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:	Firstcare Beneavin House
Name of provider:	Firstcare Beneavin House Limited
Address of centre:	Beneavin House, Beneavin Road, Glasnevin, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	01 May 2024
Centre ID:	OSV-0000694
Fieldwork ID:	MON-0042146

About the designated centre

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

The designated centre is located in north County Dublin and is close to local shops and amenities. There is a car park situated at the front of the building and disabled parking is available. Beneavin House is a purpose built nursing home that provides accommodation for 150 residents over the age of 18 years. The nursing home offers 24 hour care to dependent residents with low. Medium, high and maximum dependencies including people living with dementia. Accommodation is provided across four floors which are arranged around a central courtyard garden. Oakfield unit is situated on the ground floor and has 31 single bedrooms and four twin bedrooms. Willowbrook is situated on the first floor and has 35 single bedrooms and five twin rooms. Claremont is situated on the second floor and has 41 single rooms and one twin room. Claremont is divided into two units Claremont and Claremont Walk. Claremont Walk provides accommodation for 11 residents living with dementia and is designed specifically to meet their needs. Most of the bedrooms on Oakfield, Willowbrook and Claremont units have en-suite facilities. Cedars Unit is on the fourth floor and has 19 single and two twin bedrooms. All bedrooms on Cedars are en-suite. Each floor has additional communal bathrooms and wheelchair accessible toilets. There are communal lounges and dining rooms on each floor and Claremont has an additional lounge. There is also a hairdressing salon, an oratory and a family room with overnight facilities which can be organised through the Home manager. Activity rooms and a smoking room for residents are also available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	121

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 1 May 2024	08:00hrs to 16:15hrs	Sinead Lynch	Lead
Wednesday 1 May 2024	08:00hrs to 16:15hrs	Aislinn Kenny	Support
Wednesday 1 May 2024	08:00hrs to 16:15hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

Residents who spoke with inspectors were happy in the centre and said that they enjoyed living there. Inspectors observed kind and respectful interactions with residents throughout the day by staff and management. Throughout the inspection, the inspectors observed that there was adequate staff to meet the needs of the residents in a timely manner. Residents had their call bells answered promptly and residents told the inspectors that there were always staff available to support them.

Resident had access to a ground floor courtyard. There had been new seating purchased since the last inspection which provided residents with ample seating to enjoy in the good weather.

Since the last inspection the registered provider had placed the codes to the lifts in a prominent place which did not restrict residents and visitors movement around the centre. The front door was key coded, however, there was a person at the reception 12 hours a day to give visitors ease of access.

Following an introductory meeting the inspectors walked around the building, during this walk around there were immediate risks identified in relation to Regulation 28: Fire Precautions. A fire exit was blocked on the Claremont unit by a table and bin, this was removed immediately. In the smoking room of the Claremont unit there was a plastic bucket being used as an ashtray which contained a large amount of cigarette butts. This was removed before the end of the inspection. There were also areas that required attention under Regulation 17: Premises. These are outlined further in the report and under the relevant regulations.

Activities were provided on each floor and inspectors observed there was pancake making on the day of inspection in the Claremont unit and residents were enjoying their tea and pancakes in the day room. Residents were very complimentary about the activities in the centre. One resident who said they had been living in the centre for more than two years said this was now their home and they felt very proud and lucky to live there.

The centre was spacious with surfaces, finishes and furnishings that were easy to clean. Residents' bedroom accommodation comprised of both single and twin bedrooms, all with ensuite facilities. All bedrooms and communal areas had wide corridors and assisted handrails throughout. Overall, the general environment and residents' bedrooms, communal areas and toilets inspected appeared nicely decorated and clean. Residents and visitors spoken with were very happy with the standard of environmental hygiene.

The ancillary facilities generally supported good infection prevention and control. For example, the on site laundry supported the functional separation of the clean and dirty phases of the laundering process.The large laundry room supported two other centres also, this room was clean, organised and well ventilated. There were

dedicated housekeeping rooms on each floor for the storage and preparation of cleaning trolleys and equipment and sluice rooms for the holding and reprocessing of bedpans, urinals and commodes.

Capacity and capability

The registered provider had demonstrated their efforts to provide a safe service for the residents in the centre although some improvements were required. These improvements were required in relation to Governance and Management, Fire Safety, Premises, Policies and Procedures and Residents Rights. These are discussed further under their respective regulations.

The inspectors found that there was a clear governance and management structure in place. However, improvements were required in relation to ensuring the service provided was effectively monitored. There was a person in charge of the centre who worked full-time and they were supported by three assistant directors of nursing, 4 clinical nurse managers and a team of nursing and support staff.

Firstcare Beneavin House Limited is the registered provider for Firstcare Beneavin House. The senior management team consisted of a Chief Operating Officer, a Regional Director, Associate Regional Director and the person in charge.

There were sufficient staff on duty to meet the needs of residents living in the centre on the day of inspection. Call bells were answered promptly and residents appeared content with the staffing levels.

There was a suite of policies available in the centre. However, these did not guide practice in relation to responding to emergencies. The incorrect numbers were displayed in this policy for emergency services. The notification that is a requirement to be completed and submitted to the Chief Inspector of Social Services in the event the centre is required to evacuate residents was not the correct notification.

The Director of Nursing had overall responsibility for infection prevention and control (IPC) and antimicrobial stewardship. The provider had also nominated an assistant director of nursing to the role of the IPC link nurse has completed the link practitioner course .This link practitioner had protected time for IPC and was enthusiastic in their role.

A review of notifications found that outbreaks were generally managed, controlled and reported in a timely and effective manner. Staff spoken with were knowledgeable of the signs and symptoms a respiratory illness and knew how and when to report any concerns regarding a resident.The provider had a number of processes in place to ensure a high standard of environmental hygiene. These included cleaning instructions, checklists and colour coded cloths to reduce the

chance of cross-infection. Housekeeping trolleys were clean and well-maintained with a lockable store for chemicals.

The centre had a range of audits in place. However, regular infection prevention and control audits that included standard precautions were not undertaken. There had been no infection prevention and control audits undertaken in 2024 to date, apart from hand hygiene audits. As a result there were insufficient assurance mechanisms in place to ensure compliance with *The National Standards for infection prevention and control in community services*. Details of issues identified are set out under Regulation 23.

Documentation reviewed relating to water safety provided the assurance that the risk of *Legionella* was being monitored in the centre. For example, routine water testing for *Legionella* in hot and cold water systems had been undertaken, the provider had identified high counts of *Legionella* bacteria in four samples tested. Remedial actions had been taken and re-sampling found that the actions had been not been effective in lowering the levels of contamination.The areas with high levels of bacteria in the water were closed to protect residents, the person in charge gave assurance that a full disinfection of the water system is under review by the senior management team. However, further attention is required to ensure that the hand hygiene sinks in the medication rooms are included in the flushing schedule and maintained properly to reduce the risk of further high counts of *Legionella* in these outlets, further details are discussed under Regulation 27.

Regulation 14: Persons in charge

There was a person in charge who worked full-time in the centre. The person in charge is a registered nurse and they met the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

Through a review of staffing rosters and the observations of the inspector, it was evident that the registered provider had ensured that the number and skill-mix of staff was appropriate for the infection prevention and control and antimicrobial stewardship needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

All staff had received education and training in infection prevention and control practice that was appropriate to their specific roles and responsibilities. Inspectors identified through talking with staff that further education is required in the decontamination of residents` equipment. Copies of infection prevention and control national clinical guidelines were available and accessible to staff working in the centre. Staff had completed antimicrobial stewardship on line training.

Not all staff had up-to-date training on managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and there were 11 gaps noted.

Judgment: Substantially compliant

Regulation 21: Records

The registered provider did not ensure that records set out in Schedule 4 were available for inspection. There were three requests made to obtain the complaints register and any investigations as part of this register which were not made available.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems in place did not ensure the service was effectively monitored, for example;

- All records were not made available to the inspectors, to include the complaints log.
- Not all staff had up-to-date training on managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and there were 11 gaps noted. There was a plan in place for the remaining staff to complete their training in the coming months.
- The review of policies was not comprehensive and the updates were not sufficient for the emergency policy. The emergency policy is a requirement of Schedule 5 of the regulations.
- The compliance plan in relation to the inspection carried out on the 17th May 2023 was not completed within the required and assured time-frame in relation to Regulation 28; Fire precautions

- There were insufficient assurance mechanisms in place to ensure compliance with the *National Standards for infection prevention and control in community services (2018)*. Local infection prevention and control audits that covered all standard precautions were not in place to give assurance that residents were protected against a healthcare associated infection.

Judgment: Not compliant

Regulation 31: Notification of incidents

The Chief Inspector of Social Services had been informed of all incidents which occurred in the centre within the required time-frame.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had an accessible and effective procedure for dealing with complaints which included a review process. However, on the day of inspection the complaints that had been received and any investigations were not made available to the inspectors.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing the policies and procedures as set out in Schedule 5 of the regulations. However, these policies required review, for example:

- Responding to emergency policy detailed two emergency numbers that were no longer in service. The incorrect notification to be submitted to the Chief Inspector of Social Services was recorded to use in case of an emergency evacuation. The policy also states that sledges would be available on each floor for emergency evacuation, however they were not available on the ground floor.

Judgment: Substantially compliant

Quality and safety

Inspectors found that residents enjoyed a good quality of life while residing in the centre. Residents were supported to live as they wished and were encouraged to be as independent in their decision making as they were in their own homes.

The registered provider had ensured that all residents had access to appropriate medical and health care, including a general practitioner (GP), physiotherapy, speech and language therapy and dietetic services. Residents weights and observations were completed at least monthly or more frequently if required.

Residents' with communication difficulties were being facilitated to communicate freely. Their care plans reflected residents' personal needs with communication difficulties and were appropriately reviewed and updated.

Residents' rooms were spacious and nicely decorated, each resident had ample storage for their belongings and lockable storage in their bedrooms. There were balcony areas off some of the bedrooms accessible by a door from the bedroom however the majority of the door handles were not working thus restricting access to these areas. Privacy arrangements also required review in two residents rooms to ensure the privacy and dignity of residents. There was a centralised laundry system in the centre and residents clothing was returned to them promptly.

Overall, some areas of the premises required attention to ensure they conformed to the Schedule 6 requirements. This is outlined further under the regulation.

The inspectors saw that behaviour support plans were in place for residents with 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). Inspectors saw staff engage with residents in a dignified and respectful way during the inspection and appeared to know staff and appropriate assessments were used to support residents care plans.

The centre had an electronic resident care record system. Pre-admission assessments were undertaken to ensure that the centre could provide appropriate care and services to the person being admitted. A sample of pre-admission assessments found these were in place for all residents except one. Care plans viewed by the inspectors were generally comprehensive and person- centred with some exceptions. Care plans were not formally reviewed every four months or sooner if required. Further work was also required to ensure that all resident care plans contained appropriate information regarding the care of a residents who had an multi-drug resistant organism (MDRO) and a urinary catheter. Details of issues identified are set out under Regulation 5.

The centre was a pension agent for two residents and there were four others in the application process. The registered provider had a safeguarding policy in place and staff had received training in this area. There had been a recent change in the

nominated pension agent for residents and this had not yet been reflected in the paperwork reviewed.

Conveniently located alcohol-based product dispensers along corridors and within resident bedrooms facilitated staff compliance with hand hygiene requirements. Hand hygiene sinks were also available within easy walking distance of all resident's bedrooms, along the corridors these sinks were compliant with the specifications of a clinical hand hygiene sink.

Inspectors identified some examples of good practice in the prevention and control of infection. For example, waste, used laundry and linen was segregated in line with local guidelines at point of care. Staff were observed to have good hand hygiene practices and the correct use of personal protective equipment (PPE). However, staff did not have access to safety engineered sharps devices which minimise the risk of needle-stick injury and further improvements were required in the decontamination of residents equipment.This is further discussed under Regulation 27: Infection Prevention and Control.

Regulation 10: Communication difficulties

Residents' with communication difficulties were supported to communicate freely and staff were aware of their needs. The inspectors found that each resident's communication needs were assessed and a care plan was in place for residents who needed support with meeting their communication needs.

Judgment: Compliant

Regulation 11: Visits

Adequate arrangements were in place for residents to receive visitors and there was no restriction on visiting. Visitors spoken with by the inspector were complimentary of the care provided to their relative and were happy with the visiting arrangements in place.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were supported in accessing and retaining control over their personal property, possessions, and finances. Residents' clothing was laundered by staff in a

centralised area within the centre, and each resident had adequate space to store and maintain their clothes and personal possessions.

Judgment: Compliant

Regulation 17: Premises

While the premises were designed and laid out to meet the number and needs of residents in the centre, some areas required maintenance and repair to be fully compliant with Schedule 6 requirements. For example:

- Some of the store rooms have wooden shelving that does not facilitate effective cleaning. For example, one of the linen rooms and the storeroom on the third floor.
- A significant amount of door handles were broken and could not be used to access the outside balcony areas
- There was no call bell in the activities room on the Claremont unit
- A plug socket was hanging off the wall in the dining room on the Claremont unit

Inappropriate storage arrangements were in place in areas of the centre. For example;

- There was a PPE trolley, clinical waste bins and a weight chair being stored in the activities room in Claremont.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27 infection control and the *National Standards for infection prevention and control in community services* (2018), however further action is required to be fully compliant. For example;

- The needles used for injections and drawing up medication lacked safety devices. This omission increases the risk of needle stick injuries which may leave staff exposed to blood borne viruses.
- The hand hygiene sinks in two of the medication rooms were too small to enable good hand hygiene practices. On the day of inspection both sinks had visible biofilm in the plughole and were not draining properly.This meant that staff could contaminate their hands and increase the risk of infection spread to residents and surfaces.

- Some of the urinals used to empty urinary catheters were washed in the residents own sink instead of being decontaminated in the sluice.This practice increased the risk of residents getting a catheter associated urinary tract infection.
- The high levels of *Legionella* bacteria in the water system was not on the centres risk register and the risk assessment provided on the day of the inspection had another centres name on the document.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider did not 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 reasonable practicable, residents, are aware of the procedure to be followed in the case of fire.

- Peep (Personal emergency evacuation plans) did not guide staff on how to safely evacuate residents
- The compliance plan to the last inspection provided assurances that fire drills would be completed bi-monthly. However there was a 10 week gap between fire drills.

The registered provider did not take adequate precautions against the risk of fire, or provide suitable fire fighting equipment, for example:

- There was a plastic bin in the smoking room for disposing of cigarettes

The registered provider did not have adequate arrangements for containing fires. For example:

- Gaps around service penetrations in walls and ceilings were found in two communication rooms. This was a repeat finding from the last inspection.
- There was paint on the fire seal of room 545
- The fire door on room 529 was not closing sufficiently

The registered provider did not ensure that there were adequate means of escape. For example:

- There was a table and bin obstructing the fire exit on Claremont unit
- There were six food/serving trolleys obstructing the fire exit on Willowbrook unit
- There was no signage in place to direct evacuees from the centre to the external assembly point. This was a repeated finding from the previous inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A computerised system was used for care planning. Overall, the standard of care planning was good and person centred with some exceptions. For example;

- Care plans were not always formally reviewed within four months or as needed. For example; safeguarding care plans were not updated following incidents that had been reported to the Chief Inspector.
- The care plan for a resident that was colonised with an MDRO stated that there should be a sign on the door to take precautions and staff needed to don and doff PPE. This is not in line with best practice guidelines as only standard precautions are required.
- The care plan for a resident with a urinary catheter had guidance for staff to decontaminate the container used to empty the catheter every Sunday. This is not in line with best practice guidelines as the container should be decontaminated after every use and this meant the resident maybe exposed to a healthcare associated infection.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to appropriate medical and allied health care services. A number of antimicrobial stewardship measures had been implemented to ensure antimicrobial medications were appropriately prescribed, dispensed, administered, used and disposed of to reduce the risk of antimicrobial resistance. For example the volume, indication and effectiveness of antibiotic use was monitored and analysed each month. Staff had knowledge of "skip the dip" a national programme to reduce the use of dipstix to determine if a resident had a urine infection.Posters were available to inform and guide staff in the treatment rooms.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was clear documentation of the types of restraint used in the centre and overall good practice in the assessment and use of restraint.

Judgment: Compliant

Regulation 8: Protection

The safeguarding policy had been reviewed within a three year time frame. Staff had received refresher training in safeguarding vulnerable adults. All staff were garda vetted. The registered provider was a pension agent for two residents with four other residents currently engaged in the application process.

Judgment: Compliant

Regulation 9: Residents' rights

Some residents were not provided with the opportunity to undertake personal activities in private. For example:

- Privacy arrangements for one bedroom required review as the residents bed was visible from a window in the communal area.
- One twin bedroom did not ensure privacy and dignity was maintained, the curtains did not close fully.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
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 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Firstcare Beneavin House OSV-0000694

Inspection ID: MON-0042146

Date of inspection: 01/05/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The remaining 11 staff will have completed managing responsive behaviour training by 30th June 2024. Staff will receive refresher training in decontamination of resident equipment by 30th June 2024.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A system has been put in place to ensure that all records will be made available during an inspection in a timely manner –complete	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

A system has been put in place to ensure that all records will be made available during an inspection in a timely manner –complete

The Regional Director will review records at the monthly governance meeting to ensure compliance with this system- from 31st May and ongoing.

The training matrix will be reviewed by the Person in Charge and Regional Director at the monthly governance meeting to ensure that gaps are addressed and training needs identified through observation and audit are reviewed and adequate training opportunities are provided for staff- from 31st May 2024 and ongoing.

A process has been established to ensure that local policies are reviewed by the Person in Charge to ensure that they are up to date-complete.

This process will be overseen by the Regional Director at the monthly governance meetings –from 31st May 2024 and ongoing.

The Regional Director will review all compliance plans monthly with the Director of Nursing to ensure that outstanding actions are completed fully and within the agreed timeframe- from 31st May 2024 and ongoing.

A review of the current IPC audit programme is underway to ensure that audits are conducted appropriately to identify improvements required in standard precautions. This will be complete by 31st July 2024.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
A review has been completed to ensure that the agreed system of recording complaints received and investigations conducted is in place- complete.

The Person in Charge and Regional Director will review the complaints management system monthly at the Governance meeting to ensure compliance with this system- from 31st May 2024 and ongoing.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: The Emergency Policy has been reviewed and updated with the appropriate information-complete A process has been established to ensure that local policies are reviewed by the Person in Charge to ensure that they are up to date-complete. This process will be overseen by the Regional Director at the monthly governance meetings –from 31st May 2024 and ongoing.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The replacement of wooden shelves with suitable metal shelving, in the linen room and storeroom, will be complete by 30th September 2024 Door handles for balcony doors will be replaced by 29th of July 2024 The call bell for the activity room has been ordered and will be installed by 31st July 2024. The broken plug socket has been replaced-complete Staff refresher training has been provided to ensure the appropriate storage of clinical and non-clinical items at all times-complete A new electronic system is now in place to log daily maintenance tasks within the centre. Additionally, the maintenance report is reviewed at monthly governance meetings by the RD to ensure all matters are closed within reasonable timeframe- completed The response to all actions is overseen by the Person in Charge and Regional Director through reports provided at governance meetings- from 31st May 2024 and ongoing	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control:	

A review of the current IPC audit programme is underway to ensure that audits are conducted appropriately to identify improvements required in standard precautions. This will be complete by 31st July 2024.

Action plans to address improvements identified through audit and observation will be agreed at the monthly IPC meetings & Governance meetings by the Person in Charge and Regional Director- from 31st May 2024 and ongoing.

Refresher training will be provided to staff to ensure that flushing of all water outlets is conducted to the appropriate standard daily. The Person in Charge will review this practice daily during walkabouts and through audit of the records- from 31st May 2024.

The legionella risk assessment has been reviewed and updated- completed.
The Person in Charge and Regional Director will review the risk register monthly at the governance meeting to ensure that it is updated and reflects all existing and emerging risks in the centre- from 31st May 2024.

The chlorination of the water system was completed on 30th May 2024.

Retesting of the water was conducted on 4th of June 2024 and awaiting results.

Safety engineered sharps are in stock and nursing managers have received refresher training on ordering these to ensure that they are available at all times- complete

Staff will receive refresher training in decontamination of resident equipment by 30th June 2024.

The two hand hygiene sinks in the clinical rooms will be replaced with larger hand hygiene sinks by 30/09/2024

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Enhanced monitoring of monthly fire evacuation drills is now in place with each drill and actions /learnings arising reviewed and actioned at the monthly Quality and Safety committee meetings and monthly Governance Meetings with the Regional Director- complete

All PEEPs have been updated to ensure they guide staff on how to safely evacuate residents- complete

The PIC and ADON's are responsible for ensuring PEEPs are reviewed at least three monthly or earlier depending on the needs of each resident and this will be audited monthly to ensure compliance- from 31st May 2024

The plastic bin in the smoking room was immediately removed and replaced with a metal equivalent- complete

A system is now in place to ensure that the smoking room is reviewed daily to ensure that all equipment is appropriate and low risk from fire- complete.

Alternative storage space has been identified for food trolleys to ensure fire exits remain unobstructed and staff have been reminded of the importance of keeping exits unobstructed- complete.

The Fire Assembly Point has been reviewed and works will be completed by 8th of July 2024

New signage has been ordered to clearly direct people to the assigned assembly point. The Assembly Point Markings in the front entrance car park will be completed by 8th of July 2024.

All gaps around the service penetration in walls and ceilings and fire door repairs have been addressed- complete

Robust monitoring of fire door visual inspections is now in place with findings reviewed and actioned at monthly governance meetings- from 31st May 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:
A quality improvement initiative is currently underway in the centre to improve the overall standard of person centered care planning (to include timely updates for safeguarding, IPC). This will be completed by 30th September 2024

The standard of care plans will be reviewed by the Person in Charge and overseen by the Regional Director at monthly Governance meetings- from 31st May 2024 and ongoing.

Regulation 9: Residents' rights	Substantially Compliant

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

On the day of the inspection curtains were replaced to ensure the resident's privacy was maintained- complete

All curtains in twin bedrooms has been reviewed and replaced to ensure they close fully- complete
More robust review of environamental audits is underway to ensure deficits are identified and adressed in a timely manner- from 31st May 2024.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/06/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2024
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	31/05/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to	Substantially Compliant	Yellow	31/05/2024

	be safe and accessible.			
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.	Not Compliant	Orange	31/07/2024
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	30/09/2024
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	Orange	31/05/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	08/05/2024

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	Orange	08/05/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/05/2024
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	31/05/2024
Regulation 04(3)	The registered provider shall	Substantially Compliant	Yellow	31/05/2024

	review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	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	30/09/2024
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake	Substantially Compliant	Yellow	31/05/2024

	personal activities in private.			