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:	Tara Winthrop Private Clinic Ltd.
Name of provider:	Tara Winthrop Private Clinic Ltd.
Address of centre:	C/O Grace Healthcare, Blanchardstown Corporate Park Block 1, Ballycoolin Road, Dublin 15
Type of inspection:	Unannounced
Date of inspection:	19 June 2023
Centre ID:	OSV-0000183
Fieldwork ID:	MON-0040242

About the designated centre

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

Tara Winthrop private Clinic is situated close to the village of Swords, Co Dublin. The centre provides nursing care for low, medium, high and maximum dependency residents over 18 years old. The centre is organised into five units made up of 140 beds of which 112 are en-suite bedrooms. There are eight sitting room areas and six dining room areas and at least 15 additional toilets all of which are wheelchair accessible.
The centre is set in landscaped grounds with a visitor's car park to the front of the building. It is serviced by nearby restaurants, public houses, library, cinemas, community halls, the Pavilions Shopping Centre, a large variety of local shops, retail park and historical sites of interest and amenity such as Swords Castle, Newbridge House and Demense, Malahide Castle and Demesne.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	119

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
Monday 19 June 2023	07:35hrs to 18:00hrs	Lisa Walsh	Lead
Monday 19 June 2023	07:35hrs to 18:00hrs	Helena Budzicz	Support
Wednesday 19 July 2023	07:35hrs to 17:10hrs	Margo O'Neill	Support

What residents told us and what inspectors observed

The overall feedback from residents' was that they liked living in Tara Winthrop Private Clinic. Residents' spoken with were complimentary of the staff and said they were good to them. Inspectors observed that the staff showed a kind and caring attitude towards the residents' they cared for. However, inspectors found that some of the governance and management systems in place needed to be improved to ensure the service was safe and appropriately monitored.

On arrival at the centre, inspectors were met in the reception area by the nurse on night duty. Inspectors spent time observing interactions in different units and spoke with residents and staff. The centre is divided into five units which are set out across two floors. They are referred to as the Lambay unit, Shennick unit, Erris unit, Columba unit and Iona Unit. The Lambay unit, Shennick unit and Erris unit are on the ground floor and each unit has its own day space, dining room and internal garden. The Columba unit and Iona unit are on the first floor and are managed as one unit in the day-to-day running of the centre; sharing the same team of staff, dining room and day space.

After inspectors had walked around the centre, there was an opening meeting with the person in charge and the chief operating officer. Following this, inspectors inspected the premises, the person in charge was in attendance.

Residents' bedrooms comprised of 82 single occupancy and 29 twin occupancy bedrooms. Residents' had access to either an ensuite or to a shared bathroom. Inspectors observed that the personal floor space and storage facilities for residents in the shared bedrooms was not adequate. The allotted floor space for some of the shared bedrooms, did not include the space occupied by a chair and personal storage space for each resident of that bedroom. This is required under S.I. No. 293 of the Care and Welfare Regulations 2016.

The centre was warm and maintained to a good standard. Many rooms throughout the centre had changed purpose, however, the room signage had not yet been replaced to reflect this. Inspectors were informed and observed that new signage had been purchase and a plan was in place to replace signage. In the reception area there was a shop which sold sweets, drinks, newspapers and magazines. The units on the ground floor had access to internal gardens which had well maintained paths and flower beds. However, there was limited garden furniture for residents to sit and enjoy the outdoor space.

Inspectors observed residents' taking lunch in their bedrooms or in the various dining spaces throughout the centre. Food was being served from bain-maries which were located in the dining rooms and food provided to residents appeared appetising. Residents were offered a choice of food for each meal and a menu was on display. Inspectors observed that meal times were a social occasion for many residents with residents sitting and conversing together and with staff. Inspectors

observed that staff provided support to residents who required additional assistance and encouragement with their meals in a patient and kind manner. However, inspectors also noted that some of the care provided was task orientated in nature. For example, staff were observed placing clothes protectors on residents without asking permission.

Residents' and their loved ones reported to inspectors that staff were kind, patient and 'go over and above' to help residents', however, 'there was not enough of them'. For example, one resident told inspectors that staff levels were insufficient resulting at times in waits for assistance of up to 30 minutes to attend the bathroom. Residents reported that there was insufficient staff to assist with breakfast on days when they were leaving the centre to attend appointments early in the morning. Residents' reported there were often delays in night time staff answering call bells and that on one occasion a resident had to phone their relative to phone the centre in order for staff to answer their call bell. Visitors who spoke to inspectors reported concerns regarding night time staffing levels, in particular, arrangements in place to cover staff sickness and absence as there were four nurses on at night to cover the five units in the centre. They also expressed concern regarding the lack of senior management support for staff particularly at times of staff shortage and during other challenging times, such as, when there was an outbreak of COVID-19.

There was an activity programme in place. Inspectors observed that there was a sensory session provided for residents on the Columba and Iona unit on the morning of inspection. In the afternoon on the Lambay unit there was live music. Apart from this there was limited other recreational and occupational opportunities for meaningful activities observed to be provided to residents on the day of the inspection.

Inspectors observed that there were lengthy periods of time where some residents were observed sitting in communal areas watching television without other meaningful activities. Residents reported that there was 'generally not a lot on in the morning'. Visitors who spoke to inspectors reported that some activities were not appropriate for some residents. For example, on the Lambay unit where some residents had reduced mobility and function in their upper limbs, they were provided with activities such as bingo which required the use of upper limbs.This is discussed further under the quality and safety section of the report.

During the morning handover for staff, inspectors observed that there was a weekly shower/bath schedule in place for residents. Inspectors were provided with a copy of the weekly schedule. Two residents who spoke with inspectors confirmed that they were unable to have showers on a daily basis despite having had a shower on a daily basis prior to admission. Inspectors spoke with staff and they confirmed that there was a schedule in place and that bathing was facilitated once or twice a week.

Inspectors observed instances of poor practices when residents' dignity and privacy were compromised by staff. For example, staff left the bedroom and ensuite door open when providing personal care to one resident. Furthermore, on review of resident council meeting minutes inspectors identified that residents reported issues

relating to their privacy and dignity. For example, residents reported that 'staff pop into other residents' rooms to borrow' continence pads or wipes while residents were still sleeping. Other residents reported repeatedly that they felt that staff treated them like children and ignored their requests for less noise from banging doors and conversations at night time. This had not been addressed despite being brought to the attention of staff on three occasions.

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

Capacity and capability

Overall, inspectors found that there was a high level of non-compliance and improvements were required in clinical oversight and management systems to ensure the service was safe, consistent and of a good quality. Action was required to achieve regulatory compliance for the following regulations; governance and management, fire precautions, staffing, premises, infection control, residents rights, protection, individual assessment and care planning, managing behaviour that challenges and notifications.

The inspection was carried out to monitor compliance with the regulations and to inform the upcoming renewal of registration for Tara Winthrop Private Clinic. A completed application applying for the renewal of the centre's registration had been received by the Chief Inspector prior to the inspection and was under review. Tara Winthrop Private Clinic Limited is the registered provider for Tara Winthrop Private Clinic.

The person in charge had commenced their role in March 2022 and was responsible for the day-to-day running of the centre. Two assistant directors of nursing (ADON) and four clinical nurse managers (CNM) supported the Person in Charge in her role.

During day time, one ADON was present in the centre Monday to Sunday and four CNM's to provide management support to staff. There was an on-call arrangement in place to ensure that there was a senior member of the management team contactable at weekends to provide additional support if required. At night, there was a reduction of supervisory nurses on duty to cover all five units in the centre. This resulted in CNM's providing clinical care to residents and undertaking the role of the staff nurse.

The management systems to monitor the quality and safety of the service provided included a schedule of audits. Inspectors reviewed a sample of completed clinical audits and found that the audits did not identify a number of risks identified during the inspection. Furthermore, inspectors noted during the inspection information provided by senior management was not clear and inspectors had to ask for

clarification. The annual review for 2022 was available on inspection and sets out a quality improvement plan for 2023.

There were insufficient resources to meet the assessed needs of residents. Inspectors found that staffing was insufficient to meet the assessed needs of residents. Staff rosters, for all staff in the centre, from the previous two working weeks and the week of inspection were reviewed. On three occasions, there was an insufficient number of staff on duty to meet the needs of the residents in the centre. Furthermore, on the day of inspection, there was an inadequate number of staff to meet the activities needs of the residents. There were two activity staff to cover the five units. This is a repeat finding from the previous two inspections. This impacted on the provision of meaningful activities to all residents. For example, inspectors observed residents seated in front of the television while it was turned off with loud music playing in the Shennick unit. Contingency plans to cover staff shortages or leave were also found to be inadequate, this is discussed further under regulation 15: staffing.

Inspectors were informed that all staff working in the centre had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 in place prior to commencing employment in Tara Winthrop Private Clinic.

Staff were supported to access mandatory training. Following a review of records gaps in fire safety and manual handling training were identified which could impact on the safe delivery of care to residents. However, a staff educational plan for 2023 was in place and dates for both fire safety and manual handling training were in place with staff scheduled to attend. Further training and supervision was also required to ensure that staff were providing safe, quality care, this is further discussed under regulation 16: training and staff development.

Inspectors reviewed records of incidents in the centre and found that three were not submitted to the Chief Inspector, as set out in Schedule 4 of the regulations.

Inspectors were provided with all Schedule 5 policies and procedures and found that they had been updated at intervals not exceeding three years. Inspectors were provided with a written statement of purpose and found that it did not contain all required information. For example; there were a number of external buildings that were essential to the running of the centre that were not included in the statement of purpose or floor plans of the centre.

Registration Regulation 4: Application for registration or renewal of registration

An application for the renewal of registration of the designated centre had been received by the Chief Inspector and was under review.

Judgment: Compliant

Regulation 15: Staffing

The registered provider did not ensure that the number and skill mix of staff was appropriate and adequate to meet the needs of residents and with due regard for the size and layout of the centre. For example:

- Due to lack of sufficient number of nursing staff on the day of inspection, one Clinical Nursing Manager (CNM) in a unit was providing clinical care which reduced the availability of staff to meet the needs of residents.
- The number of supervisory nurses has been reduced by two, from six CNM's to four. There was a lack of nursing staff resulting in the CNM working at night undertaking the role of a staff nurse.
- There was insufficient staff to provide meaningful activities. Activity staffing levels were inadequate to meet the needs of the 119 residents living in the centre. Three full time and one half time staff members were employed to provide activities. On the day of inspection, one full time activity coordinator and one activity coordinator from another centre in the group were providing this service. Inspectors observed that there was limited opportunity for recreational or occupational activities throughout the day of inspection on all five units of the centre due to staff vacancies and illness.
- From a sample of rosters reviewed, the planned schedule for healthcare assistants had not been met resulting in gaps in the roster. from speaking with staff and residents inspectors found that their assessed care needs such as personal hygiene , assistance with toileting and responding to call bells had not been met.
- A review of the fire drill records found that staffing at night time required review to ensure that there were sufficient staff to safely evacuate residents.

Contingency plans to cover staff shortages or leave were inadequate. Out of the six and a half activity coordinator posts, three were vacant. Inspectors identified that an activity coordinator from a different nursing home within the group had been transferred to Tara Winthrop Private Clinic on the day of inspection and when speaking to inspectors were unfamiliar with the needs of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

A schedule of training was available for review. Inspectors found that fifty five staff were out of date with fire safety training and eleven staff were out of date with manual handling training. Training was planned for both fire safety and manual handling in later June and July.

Additional training and supervision of staff practices were required to ensure safe care delivery in line with evidence-based nursing practices and infection control as evidenced by findings of this inspection. This is further discussed under Regulation 5: Individual assessment and care plan, Regulation 9: Residents' rights, Regulation 27: Infection control and Regulation 29 medicines.

Judgment: Not compliant

Regulation 22: Insurance

The designated centre had a current certificate of insurance which indicated that cover was in place against injury to residents, staff and visitors. It included insurance against other risks, such as loss or damage to residents' property.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that the centre had sufficient resources for the effective delivery of care in accordance with the statement of purpose. Staffing levels were found to be insufficient, and contingency plans to cover staff shortages or leave were found to be inadequate, as detailed under Regulation 15: Staffing.

Insufficient staffing levels resulted in poor oversight of staff practices. For example, some assessments were not completed properly and did not correlate care planning information. Furthermore, inspectors became aware of a safeguarding allegation which had not been recognised as a safeguarding concern.

Management systems in place failed to ensure the service provided was safe, consistent and effectively monitored. Inspectors identified the following concerns:

- There was a lack of oversight of fire safety precautions as identified under Regulation 28, including oversight of fire risks and the safe evacuation of residents. An urgent compliance plan request was submitted to the provider following the inspection to ensure that all residents with high-dependency needs could be evacuated safely. Further assurance was required following the response received.
- The provider had failed to address the actions from compliance plans submitted to the Chief Inspector following the inspections completed in 16 November 2022. For example, Regulation 15: Staffing, Regulation 17: Premises and Regulation 23: Governance and Management had not been addressed.

- The process for the review and management of residents' individual care needs, assessments and care plans required further oversight. For example, inspectors reviewed a sample of assessments and care plans and found that the dependency assessment tool used did not correctly reflect the needs of the residents assessed.
- Oversight for ensuring residents' rights were maintained and supported required strengthening. For example, inspectors observed that there were institutional practices around bathing and personal hygiene for residents. This is further detailed under Regulation 9: Residents' rights.
- Oversight of the medicines practices in the centre was not adequate. Inspectors found a number of issues that had not been identified by the management team, and there was a risk that medication was not being monitored and stored appropriately.
- Appropriate resources and equipment were not available for residents with high-dependency needs as outlined under Regulation 17: Premises.
- Current arrangements for the auditing of infection prevention and control and oversight of cleaning processes did not adequately identify areas that required improvement.
- Oversight systems for the submission of notifications to the Chief Inspector were not effective. Since the last inspection, inspectors found that three notifications had not been submitted as required under Regulation 31: Notifications of Incidents.
- While there was an auditing system in place, the audits were not sufficiently robust to pick up areas for improvement or to provide meaningful information for effective data trending and oversight. For example, the infection prevention and control audits in place did not identify the areas for improvement that inspectors had identified on the day of inspection.
- The oversight and systems for monitoring restrictive practices in the centre were not robust. While restrictive practices were monitored through the centre's key performance indicators and restrictive practice register, some practices were not recognised appropriately. For example, the use of restrictive practices such as bedrails were recognised as environmental restrictive practices and not as physical restrictive practices. Furthermore, although the centre had notified the Chief Inspector in the quarterly notifications about the use of door locks and holding cigarette lighters for residents; these practices were not included on the restraint register. The use of chemical and physical restraints was not on the register.

Judgment: Not compliant

Regulation 3: Statement of purpose

An updated statement of purpose for Tara Winthrop Private Clinic was made available for inspectors and it contained the required information regarding the service and designated centre. However, there was a number of buildings essential

to the operation of the designated centre that was not included in statement of purpose.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Inspectors identified that three notifiable incidents had occurred; however, the Chief Inspector had not received the appropriate notifications. The person in charge submitted the required notifications retrospectively.

Judgment: Not compliant

Regulation 4: Written policies and procedures

All required policies and procedures as set out in Schedule 5 were available to inspectors and had been updated at intervals not exceeding three years.

Judgment: Compliant

Regulation 21: Records

The registered provider failed to ensure that the records set out in Schedule 3 were kept in the designated centre and available for review on inspection. For example:

- Temperature records were not available for all clinical store rooms to ensure that medicine was being stored within professional guidelines.
- Inspectors were unable to review records regarding residents' accounts on the day of inspection as these were not available.

Judgment: Substantially compliant

Quality and safety

Overall the inspectors were not assured that the systems in place overseeing the quality and safety aspects ensured that all residents living in the centre were protected by safe practices which promoted a good quality of life. Management

systems in place had failed to fully oversee aspects of the care of residents and insufficient staff resources available impacted the provision of care for residents. Further action was required by the provider to come into compliance with the regulations, particularly in relation to fire safety, infection control, managing behaviour that is challenging, assessment and care planning, residents' rights, and premises. Improvements were also required in relation to medication management.

Although efforts were made to support residents' rights, action was required to eliminate institutional practices occurring and to ensure that approaches to care were person-centred to ensure that residents' rights were protected and upheld. Opportunities for recreational and occupational activities were found insufficient. Further detail is provided under Regulation 9: Residents' Rights.

Residents spoke to inspectors about how they liked staff, describing them as "lovely". Inspectors also observed kind interactions between staff and residents. However, inspectors found that due to staff shortage residents were required to wait for care.

Residents' social and health care needs were assessed using validated tools; however, inspectors found that some were not completed appropriately and did not correlate with care planning information. Furthermore, some of the residents were admitted to the centre without ensuring that appropriate equipment was available in the centre to meet their personal care needs. This is outlined further under Regulation 5: Individual assessment and care plan.

Restrictive practices required action as they were not always managed in accordance with the national restraint policy and guidelines. Inspectors reviewed incidents where residents displayed responsive behaviours, and inspectors were not assured that all appropriate actions were taken according to the centre's policy. This is discussed in the report under Regulation 7: Managing behaviour that is challenging.

Inspectors reviewed the laundry facilities and found that the laundry area was small and not well laid out with regard to the segregation of clean and dirty laundry. The layout of laundry facilities required review, to prevent the cross contamination of clean clothes.

Inspectors were not assured that medicine practices were in line with the safe storage of medicines professional guidance. The storage of unlocked medicine to be returned to the pharmacy, on a corridor presented a risk to staff and residents.

There were areas of communal, outdoor and private spaces for residents to use. However, as found in the previous inspections, some parts of the premises required improvement. This is discussed under Regulation 17: Premises.

The provider had comprehensive fire safety procedures in place. However, further actions were required in relation to fire precautions to ensure the safe evacuation of residents in the event of a fire, as outlined under Regulation 28: Fire precautions.

Oversight of safeguarding required improvement. During the inspection, inspectors became aware of a safeguarding allegation which had not been recognised as a safeguarding concern. Inspectors also identified that a number of safeguarding concerns had not been notified to the chief inspector. This is outlined under Regulation 8: Protection.

Regulation 17: Premises

Inspectors identified that some areas of the premises did not comply with the requirements set out in schedule 6 of the regulations as follows;

- There was inadequate ventilation in the clinical rooms and stores across all units in the centre. As a result of this, appropriate temperatures could not be maintained to ensure the safe and appropriate storage of medicines and nutritional supplements.
- There was inappropriate storage around the centre. For example, access to the toilet was blocked by three shower chairs in the communal bathroom and two hoists were stored in the corridors or in the day room.
- The ventilation in the linen room on the first floor was not effective and resulted in a strong odour of urine.
- Specialised showering equipment was not available for residents with high-dependency needs.
- Some areas of the centre required maintenance or replacement; a door handle was broken in the communal bathroom, a shower rail was found to be rusted, and seating throughout the centre was identified as too low to support residents' freedom of movement.

Furthermore, a number of repeat findings were identified.These are detailed below:

- Not all bedrooms had a lockable storage space available to residents for the safe keeping of personal money and valuables.
- Room signage had not yet been reviewed in order to reflect the purpose of the rooms.
- Progress had not been made to improve the layout of the other multi-occupancy rooms. For example, some twin bedrooms did not have enough floor space to include a bed, a chair and personal storage space for each resident.
- There were several areas outside used for smoking; these areas had no shelter or call-bell. However, some call-bells were installed on the day of the inspection.

Judgment: Not compliant

Regulation 27: Infection control

The oversight of infection prevention and control practices required strengthening to ensure it was robust and in line with the National Standards for infection prevention and control in communities in 2018. For example;

- There was inappropriate storage of residents' equipment in communal bathrooms and some store rooms and medical equipment, such as nebulisers in store rooms which could result in cross contamination.
- An open sharps bin container was stored in the resident's bedroom, and the temporary closing mechanism was not in use. This increased the risk of staff sustaining a needle stick injury.
- Equipment such as shower chairs and nebulisers were observed to be unclean. Some equipment, such as grabrails, were rusty. This compromised the effective cleaning of those items and increased the risk of cross infection.
- There was inadequate oversight of staff PPE practices. For example, some staff did not consistently wear face masks correctly in line with national guidance.
- The covering on the walls and floor in the shower rooms were peeling off.
- There were insufficient local assurance mechanisms in place to ensure that the environment and some equipment was decontaminated and maintained to minimise the risk of transmitting healthcare-associated infections. For example; the cleaning checklist systems used for day-to-day cleaning were not filled in on a daily basis.
- Units used for personal protective equipment (PPE) equipment storage in the corridors were observed to be very unclean.
- A cleaning cabinet with chemicals and cleaning equipment beside the main kitchen was seen unlocked. The facility was unclean and stained. This increased the risk of cross contamination.
- The laundry areas was not managed in a way that reduced the risk of cross infection. The system in place to ensure that items for laundering moved from the dirty area to the clean area was not implemented, as evidenced by the storage of linen bags containing soiled linen and in the clean linen area of the laundry. Additionally, clean laundry, such as mops, were stored beside the mops waiting to be washed.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. For example;

- The personal emergency evacuation plans for two residents with high-dependency needs did not contain sufficient information to ensure the safe and timely evacuation of residents from the centre, in line with their assessed

needs. The information was not readily accessible to staff in the event of a fire emergency. This was rectified on the day of the inspection.

- Inspectors observed that there was no suitable fire evacuation equipment for three residents with specific high-dependency needs. Additionally, there was no fire drill completed on how to safely evacuate these residents in the event of a fire emergency. Following the inspection, an urgent compliance plan was sought to ensure the registered provider made adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.
- Inspectors observed that some of the evacuation routes and fire equipment were obstructed by residents' equipment such as hoists and trolleys.
- Some of the escape signs were not working as they were not lighting up on some evacuation routes.
- An external fire exit route was not safe, leading through a busy car park area beside the fire exit; additional emergency lighting was required to illuminate the route of escape in the event of a fire evacuation at night time.
- The fire assembly point signs outside at the back of the centre were not visible.
- There were no fire safety signs where the oxygen cylinders or concentrators were in store or use.
- Combustible materials such as paint were stored in the electrical store room.
- The fire containment in some areas around the centre was compromised as inspectors observed holes in the wall beside the high voltage box in one of the store rooms on the first floor and in the electrical room.
- Although staff had received fire safety training they had failed to recognise that suitable fire evacuation equipment was not available for all residents. Furthermore, some escapes routes and fire fighting equipment were impeded and not always easily accessible. For example, equipment such as hoists were stored in front of fire extinguishers blocking easy access to this equipment and a large washing storage bin blocked an escape route.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors were not assured that medicine practices were in line with the safe storage of medicines professional guidance. For example:

- Two unlocked boxes with medicines prepared to be returned to the pharmacy were left unattended on the unit corridor in the Lambay unit.
- Some medicinal products supplied for residents were not stored safely or in line with the product advice. For example, some of the records showed a room temperature of 26 degrees Celsius for a number of days. Labelling of some of the medicines stored stated that storage was required at a temperature maximum of up to 25 degrees Celsius.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed the assessments and care plans and found that the dependency assessment tool was not being used correctly to reflect the needs of the residents. For example, the assessment stated that the resident was able to walk with the assistance of one person; however, the manual handling assessment stated that the resident was unable to walk and required a hoist transfer.

There was no evidence that appropriate health and social care professionals, such as occupational therapists, were involved in the resident's comprehensive assessment to ensure that the resident had availed of appropriate care with suitable equipment.

While the personal care plan stated that two residents with high-dependency needs would like to have showers at least once a week, this was not provided as there was no bariatric specialised shower equipment available.

Inspectors identified for one resident who smoked that there was unclear information to guide staff regarding the measures in place to keep the resident safe when smoking. For example, the care plan indicated that the resident required 'intermittent supervision' when smoking. When inspectors asked for further information regarding what this meant in practice, staff were unclear regarding what level of supervision was required and provided.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

A review of residents' care plans in relation to 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) found that responsive behaviours were not appropriately managed within the centre. Where a resident expressed responsive behaviour, and the care plans stated that the appropriate assessment tool should be used to assess the residents' needs, this assessment was not completed. On another occasion, there was no care plan available with a description of triggers and de-escalations techniques to guide the care staff in safe care delivery.

In the Shennick unit, inspectors were informed and observed that all bathroom and toilet facilities, with the exception of a bathroom closest to the main sitting area,

were locked in response to behaviours of concern. This was restrictive on the other residents living in this unit.

Judgment: Not compliant

Regulation 8: Protection

Inspectors found that there were no clear records regarding reports or investigations of allegations, incidents or concerns of a safeguarding nature. Inspectors also found that three safeguarding concerns had not been reported to the Chief Inspector.

Safeguarding care plans to direct staff were found to be inadequate. For example; a concern had been raised regarding a resident which had not been identified as a safeguarding concern. A safeguarding plan was found to be in place regarding another concern for this resident however it did not detail the steps for staff to take to keep the resident safe. For another resident inspectors found that there was no safeguarding plan in place, only reference to a referral to advocacy services in a communication care plan, despite a safeguarding concern having being raised.

The registered provider acted as a pension agent for 10 residents at the time of the inspection.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors identified the following issues that impacted on residents' rights in the centre.

- Inspectors observed practices which were institutionalised rather than person-centred. For example; residents were allocated days when they were scheduled for a shower. This resulted in residents being offered showers on certain days and not as stated in their care plans on a daily basis.
- Staff did not always support residents' right to privacy and dignity when providing personal care to residents. For example, inspectors, while standing in the corridor, overheard staff and the resident while providing personal care as both the resident's bedroom and en-suite doors were open.
- Residents reported in their meeting that staff were putting residents to bed without asking if residents wanted or consented first. A resident experienced staff repeatedly asking if they wanted to wear incontinence pads despite the resident not being incontinent. Inspectors observed task-orientated care during meal times; for example, staff placed clothing protectors on residents without asking residents if they consented to wear the protector first.

- Residents occupying multi-occupancy bedrooms were not afforded the opportunity to undertake all personal activities in private due to the layout of the rooms. This had been identified on the last inspection.

Inspectors were not assured that all residents had the opportunity to participate in activities in accordance with their interests and capabilities. For example:

- Inspectors observed high dependency residents in the sitting area beside the nursing desk on the Columba and Iona units, both being able to fully participate in an exercise activity. At the time, the area was observed to be crowded and over-stimulating, with music playing loudly as well as a television playing in the same area.
- Feedback received from visitors indicated that the activities available to residents were not always appropriate to residents' capabilities or age, and the activity programme required further development, particularly as a number of younger residents resided in the centre. For example; for some residents who no longer had upper limb function, activities such as bingo were not appropriate as residents could not physically engage.
- Inspectors observed in a number of communal areas throughout the inspection that there were insufficient meaningful activities. For example, in the Shennick unit, inspectors observed that throughout the day there was no meaningful activation provided on this unit for residents. Inspectors observed 16 residents sitting in the sitting room in the morning where music was playing. Residents were sat in rows of seats which were arranged so that residents sat with their backs to other residents. Most residents were sat silently while others were asleep. When inspectors asked why all the residents were sitting facing the television when it was turned off, staff responded by turning the television on and leaving it on a channel displaying cartoon programmes. This was not appropriate activation for residents.

Judgment: Not 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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Compliant
Regulation 21: Records	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Tara Winthrop Private Clinic Ltd. OSV-0000183

Inspection ID: MON-0040242

Date of inspection: 19/06/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
On the day of inspection, there was adequate nursing staff numbers in line with the occupancy and assessed needs of the residents on the day. This is reviewed on an ongoing basis within the centre.

On the day shift there were 3 CNMs and 8 nurses on day duty. These were also supported by an ADON and the PIC.

Furthermore 1 additional RGN post is being added to the night time complement to support the CNM on night duty remaining supernumerary to improve supervision and oversight. Recruitment for this role will be completed by the 31st of August 2023.

Recruitment is ongoing for the activity coordinators post within the home and has been over an extended period of time. It is imperative that the most suitable candidate are chosen for such a pivotal role. Contingency measures such as the use of other staff from within the group will continue. And this will be supported with staff delegated to complete activities on a day-to-day basis in the interim. This will be overseen by the Clinical Nurse Managers on each unit.

External activities will be contracted to provide additional activities within the home on an ongoing basis. The activities schedule including external activity services will be displayed at reception and within each unit. This will be in place from September 1st of 2023. This will be overseen by the ADON.

Based on the occupancy on the day of inspection, there was an adequate number of staff in place in the centre. This will be reviewed on an ongoing basis, with consideration given to a review of processes of work and organisation of work on a daily basis to ensure the needs can be met. A full review of the dependency levels of all residents was undertaken with new assessment tools. This was completed for all residents on the 31st of July 2023. This will be monitored by the ADONs on a monthly basis.

A fire evacuation strategy was developed in conjunction with a competent, external fire safety expert and the current staffing levels at night are adequate to safely evacuate residents in line with current staffing levels. This was completed by the 4th, August 2023.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
It is acknowledged that on the day of inspection, there were 55 staff members out of date in fire training and 11 in manual handling. On the day of inspection, the inspectors were aware that these trainings had been scheduled and have been completed now. Going forward, a review will be undertaken of the training matrix every quarter, to proactively schedule training before it expires for any staff member.

Ongoing review of training needs is underway within the centre. The Person in Charge has responsibility for oversight of training in line with the regulation.

Fire drills are completed locally on each unit, to ensure that staff have participated in regular fire drills. This is monitored with oversight by the CNM on each unit and reviewed by the PIC and GM. The attendance of fire drills will be monitored on a monthly basis at the senior managers meeting.

A full review will be undertaken of the training needs within the centre, with additional training scheduled on a number of areas as outlined in the report. These will be completed for all staff by the 31st of October 2023. Education sessions on person centred care and dementia are being delivered with staff by the Medical Officer on site on an ongoing basis.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review was undertaken of the current governance structure and roles and responsibilities of the senior management team. A General Manager post is being introduced to the governance structure to support the senior management team in their delivery of quality services in line with the regulations. The recruitment of the GM role is ongoing. In the interim a temporary arrangement is in place with a senior management personnel from the group since the 1st of August 2023.

Assurances were provided following the inspection of fire safety precautions. These

included the purchase of additional fire evacuation equipment, a review of the fire evacuation strategy and the completion of additional fire drills. These were completed by the 4th, August 2023.

Any outstanding actions from the compliance plans have been reviewed and will be incorporated into this action plan. Weekly meetings will be held by the Senior management team and group management team to improve oversight of any outstanding actions. This was commenced on 1st of August 2023.

A review was undertaken of the assessment process within the home and introduction of more suitable dependency assessment tools was completed by 31st of July 2023. All staff have been communicated with to ensure their understanding. These are being audited on an ongoing basis by the ADON to ensure that they correctly reflect the needs of the residents. This will be completed by September 30th, 2023.

A review of clinical practice has been undertaken to ensure a person centred approach to care. This is monitored on an ongoing basis by the CNMs of each unit. Resident's preferences are clearly documented within their care plans. The documentation and review of same will be completed by 31st of August 2023 and on an ongoing basis thereafter.

Auditing processes will be supported by peer led audits and audit training will be provided to the clinical team. This will be completed by October 31st, 2023. An external IPC expert will be auditing processes within the home on the 1st of September with training scheduled for care and hygiene staff on the 1st of September.

Education on incident reporting for all staff will be completed by September 30th. A weekly report is in place of all incidents and potential notifications and is reviewed by the senior management team to ensure that notifications are identified and submitted appropriately. This has been in place since 31st of July 2023.

A full review of the monitoring and documenting of restrictive practice within the centre has been completed. A restraint register is now in place for all restrictive practices including environmental, physical, and chemical. This is maintained by the Clinical Nurse Managers of each unit and reviewed by the Person in Charge on a weekly basis.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The external maintenance shed, and storage units have been added to the Statement of Purpose and a copy was sent to the inspector on the 4th of July 2023 for review.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The three notifiable safeguarding incidents which were reported to the relevant safeguarding team and SAGE advocacy were then retrospectively notified to the Inspector on 20th June 2023.

With immediate effect from the HIQA inspection feedback meeting, the Director of Nursing and all Senior Management team have full insight into incidents to be notified to the inspector. Where there is any doubt in notifying incidents, the Director of Nursing will contact the inspector for clarification.

Training for the ADONs on the statutory notifications of incidents will be delivered by the group quality team by 17th August 2023.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The Assistant Director of Nursing has oversight daily on the temperature record checks while completing their daily nursing round. This is in place since June 19th, 2023.

All records are kept at the centre and were available on the day and will be moving forward

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Maintenance has completed a review of ventilation, and temperature control in clinical and storerooms. As a result, new environmental thermometers have been purchased. This was completed on the 15th of August with maintenance review ongoing.

A complete review of storage facilities and storage use is underway within the centre by the General Manager. The aim of this review is to reconfigure and improve use of storage facilities within the centre. This will be completed by September 30th 2023.

All required specialist showering equipment has been purchased and assigned to the appropriate residents. This was completed by the 26th of July 2023.

There is maintenance staff on duty daily within the centre, their schedule of works is reviewed with the General Manager daily to progress any outstanding actions. In addition, an electronic app to oversee and plan maintenance works will be introduced in the home by the 30th of September 2023.

There will be regular maintenance meetings held with the General manager and maintenance team to ensure works are completed within the home.
An external company has been contracted to complete the works of installing locks into the current storage within residents' room. This work will be completed by September 30th 2023.

Room signage installation was in progress on the day of inspection and was completed on the 25th of July 2023.

At the time of inspection, there was a plan in place to address the layout of multi-occupancy rooms. Railings are being installed to facilitate appropriate storage and personal space for residents in multi-occupancy rooms. Date previously given for completion of these works was June 2024 to allow for the challenges of delivery. This works will be completed by the 30th, September 2023.

An allocated smoking shed has been ordered and will be installed outside Lambay unit courtyard and in use by 30th of September 2023. Call bells have been installed in all smoking areas; this was completed on June 20th 2023.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A complete review of storage facilities and storage use is underway within the centre, to be completed by September 30th 2023. Ongoing supervision of correct storage will be completed on a regular basis by the Clinical Nurse Managers and ADONs with feedback given to all staff in a timely manner to ensure adherence.

Education sessions to be delivered to all staff on the proper use and management of sharps. This will be completed by August 31st, 2023, by the ADONs and PIC.

Any damaged equipment has been removed and replacement programme underway. Ongoing supervision of cleaning processes will be introduced and managed by the senior management team. This was introduced in July 2023 with ongoing review of same.

All staff have been requested to complete online training on PPE use by the 30th of August 2023. Their compliance will be audited on a regular basis by the management team, and feedback or any required improvement addressed. These audits will be completed by September 30th, 2023. An external IPC competent person will complete an audit and education sessions by the 10th of September 2023.

The cabinet beside the main kitchen has had a lock installed on the 20th of June 2023. This cabinet is cleaned daily by the kitchen staff after their shift. This is monitored by the Head Chef on the day and the Group Catering Manager.

A review of the flow of works in the laundry was completed and the machines have been separated by a divider to ensure no cross contamination of clean and dirty laundry. This was completed on July 14th, 2023, with ongoing supervision by the General Manager to ensure that correct process is being adhered to.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: A full review of all PEEPs within the home was completed and updates were made where required. All PEEPs are located in the wardrobe of the residents for ease of access and visibility. This was completed by June 30th, 2023. There is ongoing monitoring of same by the CNMs on the unit with additional oversight by the ADONs and PIC on a weekly basis.

Additional fire evacuation equipment for those residents with high dependency needs has been purchased and is in place since 31st of July 2023. An urgent compliance plan was submitted to the inspectorate following the inspection. Ongoing monitoring is in place by the senior management team to ensure that any necessary actions are completed.

The external fire exit through the car park was reviewed. This fire route has been deemed appropriate by an external competent fire safety expert as part of the centres fire evacuation strategy.

There is no fire assembly point at the back car park however the Fire Emergency Lights will lead to the front of the building where the Assembly Point is located. An assessment will be carried out by an external Fire Safety specialist in relation to additional emergency lighting on the 25th of August 2023. Completion dates for installing the emergency lighting will be dictated from this assessment.

Any rooms with oxygen cylinders or concentrators stored or in use, now have visible Oxygen signs in place. This was completed on June 20th, 2023.

Any combustible material has been removed from the electrical storeroom. This is monitored on an ongoing basis to ensure no reoccurrence by the maintenance team. This was completed on June 20th, 2023.

The hole identified beside the high voltage box in one of the storerooms has been filled and therefore fire containment is not compromised. This was completed on July 31st, 2023.

The senior nurse allocated on each shift completes a daily Fire Safety checklist at the beginning of shift. This process is reviewed daily via spot checks by the ADON / CNM on duty and weekly oversight from the PIC. This will be reviewed and completed by September 30th, 2023.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The process around medication storage was reviewed within the centre with all returns to pharmacy now stored and locked behind the nurse's station. All staff have been communicated with and this process will be reviewed on an ongoing basis by the senior management team to ensure adherence. This was completed by June 30th, 2023.

Maintenance has completed a review of ventilation, and temperature control in clinical and storerooms. As a result, new environmental thermometers have been purchased to ensure temperatures are recorded in a timely manner.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A review was undertaken of the assessment process within the home and introduction of more suitable dependency assessment tools was completed on 25th, July 2023. All staff have been communicated with to ensure their understanding. This process will be audited on a monthly basis by the clinical nurse managers, any feedback from findings will be communicated with all staff and any quality improvements addressed.

Education to be completed with nursing staff to ensure comprehension of the revised assessment tools. An audit will be completed by September 30th, 2023. Ongoing auditing and monitoring will be completed by the senior management team with feedback, or any required improvement addressed.

There is a national delay in OT referrals to the HSE. The centre will continue to refer to public OT and, in the interim, encourage private OT referrals if required based on residents needs and in agreement with the resident/their family. There is a process in place within the centre in the management of referrals. Physiotherapy service is provided on site, and they are involved with the admission assessment process.

All required bariatric equipment is in place and used in line with the preferences of the individual resident. This was completed on the 25th of July 2023.

All smoking care plans to be updated in line with residents' preferences and required care needs. All staff caring for residents who smoke are aware of their needs as indicated in their care plans through regular communication such as handover and safety huddles. Audits will be completed on these care plans by September 30th and any required quality improvements will be managed by the management team.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Full review of all care plans with responsive behaviours and assessments will be completed by the PIC and ADONs. All care plans will be updated in line with best practice and in accordance with the assessments completed for the required needs of the residents. This will be completed with oversight from the senior management team, through ongoing audit and review by 30th September 2023.

The practice of locking bathroom doors in Shennick is no longer in place. This was discontinued immediately post inspection on June 19th, 2023. Ongoing supervision and management of a resident with behaviours of concern is in place by the team.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All staff have completed online safeguarding training. All members of the senior management team to complete relevant Safeguarding training to ensure their understanding, identification, and escalation of any potential safeguarding issue.

A weekly report has been introduced of all incidents and potential notifications for review by the senior management team to ensure that notifications are identified and submitted appropriately. This has been in place since July 31st 2023.

The three notifiable safeguarding incidents had been reported to Safeguarding and SAGE advocacy and were retrospectively reported to the inspector on the 20th of June 2023.

All safeguarding care plans have been reviewed for all residents to ensure clear directives are given to staff relating to the management of the care of these residents. There will be ongoing monitoring and oversight from the senior management team, with an audit to be completed by 31st August 2023.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
All residents are offered and encouraged showers daily, this is clearly documented in their care plans. A review of residents' shower status is completed by the CNMs on duty

daily to ensure residents hygiene is prioritised.

There are policies and procedures in place for the management of dignity and respect of our residents. Informal education is being delivered on dignity and respect and person centred care to all staff. This was completed in July 2023 and is an ongoing training to be completed by all staff by September 31st, 2023. Supervision and monitoring are ongoing by the senior management team.

At the time of inspection, there was a plan in place to address the layout of multi-occupancy rooms. This is being completed at group level for a number of different homes with ongoing prioritisation changing in line with HIQA demands. Railings are being installed to facilitate appropriate storage and personal space for residents in multi-occupancy rooms. Date previously given for completion of these works was June 2024 to allow for the challenges of delivery. This will be completed by the 30th, September 2023.

Activities survey to be completed with residents by 30th of September 2023. The activities programme is being reviewed throughout the entire home with oversight by the ADON.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/08/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	06/09/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/08/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Not Compliant	Orange	30/09/2023

	provide premises which conform to the matters set out in Schedule 6.			
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	20/06/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	19/06/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	23/07/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/10/2023
Regulation 27	The registered provider shall ensure that procedures,	Not Compliant	Orange	30/09/2023

	consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/07/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Orange	06/09/2023
Regulation 28(1)(e)	The registered provider shall	Not Compliant	Orange	31/07/2023

	ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Red	23/06/2023
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	15/08/2023
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner,	Not Compliant	Orange	30/06/2023

	segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	04/07/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	20/06/2023
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	Not Compliant	Orange	30/09/2023

	accordance with paragraph (2).			
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.	Not Compliant	Orange	25/07/2023
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	19/06/2023
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	30/09/2023

Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	30/09/2023
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	30/09/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/09/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	30/09/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	30/09/2023