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:	Cherry Orchard Hospital
Name of provider:	Health Service Executive
Address of centre:	Cherry Orchard Hospital, Ballyfermot, Dublin 10
Type of inspection:	Unannounced
Date of inspection:	04 May 2023
Centre ID:	OSV-0000508
Fieldwork ID:	MON-0038958

About the designated centre

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

This centre comprises of 113 continuing elderly care beds. The centre is registered to provide 24-hour care to male and female residents. Full nursing care is available based on individualised care planning. Education is provided for nursing staff so that residents with all levels of medical needs can be cared for in the units. Health care assistants work with the registered nursing staff to provide a high standard of care to all clients. The nursing staff work under the guidance of the ward manager, supported by clinical nurse specialists and nursing administration. Included in the staff is a Clinical Nurse Specialist (CNS) in behavioural therapy and dementia. Other services are available from social and health care professionals, which include physiotherapy, occupational therapy, and social work, and there is a chaplaincy programme. The residential facilities compromise of four units- The Beech, Aspen, Willow and Sycamore. The bed capacities range from 12 to 43 residents. It is composed of single, twin, and triple-bedded bedrooms. Beech and Aspen are dementia-specific units. Both the Willow and Sycamore units have a large sitting room, dining room, physiotherapy room, occupational therapy room, snoezelen room, activity room, and a quiet room/communal room. There is also access to a large secure garden and smaller gardens.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	109

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
Thursday 4 May 2023	09:00hrs to 19:05hrs	Helena Budzicz	Lead
Thursday 4 May 2023	09:00hrs to 19:05hrs	Manuela Cristea	Support
Thursday 4 May 2023	09:00hrs to 19:05hrs	Siobhan Nunn	Support

What residents told us and what inspectors observed

From the observations of the inspectors and from speaking with residents, it was evident that residents were provided with a good standard of care by a dedicated team who knew their needs well. The inspectors met with many of the 109 residents living in the centre on the day of the inspection and spoke with 18 residents in more detail to gain insight into their experience of living in the centre.

Following an initial meeting, the person in charge and assistant director of nursing accompanied inspectors on a walk around the centre. Residents' accommodations and living space were laid out over four units within a campus-style setting. There was a warm and welcoming atmosphere across all units, which was apparent to inspectors. Residents expressed a high level of satisfaction with the support they received from staff. Staff were observed supervising residents in communal areas, including the dining room, where they provided assistance to residents when required.

The centre had plenty of communal spaces for residents' use. However, there had been very little progression in the provision of flooring replacement in the Sycamore and Willow unit since the previous inspection. Inspectors saw that only a few bathrooms were repaired, and most of the en-suites had uneven flooring, which did not provide assurance that they were safe. At the time of inspection and following a risk assessment, the en-suite of one bedroom had been taken out of use pending repair work, as it was deemed unsafe by the management of the centre. Alternative arrangements had not been made for this resident to access a bathroom facility. Inspectors requested the risk assessment and structural assessment of the building on the day of the inspection.

Inspectors observed that some improvements had been made to the Beech unit. An additional communal shower room had been installed, four-bedded occupancy rooms had been renovated, and occupancy reduced to three. However, renovation works had not been completed on the main corridor or the day room, and this resulted in these areas having an institutional appearance which did not provide for a homely environment for the residents living there. In addition, inspectors observed the corridor cluttered with large wheelchairs, which obstructed residents' free movement.

Residents' bedroom accommodation consisted of a mixture of single and twin, and triple-occupancy bedrooms. Residents' bedroom accommodation was spacious; however, inspectors observed that not all residents in triple-occupancy bedrooms had adequate storage space for residents' belongings.

As the day progressed, the majority of residents were observed in the various communal areas, watching TV, reading or participating in activities. Inspectors observed staff and residents having good-humoured banter during the activities and observed the staff chatting with residents about their personal interests and family

members.

The inspectors observed that a variety of drinks and snacks were offered and served throughout the day. The daily menu was displayed, which offered a choice. Meals served at dinner and tea time looked very appetising, with additional portions being served up where requested. There were adequate staff members to provide assistance; residents were encouraged and facilitated to have their meals independently.

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

Capacity and capability

Overall, the provider strived to provide a good service; however, this inspection found significant concerns in respect of premises and a lack of progress made by the provider to mitigate identified structural risks. While improvements in respect of medicine management were required, the overall quality of care provided to the residents living at the centre was of a good standard.

This was an unannounced risk inspection carried out by inspectors of social services to monitor compliance with the Heath Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors followed up on the actions taken by the provider to address areas of non-compliance found on the last inspection in January 2022 and to follow up on the works completed in relation to Condition 4 of the centre's registration.

The findings of this inspection were that the provider had taken some action to ensure the premises were appropriately maintained to meet the needs of the residents in the Beech and Aspen unit, albeit the standard of work completed in Beech was significantly poorer and not all required work had been completed as described in the section above 'What residents told us and what inspectors observed'. Notwithstanding those actions, this inspection found that there were other aspects of the premises, especially in relation to unstable flooring in the Sycamore and Willow unit and the provider's management systems, that did not ensure that all aspects of the service were appropriately monitored and risk assessed. Additionally, the purpose of some areas of the premises was changed without informing the Chief Inspector. As a result, the premises were not used in line with Condition 1 of registration. Following engagement with the Office of the Chief Inspector of Social Services, the provider gave assurances that the necessary action would be taken to comply with the regulations. The impact of these findings is discussed throughout the report.

The Health Service Executive is the registered provider for Cherry Orchard Hospital.

There is an established and well-defined management and governance structure in place. The management team consists of a recently appointed person in charge, assistant directors of nursing, clinical nurse managers and a team of nursing staff, health care assistants, hospitality and catering staff.

The inspectors reviewed the systems in place to manage the ongoing risk to the quality of care and the safety of the residents and found that the provider had implemented and completed a number of audits for identifying and managing risks in the centre. However, further action was required in relation to the systems in place to ensure oversight of residents' nutrition and hydration needs, medication management, fire risks and health and safety risks as outlined under Regulation 23: Governance and management.

There was evidence of regular meetings with heads of department within the centre to review key-clinical and operational aspects of the service. Records of these meetings were maintained with the agenda discussed and the actions that were agreed upon.

A comprehensive annual review of the quality of the service in 2022 had been completed by the registered provider, and there was evidence of consultation with residents and their families.

The inspectors found that the registered provider had maintained staffing levels in line with the number of staff identified in the designated centre's statement of purpose, and there was ongoing recruitment in place.

Staff had access to education and training appropriate to their role, and a training schedule was in place.

There was a suite of policies available to guide staff. However, inspectors found that some policies were not regularly updated and reviewed, and the fire policy was not available. Additionally, inspectors found that staff did not consistently adhere to the centre's policy on medication management and best-evidenced practice as discussed under Regulation 29: Medicines and pharmaceutical services.

The contract for the provision of services had been reviewed, and inspectors found that some improvements required to the contracts of care are discussed further under Regulation 24: Contact of service provision.

Regulation 16: Training and staff development

While the staff members in the centre were provided with access to appropriate training and the training records were maintained up-to-date. Staff were observed to be appropriately supervised on the day of inspection.

Judgment: Compliant

Regulation 21: Records

The registered provider ensured that all records required in Schedules 3 and 4 of the regulations were correctly and securely stored and available for inspection.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that the provider was in breach of Condition 1 of its registration certificate as areas in the centre designated for residents' use had changed the purpose and were used as a staff and storage facility, which was not in line with the registered statement of purpose.

While there were comprehensive management systems established, some of the management systems and managerial oversight in place to oversee the effective running of the service were not sufficiently robust, as not all issues identified from the previous inspections were adequately addressed. The inspectors identified a number of outstanding issues:

- Inspectors observed little progress in respect of the floor replacements in the Willow and Sycamore units. The current state of the flooring in all areas of these units appeared to pose an ongoing health and safety issue for all residents, staff and visitors. This is discussed in more detail under Regulation 17: Premises.
- While the monitoring systems for monitoring residents' weights and risk of malnutrition were in place in each unit, the information from these monitoring was not effectively communicated to the managements of the centre as seen on the day of the inspection.
- The medication management systems had failed to identify a number of medication errors identified on the day of the inspection, and these errors had not been recognised by the management team during the medication management audit.
- Oversight of fire safety required strengthening to ensure that all members of the management team were aware of fire safety policy and associated risks.
- An immediate compliance request was issued to the provider on the day of inspection in respect of ensuring all residents had unrestricted access to appropriate shower and toilet facilities

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of contracts of care was reviewed, and inspectors found that no contract had a room number agreed with the residents, and only three contracts stated the occupancy of the bedroom in which the resident was due to reside. One of the residents' contracts of care did not contain the fees to be charged, and none of the contracts reviewed had the extra costs for additional services outlined or the process for refunds, if applicable.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies, as required under Schedule 5 of the regulations, were available; however, they required full review. For example:

- 12 out of 20 policies had not been updated at intervals not exceeding three years.
- There was no Fire safety management policy in place.
- The medicine policy was not updated in line with best practice guidelines such as NMBI Guidance for Registered Nurses and Midwives on Medicine Administration (2020).

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge was recruited to the role in March 2023 and was found to meet the requirements of the regulations in terms of qualifications and experience.

Judgment: Compliant

Quality and safety

Overall, inspectors found that residents were supported to have a good quality of life, and the care and support given to residents were respectful; staff were kind and facilitated care in a friendly manner. However, inspectors observed that not all premises provided a safe and comfortable environment for residents. Further action

is required with respect to fire precautions, infection control, end-of-life care, food and nutrition, information for residents and medication management to ensure full compliance with the regulation.

Residents were provided with access to appropriate medical care, with residents' general practitioners (GPs) providing on-site reviews. Residents were also provided with access to other health and social care professionals in line with their assessed needs.

There were systems in place for the assessment, planning, implementation and review of the health and social care needs of the residents. The inspectors reviewed a sample of residents' records and saw that a variety of validated tools were used to appropriately assess the residents.

The care plans were reviewed for a number of residents with Multi-Drug Resistant Organisms (MDROs) and COVID-19 infections. The care plans outlined the appropriate precautions to prevent the ongoing spread and potential infection cross-contamination when caring for residents that were colonised with MDROs.

End-of-life care preferences and wishes were documented in residents' care plans. However, inspectors found that while end-of-life care plans were regularly evaluated, there was no evidence of regular review between staff and residents or their nominated representative. This is addressed under Regulation 5: Individual assessment and care plan.

Inspectors identified some gaps in respect of the resident's guide as identified under Regulation 20: Information for residents.

A number of issues were identified through the course of the inspection, which were not consistent with effective infection prevention and control measures. For example, inspectors observed that not all staff members adhered to the correct personal protective equipment (PPE) use, and some resident equipment and floors were observed to be visibly unclean.

There were significant findings in respect of premises, specifically the safety of flooring in Sycamore and Willow units and the failure to implement a home-like environment in Beech unit, as addressed in detail under Regulation 17: Premises. Furthermore, the inspectors found areas of premises that did not correspond with the floor plan and statement fo purpose, as registered by the Chief Inspector.

Residents had access to pharmacy services on the campus. Medication administration charts and controlled drug records were maintained in line with professional guidelines. However, the medication administration practices were not effectively monitored, and some improvements were required in the management of medications as outlined under Regulation 29: Medicines and Pharmaceutical services.

Residents had access to televisions, newspapers and radios. Residents were supported to exercise their civil, political and religious rights. Residents had access

to external advocacy services.

Safety equipment was serviced on an annual basis, and quarterly servicing was undertaken on emergency lighting and the fire alarm. Fire safety training had been provided to staff. However, inspectors identified fire safety issues, some of which were ongoing issues identified on the previous inspection in February 2022. Therefore improvements were required by the provider to bring the centre into compliance, as evidenced under Regulation 28: Fire Precautions.

Regulation 10: Communication difficulties

Care plans reviewed for residents with communication difficulties were descriptive of the nature of the communication support required by residents and different methods to be used to help residents to express their feelings and words.

Judgment: Compliant

Regulation 13: End of life

The centre had access to specialist palliative care services to provide further support to residents. Each resident continues to receive care which respects their dignity and autonomy and meets their physical, emotional, social and spiritual needs.

Judgment: Compliant

Regulation 17: Premises

Inspectors observed discrepancies in the current use of the premises and the registered statement of purpose and floor plan. For example, the communal toilet in the Willow unit was converted to a staff toilet. The Archive room in the Sycamore unit was converted into a kitchen supply store room. None of these changes had been notified to the Chief Inspector.

The inspectors observed that the registered provider did not provide premises that conformed to all matters as set out in Schedule 6. For example;

- Inspectors observed unstable and damaged flooring in all bathrooms, corridors and communal areas in the Sycamore and Willow units.
- The floor covering was damaged and patched in several places, and the sub-floor appeared to be moving and sloping, especially around the entrance to the residents' en-suite bathrooms, mostly around the toilet and shower

corners. There appeared to be a risk of the floor collapsing under the pressure from the furniture, wheelchairs, equipment and people standing on the floor. Inspectors were shown six bathrooms which had been renovated; however, in one of these bathrooms, the flooring was starting to show a ridge near the shower corner. Inspectors were not assured that the Sycamore and Willow units were of sound structure and requested a structural assessment to be submitted to the Chief Inspector's office.

- The bathroom in a resident's bedroom in the Willow unit had been out-of-order for over a week due to the identified risks to the floor. This resident had no access to a communal shower facility in this unit. An immediate compliance request was issued to the provider, and assurances were received following the inspection that appropriate action had been taken to ensure this resident had access to appropriate sanitary facilities.
- Although the Beech unit had been recently refurbished, not all works had been completed, and the unit was not in a good state of repair internally. For example, inspectors observed that the flooring was damaged, heavily marked with paint, pulling off, and gaps started to occur in the corners. In one of the newly created communal bathroom, the flooring appeared dirty and heavily marked, despite being recently cleaned. Four bedded rooms had been converted into communal spaces such as dining and sitting room, yet the medical bed head trunking, including sockets, switches and medical gas outlets, had not been removed. This was also the case in the Snoezelen room. Despite attempts to create a homelike environment, the premises in the Beech unit remained medical in appearance and lacked the warmth and comfort of a home.
- The storage for residents' mobility equipment, such as wheelchairs, was not adequate. Inspectors observed six wheelchairs lined up on the corridor in Beech unit, blocking access to handrails on one side and therefore restricting residents' movement.
- The ventilation was not adequate in the sluice room and bedrooms in the Willow unit.
- Not all residents had access to appropriate size wardrobes wardrobes, especially in the triple-occupancy bedrooms, as two residents had small single wardrobes for their personal clothes, and one had a double wardrobe. As a result, the current arrangements did not provide sufficient space for residents' clothes. This was an outstanding action from the previous inspection.
- There was a leak in the Sycamore unit in the communal bathroom, and a strong odour was present in that area. Other leaks were identified behind the washing machines and in the toilets in the laundry.
- There was a hole in the old drainage system in the clinical room in the Beech unit, posing a risk of pests entering the clinical area.
- The chairs used by staff to assist residents in the dining rooms throughout the centre were metal-shower chairs, which had a clinical appearance and did not promote a positive dining experience.
- The centre was not clean in all areas, with dirty floors seen in Beech, Willow and Sycamore units.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were provided with adequate quantities of nutritious food and drinks, which were safely prepared, cooked and served in the centre. Residents could avail of food, fluids and snacks at times outside of regular mealtimes.

Judgment: Compliant

Regulation 20: Information for residents

The residents' information guide did not contain all information as per regulatory requirements. For example, the complaints procedure required a review to include information about the advocacy services and Ombudsman. The terms and conditions relating to residency in the designated centre did not outline the relevant information about the Fair Deal arrangements.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

The documentation completed for the temporary discharge of a resident to the hospital was available to inspectors. Copies of the transfer letter when a resident was transferred in or out of the service were available to ensure that relevant information was provided to ensure that the resident could receive appropriate care. On return from the hospital, a discharge letter and relevant documentation were received and filed in the resident's individual record.

Judgment: Compliant

Regulation 27: Infection control

Overall, the inspectors found that the provider had not taken all necessary steps to ensure full compliance with Regulation 27 and the National Standards for infection prevention and control in community services (2018). This was evidenced by;

- A review of residents' equipment, such as shower chairs, chairs, bed tables

and commodes, was required as a number of them were rusty on the leg or wheel area. This posed a risk of cross-contamination as staff could not effectively clean the rusted parts of the shower chairs and commodes.
- The cleaning of nebulisers was not effective. The inspectors observed that the machine and the mask were unclean in a number of instances.
- The floor coverings in the Sycamore and Willow units appeared to be unclean, with severe dirty marks on the marmoleum. The new floor covering in the Beech unit was stained and peeling off from the wall, preventing it from being effectively cleaned and harbouring dust and dirt behind
- Two sets of four bins were observed blocking access to the sink in the sluice room in the Beech unit.
- Inspectors observed that the staff in the centre did not adhere to the correct personal protective equipment (PPE) use. For example, a number of staff members were seen wearing masks underneath their noses or chin.
- The medicinal fridge and suctions machines were stored on the floor in the clinical room in the Beech unit.

Judgment: Substantially compliant

Regulation 28: Fire precautions

At the time of inspection, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. In addition, fire precautions were not being adequately reviewed. For example;

- While emergency evacuation plans were displayed throughout the centre with a point of reference to indicate one's location in the centre, there was conflicting information with respect to some units displaying information that was not correct.
- The fire procedure in the centre did not include the procedure for shutting off the oxygen valves.
- The means of escape directional signage in the Aspen unit led into a wall. The emergency escape route signage was missing in the Beech unit.
- Some fire doors were damaged; for example, the intumescent strip was peeling off on one door. This may affect the effectiveness of the fire door to contain fire and smoke in the event of an emergency.
- Inspectors observed that oxygen bottles were stored in a storage room with hoist charging points nearby. The self-closing device to one of the fire doors was disarmed in the store room in the Beech unit. This meant that the fire door would not close automatically in the event of an emergency.
- An external fire exit route was not safe, with a slippery pathway beside the fire exits and insufficient emergency lighting to illuminate the route of escape in the event of a fire evacuation at night time.
- Inspectors observed flammable items such as paint buckets stored in the room opening into the boiler room in the Willow unit. Inspectors issued an immediate compliance action for all flammable material to be removed. The

inspectors were informed at the end of the inspection that the room was fully cleared.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspectors found that medication management practices in the centre were not in line with local policy for the protection of the residents, and inspectors found evidence that staff were not adhering to the most recent medication management guidance for nurses set out by the Nursing and Midwifery Board of Ireland which could potentially result in medication-related errors or incidents. For example:

The medicine systems in place for dispensing, administration and storage required full review. For example:

- The practices in the centre did not ensure that the 10 rights of medication administration were consistently implemented during the administration phase.
- Regular and PRN (as required) medications on the drug trolley, medicine fridge and cabinets were not correctly labelled, and the opening date on some medicinal products was missing. This meant that staff would not be aware of the date of opening and when the medication would become out-of-date and should be removed from use for return to the pharmacy. Furthermore, the staff members were administering regular and PRN unlabeled medicine as a shared medicine to multiple residents.
- Some medicinal products supplied for residents were not stored safely or in line with the product advice. Labelling of some of the medications stored stated that storage was required at a temperature maximum of up to 25 degrees Celsius. There were no records of temperature monitoring available, and the clinical room was feeling hot and stuffy.
- High-level medications such as insulin were due to be checked by two nurses as per the centre's policy, and inspectors found evidence that this did not take place; Insulin pens stored in the fridge were not labelled.
- Inspectors observed that the centre kept an emergency stock of medicines without labels, and no emergency medicine stock overview was maintained as required in the centre's policy.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The focus of this regulation was on end-of-life care planning. Inspectors found that

while all residents in the sample of care plans reviewed had their end-of-life care plans in place, residents' end-of-life wishes and preferences were discussed at the resident's admission to the centre, but there was no evidence that the end-of-life wishes and preferences were discussed and reviewed on a regular basis despite the fact that the care plan was evaluated on a four-monthly basis.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Activities were provided in accordance with the needs' and preference of residents and there were daily opportunities for residents to participate in group or individual activities. Facilities promoted privacy and service provision was directed by the needs of the residents.

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 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Regulation 14: Persons in charge	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cherry Orchard Hospital OSV-0000508

Inspection ID: MON-0038958

Date of inspection: 04/05/2023

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Centre's current management systems and managerial oversight enhanced to ensure effective robust operation of service to support the following: • Phased schedule of work generated to replace all flooring in the Willow and Sycamore units. This is discussed in more detail under Regulation 17: Premises- targeted for completion 31st March 2025 • Health and safety risk assessment completed in regards to the structural safety and flooring in Sycamore and Willow units - targeted for completion 31st July, 2023 • Ongoing review of flooring plan by local mangement team to address any risks posed to residents, staff, and visitors – ongoing • Fire safety risk assessment completed that accounts for the identified structural and flooring issues in respect of Sycamore and Willow units. This is discussed in more detail under Regulation 28: Fire precautions – targeted for completion 31st July, 2023 • Existing monitoring systems for residents' weights and risk of malnutrition in each unit enhanced to generate monthly reports for the nurse management team of the centre - complete. • Audit completed of the centre's medication management systems in collaboration with the centre's Senior Pharmacist to address identified medication errors recognised on the day of the inspection. This is discussed in more detail under Regulation 29: Medicines and pharmaceutical services- targeted for completion 31st October, 2023 • Strengthening of the existing managerial oversight of fire safety to ensure that all members of the centre's management team are aware of fire safety policy and associated risks. This is discussed in more detail under Regulation 28: Fire precautions – 31st July, 2023 Audit completed and actions taken to ensure all residents had unrestricted access to appropriate shower and toilet facilities - completed	

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
• Review of all contracts of care and actions completed to ensure room numbers across the centre align with existing occupying residents, fees to be charged and any additional costs required - completed
• Process for refunds deem not applicable on the centre's contracts of care due to its public funded status.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• Review of policies, as required under Schedule 5 of the regulations to ensure they are update - targeted for completion 31st August, 2023
• Tracker control system applied to ensure policy updates occur at intervals not exceeding three years - targeted for completion 31st August, 2023.
• Fire safety management policy generated for the centres with an implemention date – targeted for completion 31st June 2023.
• Medicine policy reviewed with updated actions aligned with best practice guidelines such as NMBI Guidance for Registered Nurses and Midwives on Medicine Administration (2020) – targeted for completion the 31st October, 2023

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The registered provider generated the following action plan supported by an walkaround with the onsite maintenance manager on the 14th June, 2023 to support the premises conforming to all matters as set out in Schedule 6.
• Schedule of work generated to replace all flooring in the Willow and Sycamore units - targeted for completion 31st March 2025
• Schedule of works for flooring Beech unit targeting the floor marking on main corridor

and promote a more homely environment in the day room – targeted for completion 31st June, 2024
• Structural assessment to be submitted to the Chief Inspector's office to provide assurance on the Sycamore and Willow units current status - targeted for completion 31st July 2023.
• Immediate action taken to ensure the resident identified in Willow Unit on day of inspection has access to appropriate en-suite shower facility - complete
• Application of funding to support a schedule of works for Beech unit targeting the floor marking on main corridor and to promote a homely environment in the day room – targeted for completion 31st June, 2024
• Review of the newly created communal bathroom in Beech unit to address the identifed markings on the flooring – targeted for completion 31st October, 2023.
• Removal of large wheelchairs in the corrider of Beech unit obstructing residents' free movement- complete
• Audit of the storage for residents' mobility equipment in Beech unit to enhance capacity that does not impact on residents' movement space - complete
• Audit of individual ventilation in bedrooms within the Willow unit and appropriate action to enhance air flow in this space – targeted for completion 31st July, 2023
• Action taken to ensure residents have access to appropriate size wardrobes for personal belongings in the triple-occupancy bedrooms – targeted for completion 31st October, 2023
• Leak in the communal bathroom of the Sycamore unit address eliminating the odour was present in that area – complete
• Drainage hole in the clinical room of Beech unit plugged going into a drainage system - complete
• Phased replacement plan for metal shower chairs used by staff to assist residents in the dining rooms throughout the centre – targeted for completion 31st March, 2024

The structural assessment was not submitted to the Office of the Chief Inspector by the time of progressing this report.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
The residents' information guide updated to ensure information was in compliance with regulatory requirements – targeted for completion 31st August, 2023. This includes amendments to support the following actions:
• the complaints procedures section to include information about the advocacy and Ombudsman services.
An outline documented of the relevant information about the Fair Deal arrangements.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Phased action place to replace equipments posing a cross-contamination risk such as such as shower chairs and commodes etc – targeted for completion 31th March, 2023
• Audit of nebulisers cleaning practices completed with plan to provide educational enhancements to promote effective cleaning action post usage – targeted for completion 31st August, 2023
• Schedule of work generated to replace all flooring in the Willow and Sycamore units - targeted for completion 31st March 2025
• Schedule of works for flooring in Beech unit targeting the identified floor marking on main corridor - targeted for completion 31st June, 2024
• Review and action taken to ensure bin locations are not blocking access essential areas such as the sink in the sluice room in the Beech unit. This action is supported by bin location monitering been included within daily cleaning staff checklists and unit manager spot checks of same– ongoing
• Management of each unit within the centre to provide education and evaluation of knowledge transfer of the staff onsite adherance to the correct personal protective equipment (PPE) use with a particular focus on face mask usage – targeted for completion 31st July, 2023
• The medicinal fridge and suctions machines removed from the floor and placed on shelving in the clinical room in the Beech unit- completed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Registered Providers undertook the following precautionary actions in collaboration with the Fire Safety Officer to ensure that residents were protected from the risk of fire;
• Emergency evacuation plans displayed throughout the centre reviewed and updated to address any conflicting information – completed.
• Fire procedure in the centre updated to include the procedure for shutting off the oxygen valves which is supported by display signage of procedure placed in each unit - completed.
• Review of all escape directional signages in the Aspen unit to ensure they are directed to a fire exit area - completed.
• Enhancement of emergency escape route signage in the Beech unit – 31st August, 2023.
• Review of damaged fire doors and action taken to ensure effectiveness to contain fire and smoke in the event of an emergency-completed.
• Removal of oxygen bottles located in a storage room when noted in close proximity

with hoist charging points - completed.
• Review of self-closing devices on the floor doors in Beech Unit to ensure they all automatic close in the event of an emergency. Education given to staff on the risk of disarment of these doors - completed
• Schedule of works for fire exit pathway and lighting to illuminate the route of escape in the event of a fire evacuation at night time – targeted for completion 31st July, 2024.
• Removal of any identified flammable items such as paint buckets stored in the room adjacent to the boiler room in the Willow unit on the day of inspection - completed.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Review of centres medication management practices onsite with the centre's senior pharmacist generated the following action plan to promote compliance with local policy for the protection of the residents,
• Revised practices in the centre to ensure that the 10 rights of medication administration are consistently implemented during the administration phase across all units within the centre – targeted for completion 31st October, 2023.
• Regular and PRN (as required) medications on the drug trolley, medicine fridge and cabinets correctly labelled with the opening date on medicinal products – targeted for completion 31st October, 2023
• Correct storage of medicinal products supplied for residents in line with the product advice – targeted for completion 31st October, 2023
• Recording system for monitoring the temperature of relevant medications stored – targeted for completion 31st October, 2023
• Review of centre's insulin administration practices and ensure compliance with centre's medication management policy - targeted for completion 31st October, 2023
• Insulin pens stored in the fridge reviewed to ensure labelling to specific residents– targeted for completion 31st October, 2023.

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:
• Audit of all residents' end-of-life care plans to ensured the wishes and preferences discussed at the resident's admission to the centre are documented and updated on a

regular basis as part of the standard care planning four-monthly review processes – targeted for completion 31st October, 2023.
End of Life care plans inserted as a line item on the agenda of the CNM2 monthly meetings to further ensure compliance on updates based on residents' changing expressed wishes - completed

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(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	31/03/2023
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	31/03/2025
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure respecting complaints,	Substantially Compliant	Yellow	31/08/2023

	including external complaints processes such as the Ombudsman.			
Regulation 20(2)(b)	A guide prepared under paragraph (a) shall include the terms and conditions relating to residence in the designated centre concerned.	Substantially Compliant	Yellow	31/08/2023
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	31/03/2025
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	31/03/2025
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the	Not Compliant	Orange	30/06/2023

	resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Not Compliant	Orange	30/06/2023
Regulation 24(2)(c)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of where appropriate, the arrangements for the application for or receipt of financial support under the Nursing Homes Support Scheme, including the arrangements for the payment or refund of monies.	Not Compliant	Orange	30/06/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	31/08/2023

	associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/06/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/06/2023
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	31/08/2023
Regulation 28(1)(e)	The registered provider shall ensure, by means	Not Compliant	Orange	30/06/2023

	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	Orange	30/06/2023
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	30/06/2023
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	31/10/2023
Regulation 29(5)	The person in charge shall ensure that all	Not Compliant	Orange	31/10/2023

	medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
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, 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.	Not Compliant	Orange	31/10/2023
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies	Not Compliant	Orange	31/10/2023

	and procedures on the matters set out in Schedule 5.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	31/10/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/10/2023