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:	Dean Maxwell Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	The Valley, Roscrea, Tipperary
Type of inspection:	Unannounced
Date of inspection:	17 April 2024
Centre ID:	OSV-0000665
Fieldwork ID:	MON-0039671

About the designated centre

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

Dean Maxwell Community Nursing Unit is a designated centre operated by the Health Service Executive (HSE). It is located centrally in the town of Roscrea in north Tipperary. The centre is single storey and is designed around two enclosed garden areas. The centre can accommodate up to 27 residents. The service provides 24-hour nursing care to both male and female residents. Long-term care, respite and palliative care is provided, mainly to older adults. Bedroom accommodation is provided in 15 single bedrooms and six twin bedrooms. Two of the single bedrooms with ensuite shower facilities are dedicated to palliative care. Some of the twin bedrooms have ensuite facilities, there are two assisted showers, specialised bath and eight toilets for residents occupying single bedrooms. There is a variety of communal day spaces provided including day rooms, dining room, conservatory and oratory. Day care facilities are provided Monday to Friday for up to 15 people from the local area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

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 17 April 2024	10:00hrs to 18:45hrs	John Greaney	Lead

What residents told us and what inspectors observed

The overall feedback from residents was that Dean Maxwell Community Nursing Unit is a nice place to live and they were happy with the care provided by staff. It was evident that residents were offered choice in many aspects of their care, such as what activities they wished to pursue, what meals they would like to eat and their individual choices around what items of clothing they wished to wear.

Dean Maxwell Community Nursing Unit is operated by the Health Service Executive. It is in town of Roscrea in close proximity to shops and restaurants and is on the same grounds as the catholic church. Bedroom accommodation comprises fifteen single and six twin bedrooms. Two of the single rooms are in an area called The Laurels and are designated for palliative care. These rooms are en suite with shower, toilet and wash hand basin. There is also a small sitting room in this area with comfortable reclining armchairs, should relatives wish to remain overnight with residents that are end of life.

The provider acknowledges that thirteen of the single rooms have limited space and has specified in the Statement of Purpose that these rooms are unsuitable for residents that require specific manual handling equipment, such as a hoist. When the dependency level of residents occupying these bedrooms increases, they will be required to move to a shared room, which have more space. Even though these rooms are small, significant renovations and redecorating has taken place since the last inspection to make them a more homely environment for residents. All of the single rooms had new wash hand basins installed together with new vanity units for residents to store their personal hygiene items. The doors to the wardrobes had also been replaced with doors that matched the vanity units. Each resident had a bedside locker and a comfortable chair at their bedside.

The twin rooms were observed to be adequate in size for two residents with adequate space to store personal belongings and possessions. These rooms, however, would also benefit from redecoration. The doors to many of the inbuilt wardrobes would not close fully. Additionally, the paintwork was scuffed, particularly on the door surrounds. The doorways to these bedrooms are narrow and would not facilitate the evacuation of residents in their beds in the event of an emergency. It was identified to the inspector and confirmed by a review of residents personal emergency evacuation plans (PEEPs) that the proposed mode of evacuation for two residents occupying twin bedrooms would involve the use of a hoist to transfer the residents to a chair. This is discussed in more detail under Quality and Safety and under Regulation 28 of this report.

Communal areas available to residents comprise a sitting room with an adjacent conservatory area, a second sitting room called the snug, a dining room and a small oratory. Residents also had unrestricted access to two enclosed courtyards. Work had been done since the last inspection to enhance these areas and make them inviting areas for residents to spend time. Plans were in place to further enhance

these areas through the addition of potted shrubbery.

Sanitary facilities are a mixture of en suites, shared bathrooms and communal bathrooms. Two of the twin bedrooms have en suite bathrooms containing a shower, toilet and wash hand basin. A further two twin rooms have en suite toilets but also share a bathroom with one other twin room containing a shower toilet and wash hand basin. The two palliative care rooms have full en suite facilities. The remaining thirteen single rooms have a wash hand basin only in the rooms but have access to communal bathrooms and toilets within close proximity to their bedrooms. The inspector noted on the walk around that the pull cord on the emergency call bell in one of the toilets was broken. This was repaired before the end of the inspection. The bedpan washer was also noted to be out of order.

Areas of the premises occupied by residents, such as bedrooms, communal day rooms and dining areas, were generally clean. However, the inspector did note that a commode in a shared bathroom was not clean. The inspector observed that hand-sanitising stations were located throughout the centre. There were a number of clinical hand wash basins and their locations were under review to ensure they were located in areas to support staff to perform hand hygiene as close as possible to the point of care.

The inspector observed that most fire doors had been fitted with automatic door closures devices. This allowed residents to keep their door open safely without impacting on fire containment measures. The inspector did note, however, that the doors to some administration offices were held open with door wedges and chairs. This would impact on their ability to function appropriately in the event of a fire. Colour coded fire evacuation maps on display on corridors identified fire zones but management were unable to confirm that these zones correlated with fire safety compartments. Clarity was required of fire compartment boundaries to ensure that residents would be evacuated to places of relative safety in the event of a fire.

Residents' personal clothing was laundered on-site. Residents expressed their satisfaction with the service provided, and described how staff returned their laundry to their bedroom promptly.

The dining experience was observed to be a pleasant and social occasion for residents. Residents were complimentary about the food served in the centre, and confirmed that they were always afforded choice. A number of residents told the inspector that they were very happy with the quality and quantity of food provided. Staff were observed to engage with residents during meal times and provide discreet assistance and support to residents, if necessary. The food served was observed to be of a high quality and was attractively presented. Residents had access to snacks and drinks, outside of regular mealtimes.

All residents in the centre were seen to be well dressed and it was apparent that staff supported residents to maintain their individual style and appearance. Residents told inspectors that staff helped them to choose their clothing daily

There were activities provided to residents throughout the day. Residents told the inspector that they could choose what activities they would like on a daily basis.

Most residents chose to spend time in the dayroom chatting with staff and other residents.

Overall, residents spoken with by the inspector stated they felt happy and safe living in the centre. Residents spoke positively about the staff that cared for them. On the day of inspection, staff were observed being respectful, caring and attentive to residents' needs. There was a relaxed atmosphere and residents were observed freely mobilising around the centre and chatting with other residents and staff. The inspector observed that some residents spent their time in the sitting rooms during the day while others preferred to spend time in their bedrooms. The centre had access to a minibus, however, this was being serviced and not available for outings. In fact the bus had not been available for sometime due to the unavailability of a driver. Plans were in place to address this as some staff had the appropriate licence to drive the bus. There was mass held in the centre each week.

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 on the the quality and safety of the service being delivered.

Capacity and capability

This inspection found that generally there was a good level of compliance, however, action was required in relation to the oversight of quality and safety and more specifically fire safety, within the centre.

This was an unannounced inspection conducted over the course of one day to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 as amended. The Health Services Executive (HSE) is the registered provider of Dean Maxwell Community nursing unit. On the day of inspection, there were 23 residents living in the centre. There were sufficient numbers of suitably qualified nursing, healthcare and household staff available to support residents' assessed needs. Management support was provided by the general General Manager for Older Persons Residential Services. Within the centre, the person in charge was supported by a clinical nurse manager and a team of nurses, multi-task attendants and support staff. This management structure was found to be suitable for the current number of residents. Communal areas were supervised at all times and staff were observed to be interacting in a positive and meaningful way with residents.

The provider had placed a high value on the training and support provided to staff. Records reviewed by the inspector confirmed that training was predominantly up to date. Five staff were overdue attendance at fire safety training and these staff were scheduled to attend this training in the week after this inspection. Training was provided on site. All staff had completed role-specific training in safeguarding residents from abuse, manual handling, and the management of responsive

behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). Staff were appropriately supervised and supported to perform their respective roles within the centre.

Overall, there was evidence of good systems of communication that included regional monthly governance and management meetings attended by senior management and directors of nursing from community nursing units in the region. There were also regular staff meetings. While there were systems in place to monitor the quality and safety of care, action was required to ensure that the system was fully implemented. There was a comprehensive programme of audits scheduled for the year. The person in charge had introduced "bite sized education sessions" as a means of imparting the results of audits to staff and to support the implementation of required improvements. The oversight of quality and safety required improvement as not not all audits were completed as scheduled. This is discussed further under Regulation 23 of this report.

There was a policy and procedure in place to guide on the management of complaints. Even though the policy had been recently updated, it did not fully comply with the requirements of the regulations. The inspector was informed that the policy was recently reviewed and would be available shortly once it had been signed off. The record of complaints viewed by the inspector identified that there was a gap of approximately one year between October 2022 and November 2023, during which no complaints had been recorded. Of the complaints recorded, all had been adequately investigated. Required improvements in the management of complaints is discussed under Regulation 34 of this report.

There were adequate numbers and skill mix of staff available to meet the needs of residents. Staff were competent and knowledgeable about the needs of residents on an individual basis. Staff were observed to be respectful to residents and were responsive to their needs and requests.

Regulation 14: Persons in charge

There was a person in charge of the designated centre. The person in charge is a registered nurse and has the required experience and qualifications to be person in charge.

Judgment: Compliant

Regulation 15: Staffing

Staffing was in line with the centre’s statement of purpose and was sufficient to meet the needs of residents. Staff members were knowledgeable of individual

residents needs and all interactions with residents were noted to be respectful.

Judgment: Compliant

Regulation 16: Training and staff development

There was an ongoing schedule of training in the centre, and management had good oversight of mandatory training needs. Staff were appropriately supervised and supported to perform their respective roles.

Judgment: Compliant

Regulation 23: Governance and management

Action was required in relation to the oversight of quality and safety. For example:

- while there was a programme of audits set out for the year, a number of the audits identified for completion in the first quarter of 2024 had not been completed
- their were inadequate arrangements for the oversight of fire safety resulting in the need to issue an urgent compliance plan on the day of the inspection

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints policy in place which was updated in October 2023, however, it did not fully comply with changes to Regulation 34 Complaints in accordance with SI 628 which came into effect in March 2023. The procedure did not provide adequate detail around the review process, should the complainant be dissatisfied with the outcome of the investigation.

Judgment: Substantially compliant

Quality and safety

Overall, resident's health and social care needs were supported by a satisfactory

standard of evidenced-based care and support from a team of staff that knew each resident well. Residents expressed satisfaction with their access to health care and reported feeling safe and content living in the centre. Improvements were noted in the premises since the last inspection. Significant action, however, was required to ensure that residents were adequately protected against the risk of fire. Improvements were also required in relation to infection control, assessment and care planning and the premises.

A review of fire precautions in the centre found that records with regard to the maintenance and testing of the fire alarm system, emergency lighting and fire-fighting equipment were available for review and these were being serviced at the appropriate intervals. Arrangements were in place to ensure means of escape were unobstructed. Notwithstanding this, significant action was required to ensure that residents were adequately protected against the risk of fire. Prior to the inspection, the provider had identified that arrangements in place to evacuate all residents in an emergency situation, particularly at night time, were not satisfactory and had rostered an additional staff member at night time in an effort to mitigate the risk. The risk primarily related to the use of hoists as an evacuation aid. A review of records, particularly fire drill records and personal emergency evacuation plans (PEEPs), identified that adequate assurances were not available to confirm that the risk had been mitigated. Fire drill records did not provide adequate detail such as number of residents evacuated or mode of evacuation and the time recorded was beyond what was an acceptable time frame within which to evacuate a compartment. Additionally, it was not evident that there was full compartment evacuations simulated to include residents that had hoists listed as part of their evacuation plans. Fire evacuation maps on display identified fire zones rather than fire safety compartments and management could not confirm with certainty the extent of fire compartment boundaries to support the evacuation of residents to a place of relative safety in the event of a fire. As a result of the findings of this inspection, the provider was issued with an immediate action plan to mitigate the risks identified. The provider responded by enhancing night time staffing further by rostering two additional staff members, to commence on the night of the inspection. The immediate action plan was followed up with an Urgent Compliance Plan on the day following the inspection. A satisfactory response was received from the provider. These are further discussed under Regulation 28, Fire precautions.

Action had been taken with regard to the maintenance of the premises since the last inspection. Single bedrooms had been renovated and even though they are small, they were homely in appearance. Improvements had also been made to the outdoor space and further improvements were planned. However, some action was required to ensure the premises complied with the requirements of the regulations and these are outlined under Regulation 17 of this report.

Housekeeping staff demonstrated an appropriate knowledge of the cleaning procedure and the system in place to minimise the risk of cross contamination. The centre was generally visibly clean on inspection. Some areas for improvement were required in relation to the cleaning and decontamination of equipment after use, clinical waste bins and floor covering. This is outlined further under Regulation 27 of

this report.

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. Residents were assessed on admission and at regular intervals thereafter using evidence-based assessment tools. Care plans were developed based on these assessments and these were seen to be personalised. The pre-admission assessment process, however, required review to ensure that the assessment process included the correlation of the physical needs of the residents with the design and layout of the centre. There was also a need to ensure that care plans were written in a manner that readily facilitated the identification of each residents needs, should there be a need for residents to be cared for by staff that do not know them well. This is outlined further under Regulation 5 of this report.

Residents told inspectors that they felt at home in the centre and that their privacy and dignity was protected. The inspector observed several positive interactions between staff and residents throughout the inspection. Interactions were polite, supportive and respectful. Staff were observed providing meaningful activities throughout the inspection. There was evidence that residents were consulted regarding the quality of the service, the menu, and activities. WiFi had been made available in the centre since the last inspection to facilitate residents to access the internet, should they so wish. The person in charge had also arranged for GAA games to be viewed through a streaming service in addition to those games that were available on terrestrial television channels.

Regulation 17: Premises

Some areas of the premises required attention, such as:

- paintwork was damaged, particularly on door surrounds and the walls of some bedrooms
- there was a door to a cupboard in the housekeeping room that had broken from its hinges and was resting on the floor beside the cupboard
- the doors on wardrobes in twin bedrooms did not close properly

Judgment: Substantially compliant

Regulation 27: Infection control

Actions require to support compliance with infection prevention and control standards included:

- the flooring was damaged in the visitors' toilet making it difficult to clean effectively
- a commode chair in a shared bathroom was visibly soiled
- the bedpan washer was out of order, which posed a health and safety risk that equipment would not be appropriately decontaminated after use
- the clinical waste bin in the sluice room was damaged and the lid could not be closed posing a risk of cross contamination
- there was a clinical waste bin stored inappropriately in the treatment room
- there were commode chairs stored in the sluice room. Some were tagged to identify that they had been cleaned after use but some were not tagged and therefore it could not be confirmed that they had been cleaned after use
- there was a hoist stored in a communal bathroom. This poses a risk of cross contamination

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required to ensure adequate containment of fire, for example:

- management were unable to confirm the extent and boundaries of fire safety compartments to support the evacuation of residents to a place of relative safety in the event of a fire
- while most cross corridor fire doors provided adequate heat and smoke seals, a small number of doors had gaps that would not adequately contain the spread of smoke
- some office doors were held open with items such as door wedges and furniture, which would make them ineffective in containing fire and smoke in the event of a fire

Action was required to ensure that all residents could be evacuated in the event of a fire. For example:

- the personal emergency evacuation plans (PEEPs) for some residents identified that a hoist would be used to support their evacuation. While a practice evacuation of one of these residents was carried out approximately 15 months prior to this inspection, it did not form part of an evacuation drill and therefore did not provide assurances that all residents in the compartment could be evacuated in a timely manner

Action was required in relation to fire drills. For example:

- while there were regular fire safety drills, the time recorded to simulate the evacuation of a compartment was excessive
- fire drills did not incorporate the simulated evacuation of those residents requiring the most assistance in the event of a fire

- there was inadequate detail in the drill records to provide assurances that staff could safely evacuate residents in the even of a fire. The drill record did not identify details such as such as number of residents evacuated and mode of evacuation for each resident

The evacuation map on display required review. The map identified fire zones and staff were unaware that fire zones did not correlate with fire safety compartments. This posed the risk that, in the event of horizontal evacuation, residents would not be evacuated to a place of relative safety

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While pre-admission assessments were conducted and care plans developed, action was required to ensure that the needs of each resident were captured to determine the suitability of the planned placement of residents and to to support the provision of care. For example:

- the design and layout of the premises can pose challenges due to the single bedrooms being small in size and unsuitable for residents requiring manual handling assistive devices. Additionally, the doors leading from shared bedrooms are narrow and unsuitable for residents requiring evacuation in their bed in an emergency situation. The pre-admission assessment of at least one resident did not take these considerations into account when assessing the suitability of Dean Maxwell CNU for residential purposes
- while there was considerable detail in the care plans, some were first written in 2019 and not rewritten since then. Due to the length of the care plans, some of which extended to three and a half pages, it was difficult to decipher the care needs of each resident. It was also found that residents routine had changed over time, such as when they liked to get up in the morning and when they wished to go to bed. This detail was not always updated in the care plans
- the care plan for one long-term resident was first completed when the resident was admitted for respite. A full review of the care plan had not taken place to reflect that the resident had transitioned to long-term residential care and a more detailed plan of care was required to reflect their needs

Judgment: Substantially compliant

Regulation 6: Health care

Residents were provided with timely access to medical and health and social care

professional services as necessary. In addition, there was good evidence that advice received was followed which had a positive impact on residents' outcomes.

Judgment: Compliant

Regulation 8: Protection

A policy and procedures for safeguarding vulnerable adults at risk of abuse was in place. All staff had appropriate vetting completed by An Garda Síochána (Irish police) prior to commencement of work in the centre. Staff spoken with displayed good knowledge of the different kinds of abuse and what they would do if they witnessed any type of abuse.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Dean Maxwell Community Nursing Unit OSV-0000665

Inspection ID: MON-0039671

Date of inspection: 17/04/2024

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 23: Governance and management	Substantially Compliant

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

Audits :
A review of the audit schedule has been completed and audits have been allocated to relevant staff. These will be fully completed by 31/05/24.
Audits completed to date include:

- medication management
- environment audit,
- sanitary facilities,
- dining room experience
- care plan audits
- residents' equipment.

Fire safety:
A review of the fire safety management strategy has been completed to provide assurance on fire safety within the designated centre:
- Additional staff have been put in place for night time staffing
- A review of all Personal Emergency Egress Plans (PEEPS) has been completed
- Fire evacuation drills have been completed including with high dependency residents.
- A schedule of fire drills has been developed and will continue in order to provide assurance on evacuation times on a regular basis and to gain learning from these evacuation drills.
- Documentation of fire drills has been reviewed and amended to accurately record the timing of drills.
- Evacuation / escape maps have been reviewed by a specialist service and updated.
- In addition to the interim measures described above to address fire safety, access and egress to the 'bariatric bedrooms' has been reviewed by an external engineering

company .
• There is now a design plan to widen the two bedroom doors for the two bariatric residents . Works will commence, subject to the tendering and commissioning process, which will allow for bed evacuation.
• The Fire Exit door at the end of the corridor will also be widened.

These works will eliminate the need for hoist transfer for these two residents.

The completion of the works is subject to the availability of contractors to complete. However, it is anticipated that these works will be complete by end of September 2024.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The current complaints policy has been reviewed and amended to bring it in line with Regulation 34: Complaints.
• Complaints policy is now compliant with Regulation 34. Completed 26/04/24.
• Complaints log sheet has been restructured and is been implemented. Completed 19/04/24.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Actions completed :
• Painting work has commenced on the door surrounds.
• Door to cupboard in the housekeeping room has been repaired.
Actions to be completed :
• Hinges on wardrobes will be repaired by 7th June 2024.

Regulation 27: Infection control	Substantially Compliant

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

Issues identified during the course of the inspection have been addressed as follows:

• Floor in visitors toilet has been addressed (25/04/24).
• Commode chair in shared bathroom has been removed and cleaned.
• Bedpan washer, which was not operational on 13/04/24 , was reported and reviewed by maintenance team on call on the 13/04/24 for immediate intervention. This was then reported to the relevant external company for remedial action.
• Clinical waste bin in the sluice room was disposed on 18/04/24 and replaced with a new domestic waste bin in place.
• Clinical waste bin stored inappropriately in the treatment room was removed on 18/04/24 and domestic waste bin put in place.
• All commodes in sluice room have been cleaned and labeled accordingly 18/04/23 and will be monitored.
• Hoist stored in the communal bathroom has been cleaned and removed to an alternative location 18/04/24.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Actions completed to ensure adequate containment of fire:
• Attic areas were reviewed to confirm compartment boundaries 19/04/24. Specialist external company attended on site on 08/05/24 to review compartments and adjust evacuation plan/escape plan drawings to compartment layout drawings. These have been updated and are in place.

• A detailed review of all fire doors was completed in November 2023. Maintenance department have completed remedial actions on these doors where appropriate. Requirement for additional specialist work has been referred to an external company.

• In office areas where doors were held open by items such as wedges, these have all been removed and doors kept closed. A staff reminder has been sent out to not keep doors open by furniture.

Actions completed to ensure that all residents could be evacuated in the event of a fire.
• Evacuation drills have been carried out on four occasions since inspection with the residents using hoist for fire evacuation. This has resulted in improved times for evacuation plus the enhanced learning associated with this. A schedule of regular drills has been developed to include hoist evacuations.

• Documentation of fire drills has been reviewed and amended to accurately record the timing of drills. Fire drills record have been updated to include staff present, the number of residents evacuated and mode of evacuation, time and details of horizontal evacuation. A schedule of simulated fire drills commenced.

• All PEEPS have been reviewed and amended to reflect more details of equipment used.

• The evacuation maps on display have been updated as a result of an assessment, completed by a specialist company, of the fire safety compartments to ensure that residents can be evacuated to a place of relative safety.

• All staff are up to date in fire safety training.

• In addition to the interim measures described above to address fire safety, access and egress to the 'bariatric bedrooms' has been reviewed by an external engineering company .
• There is now a design plan to widen the two bedroom doors for the two bariatric residents . Works will commence, subject to the tendering and commissioning process, which will allow for bed evacuation.
• The widening of the two bedroom doors for the two bariatric residents will commence, subject to the tendering process, which will allow for bed evacuation.
• The Fire Exit door at the end of the corridor will also be widened.

These works will eliminate the need for hoist transfer for these two residents.

The completion of the works is subject to the availability of contractors to complete. However, it is anticipated that these works will be completed by end of September 2024.

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 admission policy has been reviewed and amended to strengthen the criteria for admission to the designated centre taking into account the design and layout of the building which may impact on the use of manual handling assistive devices.
• Pre-admission assessments are carried out in person and environment constraints included in the assessment.
• A review of care plans has taken place, commencing 18/ 05/ 2024 and work started in updating and renewing details for those over a year admitted or as required.

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 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	07/06/2024
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	30/09/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	25/04/2024

	associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	30/09/2024
Regulation 28(1)(e)	The registered provider shall 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.	Not Compliant	Red	19/04/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	19/04/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where	Not Compliant	Red	30/09/2024

	necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
Regulation 34(1)(a)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre concerned.	Substantially Compliant	Yellow	26/04/2024
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 or on the person's admission to a designated centre.	Substantially Compliant	Yellow	18/04/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care	Substantially Compliant	Yellow	18/04/2024

	plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			