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:	Eyrefield Manor Nursing Home
Name of provider:	Norwood Nursing Home Limited
Address of centre:	Church Lane, Greystones, Wicklow
Type of inspection:	Unannounced
Date of inspection:	10 January 2023
Centre ID:	OSV-0000036
Fieldwork ID:	MON-0038712

About the designated centre

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

Eyrefield Manor is a two-storey purpose-built centre situated on the outskirts of a busy town. The centre can accommodate 53 residents, both male and female, for long-term and short-term stays. Care can be provided primarily for adults over the age of 55 years. The centre caters for residents of all dependencies, low, medium, high and maximum, and 24 hour nursing care is provided. A comprehensive pre-admission assessment is completed in order to determine whether or not the centre can meet the potential resident's needs. According to their statement of purpose, the centre provides a safe physical and emotional environment for all residents and staff and is committed to maintaining and enhancing the quality of life of the residents. Residents' accommodation comprises 11 single rooms, 18 twin room and two triple rooms. All, with the exception of two single rooms, have full en-suite facilities. These two single rooms have en-suites with toilet and wash hand basin. Other bathroom facilities are located around the building. Access between floors is via stairs and a full sized lift. Adequate screening is available in the shared rooms. The centre has two dining rooms, one on each floor. The main kitchen is on the ground floor with a kitchenette on the first floor. Adequate communal space is provided with main sitting rooms on each floor along with smaller communal rooms and seating areas. Other facilities include an oratory, hair salon, laundry rooms, and a visitors' room. All are adequate in size, decorated in a domestic manner and easily identifiable for residents to find.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	52

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 10 January 2023	09:00hrs to 19:00hrs	Bairbre Moynihan	Lead

What residents told us and what inspectors observed

The inspector greeted and chatted with a number of residents in the centre and spoke in greater detail to six residents to elicit their experiences of living in Eyrefield Manor nursing home. Overall, residents were very positive about how they spent their days in the centre, and were highly complimentary of the staff, the food and premises. Residents reported feeling safe in the centre and expressed satisfaction at how the centre was run. One resident informed the inspector that the centre "is like a five star hotel".

The inspector arrived to the centre in the morning for an unannounced inspection to monitor ongoing regulatory compliance with the regulations and standards. The inspector was greeted by the person in charge and following an introductory meeting completed a walkaround of the centre. It was evident from the walkaround that residents knew the person in charge and addressed her by her first name.

The centre is registered to accommodate 53 residents with one vacancy on the day of inspection. The centre is laid out over two floors with 11 single rooms, 18 double rooms and two triple rooms. All rooms except two single rooms contained en-suite facilities. The two single rooms contained a toilet and sink and these two residents had access to communal showering and bath facilities. Residents had access to a enclosed garden where there was ample seating available. Each floor in the centre contained visiting rooms, dining rooms and sitting rooms. In addition, the provider had installed a visiting room in the garden. The inspector was informed that this was heated and was used frequently by residents and visitors. However, this was not registered for use by residents with HIQA. The centre was surrounded by well maintained gardens with flowering plants displayed on windowsills in the internal courtyard. Residents' rooms were personalised with photographs of relatives and friends and pictures hung on the walls. A collage of photographs was displayed on the corridors on the ground floor of the residents' Christmas party and a ladies day that was held in the centre. The centre had a designated hair salon and the hair dresser attended fortnightly. Overall, the centre was well maintained and nicely decorated.

The provider had employed two WTE (wholetime equivalents) activities co-ordinators who both worked Monday to Friday. One was assigned to each floor. Activities such as bingo were observed to be taking place with good participation from residents in the afternoon of the inspection. An exercise class took place in the morning. Residents informed the inspector about live music that was in the centre on Wednesdays and how they look forward to it as "they play all the old songs". A pianist attended on Saturdays but no other activities took place over the weekend. The inspector was informed that weekends were busy with visitors and residents are tired after the week. However, residents views on this had not been sought. Notwithstanding this three monthly resident meetings were taking place. Actions from these meetings were managed through the complaints process. Meetings minutes observed identified that residents were vocal and articulated their concerns

at meetings. A satisfaction survey was completed in November 2022 with six residents and families consulted. Management stated that they surveyed 10% of the residents and relatives. All feedback provided from both relatives and residents was positive.

The inspector observed the dining experience. A number of residents from the first floor attended the dining room on the ground floor for lunch and tea. The dining room was pre prepared with table linen and the dining experience was observed to be relaxed. Staff were available to assist residents if required. Residents were offered a choice at mealtimes. Residents were particularly complimentary about the homemade soup which they had mid-morning. Fluids and snacks were observed to be provided throughout the day.

Residents' clothes were laundered onsite, labelled by staff and returned to residents. No issues around the laundering of the clothes was identified on inspection either through the complaints process, residents' meetings or residents did not raise any issues on the day of inspection.

The centre had an open visiting policy and it was evident that staff were familiar with the visitors in the centre. Visitors confirmed that there were no restrictions and they expressed how they felt welcome and how they could visit at anytime during the day.

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

Capacity and capability

This was an unannounced risk inspection carried out to monitor ongoing compliance with the regulations and standards. Additionally, the inspector assessed the overall governance of the centre to establish if the actions outlined in the centre's compliance plan from the inspection in January 2022 had been implemented. Overall, the provider had progressed the compliance plan and improvements were seen in Regulation 24: Contracts for the provision of services and Regulation 29: Medicines and pharmaceutical services. Areas for action were identified on this inspection which will be discussed below.

Eyrefield Manor was a well-run centre with effective leadership, governance and management in place. Norwood Nursing Home Limited was the registered provider for Eyrefield Manor nursing home. The centre opened in 2006 and has two company directors, the registered provider representative and the person in charge. The person in charge, worked full-time and was supported in the role by an assistant director of nursing who was supernumery, staff nurses, healthcare assistants, activities co-ordinators, catering and maintenance staff. The registered provider was

onsite daily and carried out administrative duties in the centre.

The provider had a training matrix in place and staff had access to mandatory training including fire safety, cardiopulmonary resuscitation, dementia training and safeguarding. The registered provider had good oversight of the training in the centre. However, the training matrix did not accurately reflect training completed. The registered provider assured the inspector that this was updated following the inspection.

The inspector reviewed a sample of staff files. All staff had up-to-date Garda (police) vetting in place and the professional registration for nursing staff where required was available. Gaps in the employment history of two out of the four staff files reviewed was identified. This was identified on the inspection in January 2022 and while the registered provider had endeavoured to account for these gaps this had not been addressed in all staff files.

There was evidence of monitoring of the services through audit. A monthly audit schedule was in place. Audits were not identifying many issues but those identified were actioned and discussed at a monthly quality improvement meeting. Systems of communication were in place, for example; monthly management meetings and staff meetings. Different agenda items were discussed each month but infection control was continually on the agenda. Other items discussed included complaints, safeguarding and staff training. In addition, a monthly quality improvement meeting was in place where items such as incidents and outcomes from audits were discussed. However, meeting minutes contained no time bound action plans. There was evidence that incidents were reported. A falls analysis was conducted at year end including actions for 2023. In addition, incidents were discussed at the quality improvement meeting. Incidents requiring reporting to the office of the chief inspector were notified within the required time outlined in the regulations. An annual review of the quality and safety of care was completed in 2021 and the 2022 report was in progress at the time of inspection.

A sample of contracts were reviewed. These outlined the monthly fee payable by residents and any additional fees required. The contracts also outlined the number of residents in each room for example; single, twin or triple.

The provider had only received a small number of complaints since the last inspection. There was evidence that these were managed in line with the regulation.

Regulation 15: Staffing

Staffing was sufficient to meet the needs of the residents given the size and layout of the centre. On the day of inspection, the centre had two staff nurses ,11 healthcare assistants on duty with one unexpected absence, one activities co-ordinator and three cleaners rostered and onsite. In addition, the person in charge and assistant director of nursing both of whom are supernumery were on duty.

Judgment: Compliant

Regulation 16: Training and staff development

All staff had completed training in safeguarding. Outstanding training was minimal and included one new staff member had to complete fire training and one staff member had to complete training in managing behaviours that challenge. A date for this training was arranged.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had established a directory of residents following the registration of the centre. This directory was maintained, available for review and contained all of the information specified in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

Two out of four staff files reviewed had gaps in their employment history. The registered provider accounted for these gaps following the inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had assurance systems in place in order to be assured about the quality and safety of care. However, improvements were required including:

- Meeting minutes reviewed did not contain time bound action plans.
- Findings in relation to Regulation 21: Records (detailed above) were found in the inspection in January 2022 and again on this inspection.
- While the number of monthly incidents were discussed at the quality improvement meeting there was no regular trending of incidents and therefore regular learning from incidents.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A sample of contracts was reviewed. Contracts included the fee to be set out on a monthly basis, the number of persons accommodated in the room for example single, twin or triple. A schedule of fees at the back of the contract included additional fees for example: newspapers, hairdressing and cost per private physiotherapy session.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents set out in schedule 4 of the regulations were notified to the office of the chief inspector within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was on display at the entrance to the centre. This identified the person in charge as the nominated person to investigate complaints and the name of an advocate for residents. The complaints log was reviewed. The provider had received a small number of complaints since the last inspection. A review of these showed that complaints were recorded, investigated and the satisfaction or otherwise of the complainant was recorded. In addition, the provider had an up-to-date complaints policy in place.

Judgment: Compliant

Quality and safety

The inspector found that management and staff promoted a person-centred model of care. Residents' individual rights were supported and there was good access to health and social care services, ensuring the quality and safety of care delivered to residents was of a high level. Improvements were required in four regulations:

Regulation 17: Premises, 27: Infection control, 28 Fire Precautions and Regulation 5: Individual assessment and care planning.

Open visiting was in place in the centre. It was evident that visitors were welcome in the centre and a good rapport was observed with staff members. Management stated that visitors whom they knew were provided with a code for the door. Residents' clothes were laundered onsite. There was a laundering room on each floor and a separate area where clothes were ironed and prepared for returning to the resident.

The premises was generally well maintained. The provider had employed a maintenance person who was onsite five days a week. Rooms were repainted following discharge of a resident and this was evident in a room that was vacant on the day of inspection. However, storage in the centre required review. In addition, not all residents had access to personal storage within their floor space. These will be discussed in more detail under the regulation. The centre was clean on the day of inspection. Furthermore, residents were complimentary about the cleanliness of the centre. Infection control audits were identifying a small number of issues such as a hand sanitiser was empty. Housekeeping staff were knowledgeable about their role. Staff were observed to be wearing personal protective equipment (PPE) such as face masks appropriately. Access to handwashing sinks was less than optimal, however a sufficient supply of wall-mounted alcohol hand sanitiser was available at key locations throughout the centre to support efficient hand hygiene. Notwithstanding the areas of good practice, areas requiring action were identified which are discussed below.

Systems were in place for monitoring fire safety. Fire extinguishers, the fire alarm and emergency lighting had preventive maintenance conducted at recommended intervals. Daily checks of, for example, escape routes and fire alarm checks were carried out. The fire alarm system met the L1 standard which is in line with the current guidance for existing designated centres. Signage to guide staff on the evacuation routes was clear and on display in a number of locations throughout the centre. Each resident had a personal emergency evacuation plan in place which was located inside each resident's wardrobe. There was evidence from meeting minutes reviewed that fire was discussed with staff along with evacuations, however, while the drills were completed with a fire contractor twice in 2022 none had been completed outside of this.

Residents had timely access to the GP and health and social care providers. There was evidence in residents' records reviewed that residents were referred and reviewed in a timely manner. The overall standard of care planning in the centre was good and described holistic, person-centred interventions to meet the assessed needs of residents. Care plans had been updated to reflect specific needs. Validated risk assessments were regularly and routinely completed to assess various clinical risks including risks of malnutrition, pressure ulceration, and falls. Residents records generally identified the time residents wished to get up and go to bed at. The regulations states that care plans require updating at four monthly intervals. Not all care plans viewed were updated four monthly. This is discussed further under the

regulation.

Residents' rights were protected and promoted in the centre. Choices and preferences were seen to be respected for example choice at mealtimes and a choice of when residents get up in the morning or go to bed. Residents spoken to confirmed they were given a choice. Resident meetings were held quarterly and actions were managed through the complaints process.

Regulation 11: Visits

The centre had an open visiting policy. Visitors completed a temperature check and signed the visitors book at the entrance to the centre. Visitors were observed in the centre throughout the day. The inspector was informed that visiting ceased at 8pm but if a resident was unwell family members could stay throughout the night. Communal areas for residents to receive their visitors in private were available.

Judgment: Compliant

Regulation 12: Personal possessions

Residents clothes were laundered onsite. Clothes were generally labelled with the resident's name, however, management stated there was a backlog at the moment due to the induction of a new staff member. Notwithstanding this no issues were raised at the residents' meetings or in the complaints log about the laundering of clothes. All residents had access to lockable storage for their personal possessions.

Judgment: Compliant

Regulation 17: Premises

Improvements were required in order to ensure compliance with schedule 6 of the regulations. For example:

- Not all the residents in three rooms viewed by the inspector (one twin room and two triple rooms) had access to their wardrobe within their floor space. Residents had to cross into another resident's floor space to access their personal belongings.
- There was inappropriate storage of a hoist, wheelchairs and a weighing scales in a communal bathroom. Furthermore, a storage area on the first floor had multiple items stored on the floor including bed linen and pillows.
- A visitors room was installed in the garden during COVID-19, however, this

room was not on the centre's floor plans or registered with HIQA.
- A room registered as a day room on the first floor contained a bed and locker. The inspector was informed that these were inserted during COVID-19 to isolate residents with confirmed or suspected COVID-19. The dimensions on the floor plans of this room were incorrect as this room had been divided a number of years ago to include a treatment room.

Judgment: Not compliant

Regulation 27: Infection control

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

- The sluice room did not contain a clinical waste bin.
- Hand hygiene sinks were not compliant with the required specifications.
- A medication fridge on the first floor contained dust and debris and required cleaning.
- Some of the seating in the centre was chipped and damaged. This did not aide effective cleaning.
- While the centre had comprehensive minutes of meetings held during outbreaks, no outbreak reports were completed following the closure of the outbreaks and no learning was identified.
- The hair dressing salon contained debris on the hairdressing chair.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While the provider had a positive focus on fire safety, improvements were required. For example:

- Two fire drills had been completed in 2022, both with the fire consultant. Outside of this no fire drills had taken place. Fire drills should be practiced routinely to the point that residents can be safely evacuated at all times of the day and night.
- A small number of staff spoken to were unable to describe the evacuation procedures.
- The provider was unsure if a new visiting area installed outside was linked to the fire panel.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider had systems in place for the management of medicines. Staff spoken to were knowledgeable about the systems and processes in the centre. Transcribing of medication was taking place. The signature of two staff nurses was required if this occurred and this was completed. The general practitioner (GP) signed the medication record when onsite which was weekly. This was in line with the centre's policy. Medications were stored securely including medications requiring strict control measures (MDAs). Staff had access to advice from a pharmacist and while not onsite the inspector was informed that the pharmacist was available to speak to a resident if they requested it. Management stated that medication reviews of all residents were completed monthly by the pharmacist and three monthly with the person in charge and general practitioner.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A sample of care plans and validated risk assessment tools were reviewed. The care plans of one resident had not been updated in six months. This is not in line with the requirements of the regulations which requires a formal review of the care plan at intervals not exceeding four months.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to medical care. The general practitioner was onsite routinely once weekly or would review residents outside of this if required. Outside of normal working hours an out of hours service was used. Health and social care providers were accessible if required. A physiotherapist attended once weekly to do a group exercise class with residents. If a resident required one to one physiotherapy this was at an additional cost. Speech and language therapy, dietetic, tissue viability and occupational therapy services were provided through a private company. A frailty team from a local acute hospital attended onsite if required. In addition, a mobile xray unit was available if requested. There was evidence from review of residents' files that residents were referred and reviewed by health and social care providers.

Judgment: Compliant

Regulation 9: Residents' rights

Resident activities were observed to be taking place on the day of inspection. The centre had two activities co-ordinators who worked Monday to Friday. Music was available on a Saturday and the inspector was informed that the rest of the weekend was available for residents to receive visitors and rest.

Residents were consulted about the organisation of the centre through three monthly resident forum meetings. Satisfaction surveys were completed by residents and relatives in November with six residents and relatives surveyed. Feedback received was all positive with no actions required from the feedback.

Residents had access to newspapers daily and they were observed to be reading them during the inspection. WIFI was available for resident's use.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Eyrefield Manor Nursing Home OSV-0000036

Inspection ID: MON-0038712

Date of inspection: 10/01/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: We provided documentation which accounted for these gaps in employment history to the inspector following the inspection.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: - All future meeting minutes will contain a section detailing learning points and time-bound action plans. - In the future, we will ensure that gaps in employment history are investigated and fully documented. - Currently the nature of incidents are trended and analyzed. In the future, the learning points arising from the analysis of these trends will be included in the monthly quality improvement meeting reports.	
Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
- A small number of multi occupancy rooms required reconfiguration to ensure direct access to personal storage space.
- Medical equipment has been returned to its dedicated storage area.
- Christmas cushions and linens which were temporarily stored on the floor area of storage room have been returned to a dedicated storage area.
- Garden room to be included in floor plan and statement of purpose for next renewal of registration.
- Day room on first floor which was temporarily used as an isolation room during the Covid-19 pandemic has been returned to its original use as a sitting room.
- Floor plan has been updated to reflect this room's dimensions and designation.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
- A clinical waste bin which had been removed from the sluice room for cleaning has been returned.
- Hand hygiene sinks to be installed as per specifications.
- Medication fridge on first flood is now included in cleaning schedule.
- The damaged chair in question has been replaced.
- In the future, following the closure of outbreaks, learning outcomes will be identified and included in meeting reports.
- Our cleaning schedule has been updated to included more regular cleaning of the hair salon and chair after each use.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In house fire drills to be carried out and documented in addition to those carried out by the fire consultant.

Fire drills will be carried out monthly from now on.

New garden room is linked to the fire panel.

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: All care plans to be reviewed at intervals not exceeding four months.	

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.	Not Compliant	Orange	28/02/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	09/02/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and	Substantially Compliant	Yellow	28/02/2023

	effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	09/03/2023
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.	Substantially Compliant	Yellow	28/02/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	09/02/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared	Substantially Compliant	Yellow	09/02/2023

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