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:	Gahan House
Name of provider:	Graignamanagh Elderly Association Company Limited by Guarantee
Address of centre:	Gahan House, High Street, Graiguenamanagh, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	21 September 2023
Centre ID:	OSV-0000545
Fieldwork ID:	MON-0040398

About the designated centre

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

Gahan House is located in the picturesque town of Graiguenamanagh in Kilkenny. The centre is a two-storey building that is registered to accommodate 12 people with all resident accommodation and communal space on the ground floor. The management of Gahan House is overseen by a board of six directors. The centre caters for men and women from the age of 60 years. The centre manager is employed to work on a full-time basis. Residents do not require 24 hour nursing care and care is provided by a team of trained healthcare professionals with one nurse employed for 16 hours per week. According to the centre's statement of purpose, all applicants for admission must be mobile and mentally competent at the time of admission. Each resident is provided with single bedroom accommodation. Residents whose needs change and evolve will be supported to find alternative, more suitable long term care accommodation.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

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
Thursday 21 September 2023	09:30hrs to 18:00hrs	Bairbre Moynihan	Lead
Thursday 21 September 2023	09:30hrs to 18:00hrs	Aisling Coffey	Support

What residents told us and what inspectors observed

Inspectors arrived to the centre in the morning to conduct an unannounced inspection to monitor ongoing regulatory compliance against the regulations and national standards. From the inspectors' observations and from speaking to residents, it was clear residents received good care from staff that were kind and caring. Residents informed inspectors that they felt safe in the centre and described the staff as "kind", the food as "excellent" and the environment as "relaxing".

On arrival, inspectors were greeted by the person in charge. Following an introductory meeting inspectors were guided on a walkaround of the centre. The centre is registered to accommodate 12 residents with one vacancy on the day of inspection. The inspectors chatted to the majority of residents to gain feedback on their lives in Gahan House. Gahan House is two-storey building with all residents' rooms on the ground floor. In addition, the centre had a large open plan sitting and dining room, a small sitting room where residents could meet their visitors in private and oratory, all on the ground floor. There was an additional seating area on the corridor where a number of residents were observed to be reading the newspaper, completing a quiz book, and enjoying the sunshine. The centre contained a decking area outside with doors leading out from the dining room and seating available for residents. Residents had access to a large garden which was well maintained. Colourful hanging baskets of flowers were at the entrance to the centre. All residents had single rooms containing a wash hand basin. The rooms observed by inspectors all contained a television and radio. The rooms had been personalised with photographs, pictures, soft furnishings and other belongings from residents' homes.

Resident activities were carried out by healthcare assistants. Chair-based exercises were taking place on the day of inspection. Residents were complimentary about the activities available and spoke of knitting and bingo taking place regularly. Some residents spoke of enjoying going for walks. Other residents had recently attended an organised outing to the local arboretum followed by a local hotel for a meal and spoke positively about this experience. A resident was observed going out to the local town for a few hours while inspectors were onsite. The centre had recently acquired a dog. Some residents spoke affectionately about "Bow", the centre's dog, describing him as "everyone's friend" and "therapeutic". The residents had recently commenced a weekly outing to the local library where they could maintain their links with the local community and a resident informed an inspector how much they enjoyed it. Photograph collages of the residents were displayed throughout the centre.

Inspectors found that residents were free to exercise choice about how they spent their day. Residents informed an inspector that they could get up and go to bed when they wanted and if they were out of the centre at mealtimes that their meal will be kept for them. Residents were consulted about their care needs and about the overall service being delivered. Resident meetings were held every three months

with the majority of residents attending. Records indicated that a range of issues were discussed such as advocacy, cough etiquette, hand hygiene and the food. The results of the satisfaction survey for 2022 were outlined in the annual review of the quality and safety of care. Of the ten residents surveyed five indicated that staff would not know their life story. The results did not indicate how this was addressed.

The dining experience was observed by the inspectors. This was observed to be a pleasant, social occasion with residents chatting to each other. Residents were offered a choice and inspectors were informed by residents and staff that if they did not like the choice they were provided with an alternative. The centre had no residents that required a modified diet. Residents had access to fluids and snacks throughout the day.

Open visiting was taking place and one resident was hosting a family member in their room on the day of inspection.

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

Capacity and capability

This was an unannounced inspection to assess the overall governance of Gahan House and to identify if actions outlined in the compliance plan from the inspection in August 2022 were completed and sustained. Overall, inspectors identified that a number of actions were implemented and sustained. For example; the registered provider had reviewed the contracts of care and these were now in line with the requirements of the regulation. In addition, a washable surface had been applied to the walls in a bathroom with a plan to roll it out in the remaining bathrooms in the centre. However, areas for improvement remained in Regulations 15: Staffing, 16: Training and staff development, 21: Records, 23: Governance and management and 34: Complaints.

The registered provider is Graignamanagh Elderly Association Company Limited by Guarantee and was managed by a voluntary board of trustees. The person in charge reported to a member of the board, worked full-time and was supported in the role by a staff nurse who worked six hours in a management role and 10 hours in a nursing role, healthcare assistants, housekeeping, maintenance and catering staff. Gaps in the staffing between the statement of purpose and the actual staffing levels were identified on inspection and discussed under Regulation 15: Staffing. Gahan House is a low support centre and the statement of purpose outlines that the registered provider can only accommodate residents who are low dependency. As a result the registered provider is not required to have a registered nurse on site 24 hours per day.

Staff had access to mandatory training. Improvements were identified in fire training with the majority of staff having completed it. Safeguarding training continued to have good compliance levels. It was evident from speaking to staff that they were knowledgeable on these two areas. Improvements were required in medication management training. This will be discussed along with additional areas for improvement under the regulation.

An inspector reviewed a sample of staff files. Of the files reviewed all staff had garda vetting completed prior to commencement of employment. In addition, staff that required registration with a professional regulator had up to date registration in place. However, not all the requirements of schedule 2 of the regulations were in place. Actions required are detailed under Regulation 21: Records.

The annual review of quality and safety of care was completed for 2022. The review outlined a plan to extend Gahan House to provide a larger living room for residents and a bigger kitchen, pending funding. At the time of inspection no discussion about the planned changes to the footprint of the centre had been discussed with the Office of the Chief Inspector. The review also outlined the number of falls in 2022 and the number of residents who fell. Incidents were reviewed by the staff nurse and person in charge following each incident. The majority of incidents reported were falls. While all incidents recorded in the incident log were notified to the Office of the Chief Inspector, three of the five incidents occurring since the last inspection were not notified within the required time line of three working days. This was discussed with the person in charge at that time. Three audits were completed since the last inspection. None of the audits identified any issues. Furthermore, no hygiene and or infection control audits were completed since the inspection in August 2022.

The registered provider had a complaints log in place. The inspector was informed and the complaints log confirmed that no complaints were received since the last inspection. Residents spoken to stated that they were aware they could raise a complaint with a member of staff or the person in charge. Updates were required to the policy to ensure it aligned to Regulation 34 which is discussed below.

Regulation 15: Staffing

The following gaps were identified between the statement of purpose and the actual whole time equivalent (WTE):

- The statement of purpose states there should be 8.5 WTE of healthcare assistants. On review of rosters and information submitted following inspection it was identified that there were was approximately 6.6 WTE and an additional post was created for housekeeping of 0.93. This role was previously carried out by healthcare assistants. This left a gap of 0.97 healthcare assistants.

- The assistant manager role was no longer in the centre. Of the 18 management hours that were in this post, six of these hours were replaced.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Gaps in training and staff development were identified. For example;

- Training for all staff who administered medications was out of date.
- 13 staff had not completed hand hygiene training in the last 3 years.
- All staff training in manual handling was out of date or not completed.

Judgment: Not compliant

Regulation 21: Records

The inspector reviewed a sample of four staff files. Gaps were identified which included:

- One staff file did not have an employment history and two references.
- Two other staff files had gaps in employment history.

Judgment: Substantially compliant

Regulation 23: Governance and management

The assurance systems in the centre required strengthening in order for the registered provider to be assured of the quality and safety of care. For example;

- The registered provider did not have an audit schedule in place. Three audits were completed since the last inspection. Two of these were a medication audit and nutrition and hydration. Neither of these audits identified any issues. Furthermore, no infection control/hygiene audit was completed since the last inspection.
- It was unclear what oversight the board of directors had in the centre. No meeting minutes were available for review on the day of inspection.
- In line with findings from the last inspection, trending of incidents was not taking place. While each fall was reviewed individually, the overall trending was not completed to identify trends and devise an action plan.

- The annual review of the quality and safety of care did not indicate how the results of the satisfaction survey were addressed. Furthermore, the results or time bound action plan of the satisfaction survey were not available for review on the day of inspection.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A sample of contracts of care were reviewed. The registered provider had reviewed the contracts of care since the last inspection and they met the requirement of the regulation.

Judgment: Compliant

Regulation 31: Notification of incidents

The incident log was reviewed on the day of inspection. Incidents requiring notification were notified to the office of the chief inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

Actions were required in order for the registered provider to come into compliance with Regulation 34:

- The complaints procedure was not on display on the day of inspection. Staff and a resident stated that it was normally on the window outside the day space area, but it could not be located.
- The complaints policy required updating to align with SI 628 of 2022 "Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 to 2022" which came into effect on 1 March 2023. For example; the time lines for responding to complaint outlined in the policy were not in line with the regulations.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

All policies required under schedule 5 in the regulations were available for review on the day and had been reviewed within the last three years.

Judgment: Compliant

Quality and safety

It was evident that this centre promoted a human rights-based approach to care, which was respectful and inclusive of the residents views, opinions and choices.The well-being of the residents' was at the centre of the service. Residents were consulted with and proactively engaged in the running of the centre. Some improvements in relation to premises, care planning and assessment, infection control practices and fire safety were required.

The centre had good oversight of the resident's individual health needs. Due to the low dependency of the residents, there was a very minimal level of wounds and there was no use of restrictive practices within the centre.

Gahan House is a two storey building with all residents' accommodation located on the ground floor. The centre has 12 single rooms, all containing a wash hand basins. Shared showering and toileting facilities were available for residents. The registered provider had identified a dedicated housekeeping store room since the last inspection. Inspectors were informed that they were unable to place a janitorial sink in the room due to the layout of the building. This was placed in the sluice room. This not ideal from an infection prevention and control point of view and required a risk assessment. The registered provider had reviewed the layout of the laundry room. Residents' clothes requiring laundering were stored in a closed containers. Staff were endeavouring to maintain a dirty to clean flow but were challenged by the infrastructure of the building. The centre was generally clean on the day of inspection with few exceptions. Some existing issues including the provision of clinically-compliant handwash sinks, were impacting on the ability of the registered provider to fully comply with Regulation 27: Infection control.

Systems were in place for monitoring fire safety. Signage to guide staff and residents on the evacuation routes was clear and on display in the centre and on the back of residents' bedroom doors. The fire system met the L1 standard which is in line with current guidance for existing designated centres.The fire alarm and fire extinguishers had preventative maintenance conducted at recommended intervals. Emergency lighting records were submitted following inspection. Further assurances were required to ensure the emergency lighting is functional. Daily checks of escape routes were carried out as required with few exceptions. Three fire drills had taken place since the last inspection. Fire drill records were not detailed enough to identify

the number of residents in a compartment and learning identified following the evacuations. Notwithstanding this both residents and staff were able to describe the evacuation routes. Further actions required are discussed under the regulation.

The registered provider had systems in place for the management of medicines. Staff spoken to were knowledgeable about the systems and processes in the centre. Medications were stored securely. The centre had no medications onsite requiring strict control measures (MDAs). Staff had access to advice from a pharmacist. The pharmacist attended onsite at four monthly intervals and was available to speak to residents if requested. Quarterly reviews of medications were taking place by the general practitioner and pharmacist. In addition, the nurse reviewed all medication administration records and drug kardex's weekly. Furthermore, the nurse reviewed residents' medication on admission and transfer following a stay in hospital.

Care plans reviewed were person-centred, however, they were not consistently completed at four monthly intervals so they could guide care. Validated risk assessment tools were completed at four monthly intervals and in many instances more frequently, for example; risks including falls and pressure-related skin damage.

Residents gave positive feedback regarding life and care in the centre. Inspector's identified that staff were knowledgeable about resident's likes and interests. Additional good practices are discussed under the regulation.

Regulation 17: Premises

Discrepancies were observed between the floor plans, statement of purpose and what was observed on inspection. For example; a sluice room was observed where an nurses' office was on the plans and a medication room was observed where an electric room was on the plans. While these changes were an improvement to the premises, no application to vary condition 1 of the registration was submitted to the Chief Inspector of Social Services.

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example;

- At the time of inspection, one bathroom was upgraded with a washable surface on the wall. However, a number of the remaining bathrooms the remaining bathrooms still contained a brick wall.
- Exposed piping was observed in a bathroom. This posed a falls risk and an injury risk to residents. Inspectors were informed that it was piping from a radiator that was in the bathroom.
- The glass in the window of the smoking room and the emergency exit door outside bedrooms 17 and 18 were cracked and required replacement.

Judgment: Substantially compliant

Regulation 26: Risk management

A risk management policy was in place, up-to-date and contained the requirements as outlined in regulation 26(1). Similarly there was a policy for responding to major incidents as outlined in regulation 26(2).

Judgment: Compliant

Regulation 27: Infection control

Inspectors observed that the centre was generally clean on the day of inspection, however, improvements were required in order to ensure procedures are consistent with the national standards for infection prevention control in community services. For example;

- A room registered as a staff room, contained staff lockers but in addition it was used as a store room. While the area was clean and tidy, it posed a risk of cross contamination.
- In line with findings from the inspection in August 2022, the centre had one hand hygiene sink. This sink was located in the sluice room and did not meet the required specifications. Inspectors were informed that staff used the hand wash sinks in resident bedrooms to wash their hands.
- A chlorine based solution was routinely used on the floors in the centre.
- Training in infection prevention and control and hand hygiene are discussed under Regulation 16: Staff training and development.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required in relation to fire safety management systems in the centre. For example:

- Emergency lighting records were submitted following inspection, however they did not provide assurance that the emergency lighting was free of fault or deviation.
- Three fire drills had taken place since the inspection in August 2022. Fire drills reviewed did not indicate the number of residents in the compartment being evacuated. Furthermore, the drills did not indicate if any areas for improvement were identified in the fire drill.

- A personal emergency evacuation plan was not updated on a resident whose dependency level had recently changed.
- A fire door in the oratory was not fully engaging when the fire doors closed. Deficits to fire doors mean that fire doors are not capable of restricting the spread of fire and smoke in the event of a fire.
- A resident's care plan indicated that the resident should wear a smoking apron, however, this was not available in the smoking room.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The registered provider had systems in place in relation to medication and pharmaceutical services in line with the regulation. Staff training on medications is discussed under Regulation 16: Training and staff development.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example;

- A newly admitted resident did not have the care plans completed within 48 hours of admission.
- Under regulation 5(4) care plans are required to be formally reviewed at intervals not exceeding four months. An inspector reviewed a sample of care plans. The evaluation notes which provided an update on the specific goals of the care plan were updated regularly containing detailed information, however, of the four care plans reviewed, three had not been updated within the last two to three years.
- Inspectors were informed that the assessed needs of a resident changed on the week of inspection. Management were aware of the requirement to only accommodate residents with a low dependency level. This is of concern where a registered general nurse is not on duty at all times.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to medical care. Three general practitioners (GPs) attended the centre and residents generally retained their own GP on admission to the centre. Residents had timely access to health and social care providers through the HSE upon referral. Residents were facilitated to access national screening services if eligible and there was evidence of referral in residents' files.

Residents' vital signs and weights were consistently completed monthly and residents were referred to the appropriate health and social care provider if required.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' right to privacy and dignity was well respected. Residents were afforded choice in the their daily routines and had access to WiFi, newspapers, radios, telephones and television. Independent advocacy services were available to residents and the contact details for these were on display. There was evidence that residents were consulted with and participated in the organisation of the centre and this was confirmed by residents meeting minutes.

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	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Gahan House OSV-0000545

Inspection ID: MON-0040398

Date of inspection: 21/09/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: . An application to Vary will be submitted to apply for staffing levels to meet the needs and number of residents in the home (Pro rata basis). . An application to vary for assistant manager hours will be submitted. (Pro rata basis). The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: . Medication and Hand Hygiene training will be completed by 15/12/2023. . On the training spreadsheet the time scale for retraining of manual handling was 2 years this was an error on our behalf as it should be 3 years. The certificates are still in date until 26/05/24. (copy of certificate will be forwarded on).	

Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: . All Staff records will be reviewed and brought up-date in compliance with regulation 21 by 30/11/2023	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: More audits to be completed throughout the year. Going forward meetings with the provider and Board of directors will be available for review. As part of Audit scheduling, trending of falls will be identified and an action plan completed. Annual surveys and action plan will be completed for 2023 on or before the 29/01/2024	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Complaint procedure now on display. Complaints policy is updated in line with March 2023 regulations.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Floor plans complete. Bathrooms will be completed by 31/12/2023 Exposed piping will be rectified. All damaged glass in window and door will be replaced.	

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Hand hygiene sinks will be installed in both corridors by 22/12/2023
The floor cleaner being used is a Bactericidal Hard Surface cleaner.
Hand hygiene and infection prevention and control training will be complete by staff 15/12/2023.
Storage of PPE will be in closed boxes and kept off the floor, and room will remain clean and tidy at all times.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Emergency lighting records have being brought up to date and certificate supplied to Gahan house from the electrician.
Fire drill evacuations to have more detail ie number of residents evacuated and which compartments were evacuated. Fire drills to include areas identified for improvement.
Fire doors all checked and now fully engaging.
Fire apron provided for smoking residents.

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:
New residents will be assessed within 48 hours of admission.
Care plans will be updated regularly as residents needs change and at 4 monthly intervals.
We will only provide care for low dependency residents and should their care needs become more dependent PIC or Nurse along with the residents family will help them to find suitable accommodation to meet their needs.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	22/12/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	15/12/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2023

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	30/11/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/01/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/12/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/09/2023
Regulation 28(1)(e)	The registered provider shall	Substantially Compliant	Yellow	22/12/2023

	ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.	Substantially Compliant	Yellow	30/09/2023
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	30/09/2023

Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).	Substantially Compliant	Yellow	30/09/2023
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.	Substantially Compliant	Yellow	30/09/2023
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	01/11/2023
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	Substantially Compliant	Yellow	22/12/2023

	it, after consultation with the resident concerned and where appropriate that resident's family.			