observed that many resident bedrooms were personalised with items of significance, such as family photographs, ornaments and soft furnishings. The majority of residents were satisfied with their private accommodation, however, some residents' reported concerns regarding the appearance and condition of the floor covering in their bedrooms. Inspectors observed that floor covering in multiple resident bedrooms was torn, discoloured and uneven. Inspectors noted that floor covering was rough to the touch and they heard comments from residents such as 'it looks damp', 'it never looks clean' and ' it's not a good look'. Similar to previous inspection findings, floor

covering along circulating corridors was seen to be dented and damaged in some areas, which posed a trip hazard to residents.

Further concerns raised by residents on the day of inspection, related to a temporary disruption to the hot water supply in the centre. Inspectors were informed that residents had been unable to have warm or hot showers for a number of days prior to the inspection, due to a technical fault. Several residents told inspectors they were required to wash with cold water and they voiced their dissatisfaction with this experience. One resident told inspectors that they were "living in hope" that the issue would be resolved. On the morning of the inspection, the management team were unable to provide inspectors with an estimated time-frame for restoration of the hot water supply. However, action was taken by the provider to address the issue and inspectors' were assured that the hot water supply was restored by the evening of the inspection.

A staff member was assigned to the provision of activities for residents and an activity schedule was displayed for resident information. This included one-to-one and group activities such as reminiscence therapy, exercises and music. Residents were complimentary of the activities provided.

There was sufficient space for residents to meet with visitors in private. Inspectors observed a number of residents receiving visitors during the inspection and found that appropriate measures were in place.

The next two sections of the report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance with the regulations are set out under each section.

Capacity and capability

This was an unannounced 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). Inspectors also reviewed the actions taken to address the findings of the previous inspection in March 2024, which identified non-compliance in relation to protection, residents' rights, premises, fire safety, training and development of staff, the directory of residents, complaints procedures and governance and management. Although some action had been taken to bring the directory of residents and complaints procedures into compliance with the regulations, this inspection found that the registered provider had failed to complete the compliance plan submitted following the inspection of the centre in March 2024. Consequently, the centre was in breach of a condition of registration, which related to the premises. Inspectors also found that management systems were not always utilised effectively, to identify, reduce or eliminate potential safeguarding risks in the centre. Furthermore, assessment and care planning, infection control, training and development, records,

governance and management, and notification of incidents, did not meet the requirements of the regulations.

Elder Nursing Homes Limited was the registered provider for the Lakes Nursing Home. Complete Healthcare Services Ltd are participating in the management of the service. A director of care services, a regional healthcare manager and a clinical nurse manager provided management support to the person in charge. A team of nurses, care assistants, activities, catering, maintenance and domestic staff made up the staffing compliment. The clinical nurse manager deputised in the absence of the person in charge.

An announced inspection of the service in March 2024, identified the providers failure to recognise and respond appropriately to potential safeguarding incidents in the centre. Following that inspection, the provider submitted an urgent compliance plan to the office of the Chief Inspector, which described the actions that would be taken to achieve compliance with Regulation 8: Protection. The urgent compliance plan detailed that safeguarding training would be completed, to inform staff of immediate actions, escalation pathways, preliminary screening, and investigation processes. The provider also gave assurances that the person in charge would ensure that any suspicion, concern, or allegation of abuse would be thoroughly investigated, including the notification of any suspicions or allegations to the Chief Inspector, in accordance with the centres' policies and procedures to safeguard residents.

However, this inspection found that several potential safeguarding concerns were not recognised or recorded as serious incidents.Furthermore, they were not investigated to understand the factors which may have contributed to the incident occurring, or to identify future learning so that similar incidents could be prevented. In addition, several potential safeguarding concerns had not been notified to the Chief Inspector in the required time-frame. These findings are detailed further under Regulation 8: Protection, and Regulation 31: Notification of incidents.

Prior to the inspection of the centre in March 2024, four previous inspections of the service 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. Further to the repeated failure of the provider to address the premises issues, a restrictive condition was attached to the registration of the centre in March 2024, requiring that works to the premises, be completed by July 31st 2024. This inspection found that works had not been commenced by the provider.

A second restrictive condition was attached to the centre's registration by the Chief Inspector following the inspection of the centre in March 2024, requiring the provider to carry out fire safety works in the centre. The works to be completed were set out in the action plan of a fire safety risk assessment, commissioned by the provider and submitted to the office of the Chief Inspector. Records viewed on this inspection showed that actions were completed by the provider, to ensure there were sufficient measures in place to protect residents and others from risk of fire.

Inspectors were informed that completed works were awaiting a final review by a fire consultant at the time of inspection.

There were 57 residents living in the centre on the day of inspection. The inspectors observations were that staffing levels on the day of the inspection were sufficient to meet the assessed needs of residents. Records demonstrated that staff were facilitated to attend training in fire safety, manual handling procedures and safeguarding residents from abuse. However, inspectors found that staff were not always appropriately supervised to ensure appropriate action was taken in the event op a potential safeguarding incident. For example, there was incomplete and ineffective recording, reporting and escalating of some potential safeguarding concerns. This meant that incidents could not be investigated or analysed, and no quality improvement action could be implemented to ensure that risks would be reduced.

There was an audit schedule in place to support the management team to measure the quality of care provided to residents. Inspectors viewed a sample of audits relating to infection control, call bell response times, and assessment and care planning. A review of records found that some audits were not used effectively to identify deficits in the service and drive quality improvement. For example, resident meeting records demonstrated that concerns were raised by a resident regarding call bell response times at night. A series of call bell audits were undertaken in response to the concern raised, however records showed that audits did not include response times during the night time. This incomplete information gathering impacted on the providers ability to appropriately monitor a potential risk. Furthermore, in instances when call bell response times were found to be excessive during the day, there was no action plan recorded to address this documented risk. Inspectors also found that quality improvement plans relating to environmental audits were not always addressed in a timely manner. For example, infection control audits identified deficits in relation to the premises and replacement of floor covering was the quality improvement plan. However, this action was not progressed to completion.

There were systems in place to monitor and respond to clinical and environmental risks. The risk management systems were underpinned by a risk management policy. A review of the risk register found that it did not contain some of the known risks in the centre, such as the risks associated with a disrupted hot water supply, as found on the day of inspection. There was no estimated time-frame for the return on the supply on the morning of the inspection, and the risk associated with the loss of hot water had not been assessed. Therefore, the control measures in place to mitigate the risk of the disrupted hot water supply were unclear at the time of inspection. Furthermore, inspectors noted that some risk management controls were not implemented effectively. For example, there was an open risk assessment in relation to use of the passenger lift, which was not fully operational at the time of inspection. Control measures recorded recommended a limited use of the lift in accordance technician instructions, until a new part was received and the lift was repaired. However, this control measure was not implemented on the day of

inspection and there was no signage to alert staff, residents or visitors to the centre of a requirement to restrict their usage of the passenger lift.

A sample of staff files were examined and they contained all of the requirements as listed in Schedule 2 of the regulations. Vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were in place for all staff. Inspectors found that some resident care records were not accessible as they had been removed from the centre. For example, records of clinical observations and documentation supporting increased supervision in place, as outlined in some resident care plans was not available for inspectors to review. This is detailed further under Regulation 21: Records.

There was a complaints policy in place and this was updated in line with regulatory requirements. Records of complaints were maintained in the centre and the inspectors observed that these were acknowledged and investigated promptly, and documented whether or not the complainant was satisfied.

A directory of residents was maintained by the registered provider which included all of the requirements of Regulation 19.

An annual report on the quality of the service had been completed for 2023 which had been done in consultation with residents and set out the service's level of compliance as assessed by the management team.

Regulation 15: Staffing

On the day of inspection, there was sufficient staff on duty with appropriate skill mix to meet the needs of all residents, taking into account the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised. This was evidenced by:

- Residents care plans were not always implemented. For example, a resident who was assessed at risk of falling from their beds had a care plan directing staff to ensure that the bed was left in a low low position. This guidance was not seen in practice.
- Adverse incidents were not responded to in an appropriate manner. For example, incident forms were not completed following unexplained injuries sustained by two residents.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider maintained a directory of residence in the centre which contained all information, as specified under Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements. For example;

- Records of incidents and the investigation of the incidents in which residents may have suffered harm were not documented in line with the centre's own policy, as required by Schedule 3 (4)(j) of the regulations. There was no documented investigation into incidents of unexplained injury sustained by residents.
- Not all residents' records were held in an accessible manner. Contemporaneous care records, requested by inspectors, had been placed in storage outside of the centre and they were not available to review on the day of inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that the provider failed to ensure that the management systems in place ensured the safety of residents in the centre. This was evidenced by:

- The system in place to monitor incidents to ensure that residents were safeguarded from abuse were not effective. This meant that, where there was a potential safe-guarding incident, this was not recognised as such, and therefore not managed in line with the national guidelines for safeguarding or the requirements of the regulations. This is a repeated finding.
- The system in place to manage risk was not effectively utilised. Not all known environmental risks were documented, and some controls in place to manage risks were not implemented effectively.

- Management systems had failed to identify the regulatory requirement to notify the Office of the Chief Inspector of several potential safe-guarding incidents, as set out in Schedule 4.
- Record management systems were inadequate. For example, records of clinical observations and documentation supporting increased supervision in place, as outlined in care plans, was not available for review.

The provider was in breach of a condition of registration following failure to complete the compliance plan submitted following the previous inspection in March 2024, resulting in repeated non-compliance with Regulation 17.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge did not submit all required notifications to the Chief Inspector within the required time frames, as stipulated in Schedule 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaints records found that complaints and concerns were responded to promptly, and managed in line with the requirements of Regulation 34.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that the interactions between residents and staff were kind and respectful throughout the inspection. On the day of inspection, resident's reported that they were generally satisfied with the care received. Residents voiced satisfaction with the programme of activities and the choice and quality of food available, and the provider had taken action to address fire safety risks identified on the previous inspection. Nonetheless, inspectors found the quality and safety of resident care was impacted by deficits in the care environment, and the failure of the provider to effectively implement policies and procedures to safeguard residents.

Furthermore, assessment and care planning and infection control did not meet the requirements of the regulations

The provider had implemented some systems to safeguard residents from abuse. The procedure to safeguard residents was 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. Staff were facilitated to attend safeguarding training. However, the safeguarding processes that were in place were not robust. Records demonstrated that concerns in relation to the protection of residents were not always escalated to management, investigated thoroughly, and followed up appropriately. This is a repeated finding which is detailed further under Regulation 8: Protection.

Following the previous inspection in March 2024, a restrictive condition was attached to the centres registration which required the provider to address repeated non-compliance found with the overall state of repair of the premises. The findings of this inspection were that the provider had failed to progress the works required to bring the centre into regulatory compliance. Although the design and layout of the premises was generally suitable for its stated purpose and met the residents' individual and collective needs, there was significant damage to floor covering in resident bedrooms and circulating corridors, which posed a risk of falls to residents living in the centre. Inspectors found that some floor coverings were beyond repair and they could not be effectively cleaned. This did not support effective infection prevention and control management. Further findings are detailed under Regulation 17: Premises.

Infection control precautions in place were monitored by the person in charge. Inspectors found that although the majority of communal rooms were clean, the centre had not maintained a satisfactory level of environmental hygiene. For example, some clinical hand wash sinks were visibly unclean and inspectors noted that continence equipment was left on the floor of a communal shower and not decontaminated in a timely manner. Further findings are detailed under Regulation 27: Infection control precautions.

A review of a sample of resident care records found that assessment and care planning documentation was not in line with the requirements of the regulations. An assessment of care needs was not always completed when a change or deterioration in the overall health care status of the resident had occurred. For example, daily care progress notes recorded that a resident had sustained an injury of unknown origin. However, the last recorded assessment of the residents skin integrity had been the previous month and the care plan in place did not reflect the residents current care needs described to the inspectors. This is detailed further under Regulation 5: assessment and care-planning.

A review of residents' records found that there was regular communication with residents' general practitioners (GP) regarding their health care needs and residents had access to their GP, as requested or required. Arrangements were in place for

residents to access the expertise of allied health and social care professionals for further assessment.

There was an activity schedule in place and some residents were observed to be facilitated with social engagement during the day. Residents had access to television, radio, newspapers and books. Residents were provided with access to independent advocacy services. Residents were provided with opportunities to provide feedback on the quality of the service through scheduled resident meetings.

Visiting was taking place and residents were facilitated to meet with their families and friends in a safe manner.

Regulation 17: Premises

There were areas of the premises that were in a poor state of repair. For example:

- Floor surfaces along circulating corridors on the first floor were damaged and uneven.
- Floor coverings in multiple resident bedrooms were worn, damaged, discoloured and uneven. This is a repeated finding.
- The passenger lift was not fully operational.
- The hot water supply was disrupted due to a technical fault.

There was a lack of suitable storage in the designated centre. This was evidenced by:

- Storage of multiple shower chairs in a communal bathroom on the first floor.
- There was inadequate ventilation in a sluice room and a communal shower room, resulting in malodour.

Judgment: Not compliant

Regulation 27: Infection control

A number of issues were identified which had the potential to impact the effectiveness of infection prevention and control within the centre and posed a risk of cross infection. This was evidenced by:

- Shower drains in two communal shower rooms were clogged with dirt and debris.
- Storage of an unclean commode bucket in a communal shower room.
- Some items of resident equipment were visibly unclean, such as specialised seating.

- The carpet surface at the entrance to the resident communal garden was visibly dirty.
- Several clinical hand washing sinks were visibly unclean.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors found that comprehensive assessment of need were not always completed, consequently appropriate care plans were not developed. For example:

- A resident with known 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) had no assessment in place and no care plan to direct staff regarding behavioural triggers and de-escalation techniques.

A sample of care plans reviewed were not updated to reflect the current, assessed needs of the residents, for example:

- A resident with a communication deficit did not have an up-to-date plan of care in place to guide staff. This did not ensure that staff had sufficient information on how to support to the resident with their needs.
- Care plans were not always updated when there was a change in a residents condition. For example, following a fall where an injury had occurred , or where a residents' skin integrity deteriorated.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to medical assessments and treatment by their General Practitioners (GPs) and the person in charge confirmed that GPs were visiting the centre, as required.

Residents also had access to a range of allied health care professionals such as physiotherapist, dietitian, and speech and language therapy.

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. Inspectors observations, a review of resident records and discussion with staff, demonstrated that several potential safeguarding incidents had not been recognised, documented, appropriately reported and thoroughly investigated.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had failed to ensure that residents were supported to exercise their choice with regard to their direct care needs. For example, the lack of availability of hot water impacted on the residents choice of when to have a hot shower.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Lakes Nursing Home OSV-0000447

Inspection ID: MON-0043903

Date of inspection: 25/09/2024

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 and will ensure that all mandatory training is up to date.
• The PIC will ensure that nursing staff understand how to recognise, report, record, escalate and investigate incidents by undertaking training in Incident management. The PIC and CNM will monitor the application of theory to practice.
• The PIC and CNM will ensure that there is appropriate supervision of staff. They will conduct regular walkabouts of the centre to monitor staff in practice and to guide and direct staff to deliver care in accordance with the individual care plans.
• The PIC will ensure that staff have a thorough understanding of recording unexplained injuries and/or bruising on an incident form and that the incident is escalated in line with the centre's incident management policy and procedures.
• The PIC will ensure that all incidents are discussed at handovers/safety pauses and monthly meetings.
• The PIC and CNM will undertake clinical supervision meetings at monthly intervals with individual staff nurses to review their practice, identify training and development needs and to ensure that staff are supported in their roles.
• The PIC /CNM will complete a weekly audit of clinical documentation to ensure that each resident's required care needs are addressed, that the care plan guides the delivery of care, that the care delivered is reviewed and evaluated appropriately and is in accordance with the resident's expressed preferences. Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings. Any changes or developments in the resident's condition or plan of care will be updated and documented as they occur.
• The Healthcare Manager (HCM) will monitor compliance with the above actions during weekly visits and reviews.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

• The PIC will investigate all adverse incidents where residents may have suffered harm, including incidents of unexplained injury, and will document the actions taken, findings recommendations and quality improvement plans.
• The PIC will review all resident incidents and complaints to ensure that any notifiable incidents are submitted to the Authority within the required timeframe and appropriately screened and investigated.
• The Healthcare Manager will monitor compliance with the submission of required notifications to the Authority.
• The PIC will ensure that all records are stored within the centre and that they are readily available when required.

Regulation 23: Governance and management	Not Compliant

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

• We will ensure that all staff understand what is meant by safeguarding and how incidents or complaints may be considered to be synonymous with abuse. The Healthcare Manager, Quality & Safety will conduct additional Safeguarding Workshops with groups of staff to ensure maximum participation and interaction. The workshop will include an After-Action Review of recent safeguarding incidents and the learning outcomes from these.
• The PIC will ensure that all safeguarding incidents are recorded, reported, escalated and investigated in line with the centre's Safeguarding policy and procedures.
• The PIC, supported by the Healthcare Manager will be aware of their responsibility to recognise, record, conduct a preliminary screening, investigate and respond to any allegations including escalating any concerns appropriately and submitting notifications to the Authority.
• The HCM will work with the PIC to ensure that recommendations and quality improvements are implemented.
• The PIC will ensure that the management of risk is implemented in accordance with the centre's risk management policy and all environmental risks will be recorded within the centre's risk register. The risks will be reviewed as part of the weekly management meeting and will be discussed as part of the monthly team meetings.
• The PIC will ensure that risks rated as high will have mitigations initiated to reduce the associated risk and staff will be made aware of these at daily handovers and safety pause meetings. The PIC will ensure that all staff are aware of all the risks within the centre and the controls in place to reduce the level of risk.
• Significant risks will be escalated to the Executive Team so that a strategy to reduce

the risks can be developed and implemented.
• The PIC, supported and oversee by the Healthcare Manager, will ensure that records are managed effectively, stored safely and appropriately, and available as required.
• The HCM will oversee the implementation of the Compliance Plan and will ensure that target deadlines for completion of actions are met.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

• The HCM will support the PIC in restoring compliance and to ensure that the Authority is informed of all notifiable events within the appropriate timeframe in accordance with legislative requirements.
• The PIC has reviewed all recent complaints and incidents to confirm that they do not include any safeguarding issues that would require notification to the Authority.
• The PIC will conduct safeguarding drills with all staff to monitor their knowledge, awareness and application of the centre's Safeguarding policy.
• The PIC will schedule 1:1 counselling with all staff nurses on the recording, escalation and notification of incidents.
• The PIC will ensure clinical oversight of all incidents to ensure compliance with regulatory requirement.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

• The Facilities Manager has conducted a full review of the flooring in the centre.
• A scheduled programme of works has been agreed to address the required decorative upgrades which will improve the nursing home environment.
• Since the inspection the Passenger lift has been repaired and is fully operational.
• The disruption to the hot water supply was addressed and repaired on the day of the inspection. The PIC will ensure that the Maintenance Person will continue to monitor the supply of water to the home and escalate promptly any potential risks of interruption.
• Facilities will complete a review of the ventilation within the sluice rooms and shower room.
• The shower chairs will be relocated from the communal bathroom to a safe suitable location to reduce the risk of cross contamination.

Regulation 27: Infection control	Substantially Compliant

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

• The PIC will conduct daily walkabouts of the building with the CNM to monitor standards of cleaning and identify any deficits to the Housekeeping Supervisor so that appropriate action can be taken to address them.
• The cleaning of shower drains and clinical hand wash sinks will be included in the schedule of cleaning for housekeeping staff.
• The PIC will ensure that staff clean commodes after use and that they are stored clean and ready for use.
• The PIC and CNM will ensure that all seating equipment will be included on the cleaning schedule for housekeeping staff.
• The PIC will ensure that all household staff are trained in appropriate cleaning techniques and procedures by completing a Clean Pass programme. They will also be required to refer to the centre's Housekeeping Manual if they need to query cleaning procedures.
• The PIC will develop and implement a quality improvement plan to address any identified deficits.
• The PIC will ensure that all staff are aware of the quality improvements required.
• The carpet will be addressed as part of the scheduled programme of flooring works.
• IPC practices will be discussed daily at handovers and safety and as part of the monthly management meeting to ensure staff are knowledgeable in the application of theory to practice.
• The PIC with the IPC lead will monitor appropriate IPC practices, and ensure that equipment used is cleaned, tagged and stored appropriately within the home.
• The PIC will ensure that daily cleaning schedules are maintained, including the cleaning of all shower rooms and sinks in line with Infection Prevention & Control (IPC) recommendations and guidelines.
• The PIC and IPC lead nurse will ensure that the tagging system utilized for the cleaning of equipment will be monitored daily.

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:

• The PIC and CNM will provide clinical oversight to ensure that all residents' assessments and care plans have been completed and that they are individualised and person-centred. They will ensure that the assessment tools inform the plan of care and consider the residents' current medical, health and lifestyle status. The care plans will be updated at least every 4 months or as the resident's condition or status changes, and information that is no longer current will be archived.
• The PIC will arrange a programme of education for staff about the appropriate

management of responsive behaviours, including the documentation of responsive behaviour care plans and the use of Antecedent, Behaviour & Consequence (ABC) charts to guide staff in identifying triggers for escalation of behaviours and de-escalation strategies; these will help to ensure a consistent approach by all staff to residents who display Behavioural & Psychological Syptoms of Dementia (BPSD).
• The PIC will complete a weekly audit of clinical documentation to ensure that each resident's required care needs are addressed, that the care plan guides the delivery of care, that the care delivered is reviewed and evaluated appropriately and is in accordance with the resident's expressed preferences.
• Interventions required for the management of responsive behaviours will be recorded and updated accordingly.
• Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

The PIC will ensure that staff have a thorough understanding of how to apply theoretical learning to practice, especially in relation to Safeguarding.

In addition to the mandatory safeguarding training, including training in the National Standards for Adult Safeguarding, the HCM, Quality & Safety will conduct Safeguarding Workshops. Each session will include small groups of staff to ensure maximum participation and interaction, and there will be After-Action Reviews of recent safeguarding incidents with learning outcomes from these. The management team will also be required to attend the workshop and After-Action Reviews. The HCM, Quality & Safety will facilitate open discussion and provide clarity regarding their 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, investigation and documentation.

The HCM will continue to monitor and oversee practice in the centre to ensure that management and staff are aware of the importance of recognising, reporting, escalating, investigating and resolving all forms of abuse.

The PIC, supported by the Healthcare Manager will be aware of their responsibilities in recognising, reporting and responding to any allegations including escalating and notifying any concerns appropriately.

The HCM will work with the PIC to ensure that recommendations and quality improvements are implemented in accordance with this Compliance Plan and the centre's Safeguarding policy.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• The disruption to the water supply was addressed on the day of inspection.
• The Maintenance Person will monitor the water supply and ensure where disruptions are likely that mitigating actions are identified, and the PIC will ensure that all staff are aware and that residents are communicated with in a timely manner at all times.
• The PIC, with the support of the CNM, will ensure that all residents' choices and wishes are respected.

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2024
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	31/12/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/11/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	31/12/2024

	place to ensure that the service provided is safe, appropriate, 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	31/12/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	31/12/2024
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before	Substantially Compliant	Yellow	30/11/2024

	or on the person's admission to a designated centre.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/11/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/11/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	31/12/2024
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	30/11/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably	Substantially Compliant	Yellow	30/11/2024

	practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.			