Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Larissa Lodge Nursing Home
Name of provider:	Mountain Lodge Nursing Home Limited
Address of centre:	Carnamuggagh, Letterkenny, Donegal
Type of inspection:	Unannounced
Date of inspection:	05 March 2024
Centre ID:	OSV-0005791
Fieldwork ID:	MON-0042624

About the designated centre

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

The provider plans to provide 24- hour nursing care to 64 residents over the age of 18 years, male and female who require long-term and short-term care (assessment, rehabilitation, convalescence and respite). The building is single storey. Communal facilities and residents' bedroom accommodation consists of a mixture of 48 single and 8 twin bedrooms all with full en-suite facilities. The building is laid out around central communal facilities that include a spacious lounge with multiple areas with views outside and a variety of seating options, an internal dining room with a large skylight, an oratory/prayer room and a visitors room near reception. A variety of outdoor courtyards are accessible from many parts of the building. The philosophy of care is to provide person centred, compassionate care and services with a commitment to excellence through adherence to high standards, disciplined leadership and respect for all.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	46

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 5 March 2024	09:00hrs to 17:00hrs	Nikhil Sureshkumar	Lead
Tuesday 5 March 2024	09:00hrs to 17:00hrs	Ann Wallace	Support

What residents told us and what inspectors observed

Overall, the inspectors observed that the residents were leading a good quality of life in this centre. The feedback from residents about the care and service they receive in this centre was generally positive.

Residents and their families reported they were happy with the service and that they were facilitated to raise issues if they had any concerns or complaints. They reported that there were sufficient staff available to provide care for residents and to respond to their requests for support in a timely manner. Visitors reported that staff were welcoming and treated their loved ones with respect, dignity, compassion and kindness.

The designated centre is a single-storey building located close to Letterkenny Town with access to local amenities such as shopping centres, leisure centres and local pharmacies. The centre can accommodate 64 residents in two units, and the residents are accommodated in a mix of single and twin en-suites.

Upon arrival, the inspectors met with the person in charge, and following a brief introductory meeting, the inspectors went for a walk around the centre. The centre had a relaxing and welcoming ambience. The reception area of the centre has sufficient seating for residents to sit and relax and to watch the comings and goings of staff and visitors. Inspectors observed that staff always acknowledged residents sitting in this area as they went by. A staff member was allocated in this area to attend to doorbells and visitors, answer telephone calls and to supervise residents.

The centre has spacious day rooms with seating broken up into smaller zones so that residents could choose where and with whom they sat. The centre also has a hair salon. This was busy on the day of the inspection, with residents waiting in the adjacent reception for their turn to get their hair done. The inspectors observed that the communal spaces available for residents were accessible, and staff were available to assist residents while they were in the communal areas.

There was a planned activity programme on display in the day room and a dedicated activity coordinator was assigned to support residents in their meaningful activities. The activities on offer on the day included interactive ball games, arts and crafts, and light exercise, which the residents enjoyed.

The inspector observed that call bells were attended to in a timely manner. Staff attending residents who preferred to stay in their own rooms were found to be engaging with them and provided meaningful activities such as arts and crafts.

In general, residents who required one-to-one care were provided with staff assistance and were supported to move around freely in the centre.

The centre appeared to be visibly clean, and hand hygiene facilities were available for residents and staff to wash their hands. However, the inspectors observed that the staff did not always follow appropriate hand-washing practices.

The residents were well-presented, and many commented that they chose what they wanted to wear each day and that this was facilitated by staff. Some residents also commented on the friendliness and kindness of the staff.

The corridors of the centre were bright and free of obstacles, and the residents were observed to be moving around freely.

The inspectors reviewed some of the residents' accommodated areas and found that resident bedrooms were personalised with personal items of significance, such as photographs and trinkets. Residents had access to their clothes, which were neatly organised and stored in their wardrobes.

The inspectors observed that the kitchen staff provided light refreshments to all residents in the early morning hours, and there was a choice of refreshments available to them. The staff sought menu choices from residents during this time of the day. In addition, picture menus were available to assist residents in viewing their choices. The centre's dining area had a relaxing atmosphere, and sufficient staff were available in the dining room to assist residents during their meal times. Meal times were not rushed, and residents were found interacting with each other, which was a social occasion for them.

Friends and families were facilitated to visit residents, and there was no restriction on visiting in this centre. Some visitors said there were improvements in this centre and particularly the staffing levels had recently improved.

Residents have access to television, radio and newspapers in this centre.

The next two sections of the report present the findings of this inspection in relation to the 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 inspection found that significant improvements had been made in the overall governance and management of the designated centre since the previous inspection in June 2023. The provider had effective arrangements in place to monitor care and services being provided to residents and to ensure that national standards and guidance were being implemented in line with the provider's own policies and procedures.

There was a clear commitment from the provider, person in charge and the clinical management team to promote continual quality improvement. Feedback from

residents was actively sought and used to improve services. The culture within the centre encouraged regular feedback from residents, relatives, staff and others and this feedback was being used to inform practice.

The governance systems had improved since the previous inspection in particular those relating to safeguarding and the management of responsive behaviours (How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). However, whilst there was a risk management policy and procedures in place, some gaps were evident in staff awareness and practices on this inspection.

There were sufficient staff on duty on the day of the inspection to meet the residents' needs. This was validated by residents who said that they did not have to wait for staff to attend to them if they called for help. Visitors reported that staffing levels had improved over recent months and that there were enough staff on duty when they visited. The inspectors observed that call bells were answered promptly and that staff worked well together to ensure that residents' needs were met in a timely manner.

A review of the rosters showed that staffing levels were maintained and short-notice absences were covered by staff where possible. Night staffing levels of two nurses and two carers for 46 residents would need to be kept under review. However, there was no evidence of negative impact on the current residents with these night time staffing levels. The inspectors were assured that the person in charge had the authority to increase staffing levels if required.

Staff working in the centre were clear about their roles and responsibilities and were supported in their work. The provider had comprehensive arrangements in place to develop and performance-manage staff to ensure they were clear about the standards that were expected of them in their work. Staff had good access to training and professional development opportunities.

There were systems in place, which comply with the General Data Protection Regulation (GDPR) to enable and ensure that information is confidentially maintained, is accurate, appropriate, and kept up to date and accessible to relevant staff. However, a review of the roster showed that not all staff who were working in the centre had their hours clearly set out in the document. Improvements were also required to ensure that all resident records were stored securely. These findings are set out under Regulation 21.

The provider had completed an annual review of the quality and safety of care delivered to residents in the centre in 2023. The review measured the service performance against the national standards and identified any areas for ongoing improvement. Resident feedback from resident meetings and questionnaires was used to inform the review. The level of engagement of independent advocacy services with residents and complaints received were also examined as part of the annual review.

Regulation 15: Staffing

There were sufficient numbers of staff with the appropriate knowledge and skills to care for the residents taking into account the size and layout of the designated centre.

The provider had processes in place to review staffing levels when required and the person in charge had authority to increase staffing in line with residents' needs. Where agency staff were used there was a service level agreement in place to ensure appropriate staff were deployed form the agency. Agency staff received induction training when they came to work in the centre.

Where residents were funded for additional one to one support and supervision additional care staff were sourced and recorded on the roster and allocation sheets. There were two agency staff providing additional support for two residents on the day of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Supervision of staff in the following areas did not identify when staff were not implementing the centre's own policies and procedures. For example:

- Nursing staff administering medications did not consistently follow safe medication administration procedures. These findings set out under Regulation 29.
- Infection prevention and control practices in relation to the safe disposal of used incontinence wear and dirty laundry required review to ensure that all soiled laundry was disposed in line with the provider's laundry and infection prevention and control procedures. These findings set out under Regulation 27.
- Gaps were evident in staff awareness and practices regarding the identification and management of risk in this centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider's oversight of their management systems required additional improvements. For example:

- The provider's systems for the safe administration of medicines were insufficient. For example:
  - A sharps box was left unsecured and unattended on the medication trolley during the medication round, giving residents access to items in the box that could have caused harm.
  - Medications were left out on the medication trolley whilst the trolley was unattended giving residents passing by access to these medications.
  - Staff practices in the centre did not assure the inspectors that the medicinal products were always administered to residents in accordance with the prescriber's instructions. The inspectors found that one resident had been given their medications in a crushed format, which was not the format prescribed by the resident's general practitioner (GP). Furthermore, this medication should not be given in a crushed format, which further increased the risk to the resident. The inspector also observed that the nursing staff did not offer the residents a drink of water with their medication, and they could not swallow the crushed medication, causing the inspector to seek staff assistance for this resident.
- The provider's risk management systems to prevent the risk of fire in this centre were insufficient. For example:
  - A hairdryer was left on a resident's bed after it had been used. The hairdryer was still hot from use. Furthermore, the hairdryer had not been PAT tested since 2022.
  - A fire-stopping cover had been removed from a ventilation shaft in the kitchen while repairs were carried out. This had not been replaced, which meant that if a fire occurred in the kitchen, smoke and flames could travel along this opening into the dining room. This is further detailed under Regulation 28: Fire Precautions.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents that met the criteria as set out in Schedule 4 were notified to the Chief Inspector within three working days.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear and accessible complaints procedure available for residents and their nominated persons. This procedure was displayed in the foyer of the centre and was included in the resident's guide and the statement of purpose. Residents and families who spoke with the inspectors said that they knew how to make a complaint.

The complaints officer and the review officer were identified and their contact details provided. The complaints officer and the review officer had attended additional complaints training. The complaints policy was included as part of the provider's induction training.

The complaints policy provided information about the review process and the independent advocacy services available to support persons wanting to make a complaint or who felt the response from the provider to their complaint was not satisfactory.

There had been eight complaints since the last inspection. A review of complaints showed that complaints were recorded and were managed in line with the time frames set out in the complaints policy. Complaint investigations were recorded. Complainants were provided with a written response informing them whether or not the issues raised in their complaint were upheld, the reasons for that decision and any learning from the complaint investigation.

Complaints formed part of the agenda for governance meetings in the centre and were monitored and reviewed by the provider's senior management team and through the audit schedule. Records showed that where improvements were required, this was communicated to the relevant staff and improvement actions were implemented including additional training if required.

Judgment: Compliant

Regulation 21: Records

The staff rosters did not include two students who were working in the designated centre and did not clearly identify what hours were worked by agency staff. There was a small nurses' station located in both units of this centre, which contained care plans for some residents in a folder. This folder was accessible to staff and used as a quick reference guide to provide care for residents. However, these folders were placed on the table tops of the nurses' station, making them accessible to residents and visitors passing by the nurses' station. This issue was brought to the attention of the person in charge, and they informed that this issue would be addressed immediately.

Judgment: Substantially compliant

Quality and safety

The inspector observed that residents living in this centre received a good standard of care and support in line with their assessed needs. The provider had implemented a comprehensive compliance improvement plan following the previous inspection in 2023, and it was evident that residents were benefiting from these changes and that their quality of life had improved. However, improvement actions were still required regarding infection prevention and control and care planning.

The inspector reviewed a sample of care files and observed that the residents had a comprehensive assessment of their needs completed before admission to the centre to ensure the service met their health and social care needs. A range of validated clinical assessment tools, such as malnutrition universal screening tool (MUST), level of dependency assessment tool and pressure ulcer risk assessment tools were used to determine the needs of residents. This information contributed to the comprehensive assessments, which were further used to develop an individualised care plan for each resident to meet their needs.

The care plans were generally person centred and the residents who were involved in safeguarding incidents had a safeguarding care plan to ensure their safety. However, additional information was required in some residents' care plans, especially regarding the frequency of close monitoring required for these residents with poor safety awareness to ensure their assessed needs for supervision were met.

The provider had measures in place to support appropriate infection prevention and control procedures. An infection control link nurse had been identified in this centre, and the person in charge had access to a community infection control specialist to seek specialist advice. However, the oversight of staff practices did not ensure that staff carried out appropriate hand hygiene at all times. This is further discussed under Regulation 27.

The inspector reviewed the fire safety register and found it was adequately organised and comprehensive, including regular daily, weekly, and monthly fire safety checks. The provider had recently arranged PAT (portable appliance testing) testing for electrical appliances to ensure they were safe. However, the inspectors observed that the provider's fire precautions required further review to ensure residents were protected in the event of a fire emergency.

The provider had appropriate systems in place for the handling and disposal of unused and out-of-date medicines, including controlled drugs. The provider also had arrangements for pharmacists to meet their obligations to residents. However, the inspectors observed on one occasion that medicines were not administered in line with the prescriber's directions.

Regulation 10: Communication difficulties

The inspectors observed that the residents' communication needs were regularly assessed, and a care plan was developed for residents who needed support in meeting their communication needs.

Judgment: Compliant

Regulation 11: Visits

The provider had ensured that visiting arrangements were in place and were not restricted. Alternative areas to residents' bedrooms were available and used to facilitate residents to meet with their visitors.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents had access to adequate quantities of food and drink, including a safe supply of drinking water. The daily menu offered a wide range of meal choices, which were updated regularly and displayed prominently for the residents' convenience. The mealtimes were efficiently managed by an adequate number of staff members who were readily available to provide assistance to the residents.

Judgment: Compliant

Regulation 27: Infection control

The infection prevention and control practice in the centre required some additional improvement to fully comply with Regulation 27. For example:

- The inspectors observed that some staff members did not perform hand hygiene following care delivery and entered the residents' dining area, which posed a cross-contamination risk.
- The inspectors observed that some staff did not dispose of used continence wear at the point of care, and this was placed in a waste in a corridor next to a hand hygiene facility, which posed a cross-contamination risk.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspectors observed that additional information was required to be included in some residents' care plans to guide staff in providing care in line with their assessed needs. For example:

- Two residents' safeguarding care plans required additional information regarding the frequency of supervision they required while in the communal areas to ensure their safety. One of these residents were not on regular checks to ensure their safety while they were in communal areas.
- Another resident's care plan did not contain the most up-to-date information regarding the recommendations made by the specialist mental health team.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had regular access to medical assessments and treatment by their General Practitioners (GP), and the person in charge confirmed that GPs were visiting the centre as required. In addition, arrangements were made to review residents by a medical practitioner upon admission of a resident to this centre. Residents also had access to a range of allied health care professionals, such as physiotherapists, occupational therapists, dietitians, speech and language therapists, tissue viability nurses, psychiatry of old age and palliative care.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

A restraint-free environment was promoted in the centre, in line with local and national policy. The inspectors observed that before any use of restrictive practices, each resident underwent a risk assessment. The provider also had implemented systems to regularly review the use of restrictive practises and there was a low use of restraints in this centre.

Judgment: Compliant

Regulation 8: Protection

Staff were knowledgeable regarding safeguarding residents and were aware of their responsibility to report any allegations, disclosures or suspicions of abuse. Staff were familiar with the reporting structures in place.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors found that residents' rights were upheld in the designated centre, and that their privacy and dignity was respected. Residents expressed that they received good care and support from the staff and had a choice about how they spent their day.

Judgment: Compliant

Regulation 28: Fire precautions

The provider's arrangements for reviewing fire precautions in the centre did not ensure that all reasonable measures were in place to protect residents from the risk of fire. For example:

- The inspectors observed that the provider had been using a deep fat fryer in the centre's kitchen. The inspectors were informed that they had started using this deep fat fryer only recently and that their competent person had approved its use. However, the inspectors were not assured that the provider had an appropriate system, such as a fire suppression system to mitigate the fire safety risks arising from this new appliance.
- Wedge-opening devices were used to keep the door between the kitchen and dining room open, which would prevent the kitchen door from closing automatically in the event of a fire emergency.

The arrangements for the containment of smoke and fire in the centre required improvement by the provider. For example:

- There was insufficient fire stopping around the service penetrations, such as electrical cables, which penetrated through the walls and ceiling of the centre's kitchen. This issue was brought to the provider's attention, and the provider addressed the issue following the inspection and submitted photographic evidence of this completed work.

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 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 21: Records	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant
Regulation 28: Fire precautions	Substantially compliant

Compliance Plan for Larissa Lodge Nursing Home OSV-0005791

Inspection ID: MON-0042624

Date of inspection: 05/03/2024

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: 1. One staff member was non-compliant with centre's medication management policy on the day of inspection. This staff member has completed additional training on medication management. Following a review of practices which included medication round observational audits and audit of crushed medications Medication, we are satisfied that overall practice is safe, and in line with national and centre's own policies. To ensure ongoing compliance, the audit will continue on a regular basis. 2. Disposal of waste has been reviewed, and healthcare waste bins are removed from near handwash sinks and placed in a more appropriate area where there is less risk of cross contamination. An update has been sent to staff to advise of changes. Practice will be monitored through Health and Safety walkthrough. 3. Health and safety/risk identification will be included as a part of staff meetings and HOD meetings. Risk identification management is part of health safety walkthrough, any identified issues will be addressed with staff immediately.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. All staff have attended workshop on safe disposal of sharps and proper use of sharp boxes. This is also audited as a part of medication round observational audit and health and safety walkaround. 2. One staff member was non-compliant with centre's medication management policy on	

the day of inspection. This staff member has completed additional training on medication management. Following a review of practices which included medication round observational audits and audit of crushed medications Medication, we are satisfied that overall practice is safe, and in line with national and centre's own policies. To ensure ongoing compliance, the audit will continue on a regular basis. On consultation with pharmacy, and GP they had confirmed these medications administered on the day of inspection were safe to be crushed. There is a crushed order in place for this resident and any other residents who requires medication to be crushed.
3. PAT testing of all electrical equipment is completed annually, and these were completed on 22/11/2023 for 2023 and commenced on 05/03/2024 for 2024.There had been a review of all equipment that required PAT testing, the hair dryer was the only item that was not PAT tested in 2023. All PAT testing for 2024 will be completed by 30/05/2024. Staff have been advised to store hairdryer safely after use.
4. Immediate action was taken to replace the duct cover in the ventilation system in the kitchen.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. A separate roster is maintained for students on work experience. This is because the centre uses an electronic rostering system which is only accessible for employees. The separate roster for the students continues to be in place and will be available on request.
2. The nurses' stations on both corridors are now fitted with secure cabinets for the safekeeping of sensitive documents.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. The importance of hand hygiene has been reiterated on staff meetings and HOD meetings in the centre, and regular observational audits on hand hygiene continues to be in place.
2. Disposal of waste has been reviewed, and healthcare waste bins are removed from near handwash sinks and placed in a more appropriate area where there is less risk of cross contamination. An update has been sent to staff to advise of changes. Practice will be monitored through Health and Safety walkthrough.

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:
1. The two care plans identified during the inspection were reviewed and updated to reflect the frequency of checks/supervision.
2. The resident was seen by the mental health team the day prior to the inspection. This information is now updated in the care plan. Following any visit from MDT members the recommendations are reviewed and discussed with other team members, for example GP, POLL, pharmacist etc. and the care plans are updated once the recommendations have been approved/agreed as appropriate.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. A wet chemical fire extinguisher is suitable for suppressing a deep fat fryer fire. This type of extinguisher was in place on the day of inspection. In addition to this, an automated Fire Suppression system will be installed.
2. The wedge device has been removed, and staff have been advised not to wedge the door open.
3. The hatch between the kitchen and dining area is connected to the fire alarm system and this closes automatically when the alarm goes off.
4. Immediate action was taken to replace the duct cover in the ventilation system in the kitchen.

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	12/05/2024
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	30/04/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/05/2024
Regulation 27	The registered provider shall ensure that procedures,	Substantially Compliant	Yellow	12/05/2024

	consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/09/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/09/2024
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	05/03/2024