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:	Ennis Road Care Facility
Name of provider:	Beech Lodge Care Facility Limited
Address of centre:	Ennis Road, Meelick, Ennis, Clare
Type of inspection:	Unannounced
Date of inspection:	04 March 2025
Centre ID:	OSV-0005768
Fieldwork ID:	MON-0046248

About the designated centre

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

Ennis Road Care Facility is a designated centre located on the outskirts of Limerick city on the old Ennis Road. It is registered to accommodate a maximum of 84 residents. It is a purpose-built single storey facility, where bedroom accommodation comprises 54 single and 15 twin rooms, all with en-suite facilities of shower, toilet and hand-wash basin. Additional toilet facilities are available throughout the centre. Communal areas comprise a spacious dining room, a large garden room (day room), activities room, smoking room, and oratory. Main reception is an expansive space with a grand piano, fire place, and lots of seating hubs; off the main reception is the hairdressers' salon and an area to be developed into a coffee dock. There are additional comfortable seating areas off the activities room. Residents have access to two enclosed gardens with walkways, seating and raised flower beds. Ennis Road Care Facility provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	80

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 4 March 2025	09:30hrs to 18:00hrs	Rachel Seoighthe	Lead
Wednesday 5 March 2025	09:30hrs to 15:50hrs	Rachel Seoighthe	Lead
Tuesday 4 March 2025	09:30hrs to 18:00hrs	Fiona Cawley	Support
Wednesday 5 March 2025	09:30hrs to 15:50hrs	Fiona Cawley	Support

What residents told us and what inspectors observed

This unannounced inspection was completed over two days. Overall, inspectors found that residents were content with living in the centre and comfortable in the company of staff, who were observed to be attentive to residents' needs. Staff were described as 'exceptionally good,' and residents' described the centre as 'wonderful' and 'fantastic'. While feedback was positive in relation to the kindness of staff, some residents voiced that call bell response times 'could be better' and that staff were 'always running' and 'run off their feet.'

Inspectors were met by the assistant director of nursing upon arrival to the centre. Following an introductory meeting with the management team, inspectors walked through the centre, giving an opportunity to meet with residents and to observe their living environment.

Ennis Road Care Facility is registered to provide care to a maximum of 84 residents. There were 80 resident living in the centre on the day of inspection. The designated centre is a purpose-built single-storey building, situated on the outskirts of Limerick city. The centre was bright and spacious, with easy access to private and communal accommodation areas. Resident bedroom accommodation consisted of single and shared bedrooms, with en-suite facilities.

The entrance to the designated centre opened into to a large reception area which was furnished for resident use. Resident bedroom accommodation was located along corridors leading from the reception area. Inspectors noted that many resident bedrooms were personalised with items such as photographs, ornaments and soft furnishings. Bedrooms were found to contain sufficient storage for residents to store their personal belongings securely, and for easy access to their personal items. Call bells and televisions were provided in all resident bedrooms.

There were a variety of communal areas for residents to use including dining rooms, sitting rooms, a visitors room, a hairdressing salon and a prayer room. There were also several open seating areas located throughout the centre. Inspectors noted that there was unrestricted access to two enclosed garden areas. There was a designated visitors room, however, this was not available for resident use on the day of inspection as it had been reassigned for use as an activity room, and was unfurnished.

On the days of inspection, inspectors observed that staff were working hard to provide care and support for residents. There was a bustling atmosphere in the centre and inspectors overheard friendly conversation between residents and staff. Many of the residents were observed to spend their day in the main reception area, and inspectors noted that there was a constant staff presence in this area. The reception area contained a variety of plants and an aquarium for resident interest. Inspectors spoke with a number of residents, and those who could express their views said that staff were kind, and the majority of residents were satisfied with the

service they received. One resident told inspectors that they were 'happier here than at home' and another resident described feeling 'happy and well looked after.'

As inspectors walked through the main centre, they observed that many residents were up and about and moving freely throughout the communal areas. Two members of staff were dedicated to the provision of activities and inspectors observed residents enjoying a pancake-making session during the inspection, which was very well attended by residents. There was a lively atmosphere with lots of laughter and chat between residents and staff. Several residents who did not wish to participate in activities were observed relaxing in their bedrooms, and they told inspectors that this was their preference.

Inspectors heard comments such as ' I do what I want, I prefer to stay in my room and watch TV.' and 'I have everything I want, plenty of choice. I feel safe and supported. The staff are good-natured'. While residents told inspectors that staff were kind to them, some residents described occasions where they had to wait extended periods of time for staff to assist them with their care needs. One resident told inspectors that delays in staff responding to their requests for assistance resulted in them attempting to attend to their own needs, which increased their own risk of falling.

The care environment was generally clean, with the exception of a small number of resident bedrooms and a resident communal toilet. Inspectors noted that the wall covering in one resident ensuite toilet and a floor covering in a resident communal bathroom appeared to be lifting from the wall surface. However, the general environment of the centre was noted to be in a good state of repair, and there was an ongoing maintenance programme in place.

The corridors in the centre were long and wide and provided adequate space for walking. Handrails were available along all the corridors to maintain residents' safety and independence. Residents were seen to move freely throughout the centre.

Inspectors observed a number of residents receiving visitors during the inspection and found that appropriate measures were in place to ensure that visiting was managed in a safe manner.

The next two sections of the report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance with the regulations are set out under each section.

Capacity and capability

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended). Inspectors followed up on the provider's compliance plan response to the previous inspection in April 2024, which identified non-

compliance with premises, infection control, fire precautions and governance and management. Inspectors found that the provider had taken some action to improve the care environment since the previous inspection, however, the actions taken were not sufficient to bring the centre into full compliance with the regulations. This inspection found that the oversight of some management systems were not sufficiently robust to identify, reduce or eliminate potential and actual risks in the centre. Furthermore, individual assessment and care planning, and records, did not meet the requirements of the regulations.

The provider of the centre is Beech Lodge Care Facility Ltd. A director of the company was involved in the day-to-day operations of the designated centre. There was a clearly defined management structure in place, with identified lines of authority and accountability. The person in charge was supported in the centre by an assistant director of nursing (ADON), two clinical nurse managers (CNM), and a team of nurses, health care assistants, maintenance, cleaning, catering and administration staff.

There were 80 residents accommodated in the centre on the day of the inspection. Inspectors' observations were that staffing levels on the day of the inspection were sufficient to meet the assessed needs and dependencies of residents. Communal areas were appropriately supervised. Residents who required enhanced supervision were well supported. There was a training programme in place for staff, which included mandatory training and other areas to support provision of quality care. Inspectors found that staff had completed training in the areas appropriate to their role, including safeguarding vulnerable persons, patient moving and handling and infection control. However, records showed that fire safety training was not up-to-date for all staff members.

There were systems in place to support the management team to monitor the quality of care provided to residents. There was evidence of regular staff and management meetings to review key clinical and operational aspects of the service. Clinical governance meetings were held regularly and agenda items included care planning, infection control, wound management and complaints. There was a programme of auditing in clinical care and environmental safety to support the management team to monitor the quality of care provided to residents. Inspectors viewed a sample of audits relating to key clinical areas, such as infection control. Audits viewed identified areas for quality improvement and had an associated action plan. Records viewed by inspectors demonstrated that a weekly analysis of key clinical performance indicators was completed. The management team collated clinical data such as antibiotic usage, controlled medication usage, resident wounds and nutritional care, and falls. This information was a point of discussion at clinical governance meetings and used to inform quality improvement plans.

There was a system in place to monitor call bell response times, and daily call bell reports were generated and reviewed by the management team. A sample of call bell reports reviewed by inspectors demonstrated many occasions where call bell response times were of considerable duration, without reasonable cause. While records showed that the person in charge had taken some action to address issues found, there was no record of any call bell audits completed and a time bound

quality improvement plan to address the issues identified. Resident meeting records reviewed on the days of inspection, and communication with residents, demonstrated that some call bell response times were still lengthy.

An electronic record of all accidents and incidents involving residents that occurred in the centre was maintained. Inspectors found that there was a system in place to enable staff to report adverse incidents, such as unexplained injuries to residents. This information was included in weekly key clinical performance indicator reports and discussed by the management team. However, investigations were not always completed to establish the root cause of these incidents and to rule out any potential safeguarding concern or to identify future learning so that similar incidents could be prevented.

Inspectors reviewed a sample of staff personnel files and found that they did not contain all of the information, as required by Schedule 2 of the regulations.

There was a complaints procedure in place which met the requirements of the regulations. A review of the complaints records found that complaints were managed in line with the requirements of Regulation 34.

An annual report on the quality of the service had been completed for 2024 which had been done in consultation with residents and set out the service's level of compliance as assessed by the management team.

Regulation 15: Staffing

On the day of inspection, there was sufficient staff on duty with appropriate skill mix to meet the needs of all residents, taking into account the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

Training records reviewed demonstrated that staff were facilitated to attend training in fire safety, moving and handling practices and the safeguarding of resident.

Records viewed indicated that staff were up-to-date with the centre’s mandatory training requirements, with the exception of fire safety training which is addressed under Regulation 28: Fire precautions.

Judgment: Compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements. For example, a number of staff files were incomplete and did not contain all the information required by the regulations, such as, evidence of a staff member's identity, up-to-date employment history or the required number of written references from previous employers.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that that the management systems in place to monitor the service was not fully effective. This was evidenced by:

- The system in place to monitor incidents and ensure learning from adverse incidents was not effective. For example, the documentation relating to unexplained injuries was incomplete and did not provide assurance that all possible factors relating to an incident had been explored.
- The oversight of nursing documentation was found to be ineffective. A number of care plans reviewed were poorly developed and did not clearly describe the interventions required to ensure residents' well-being and safety.
- Daily call bell reports generated by the clinical management team demonstrated that there were some occasions where call bell response times were lengthy. However, there was no documented audit of call bell response times and a time-bound quality improvement plan to address the possible risk to resident safety.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints procedure and policy, which aligned with the requirement of Regulation 34. A review of the complaints recorded found that complaints were managed and responded to in line with regulatory requirements. The satisfaction level of the complainant was recorded.

Judgment: Compliant

Quality and safety

Overall, inspectors found that the interactions between residents and staff were kind and respectful throughout the inspection. Resident's reported that they were generally satisfied with the care provided. Residents voiced satisfaction with the programme of activities and the choice and quality of food available, and the provider had taken action to address fire safety risks identified on the previous inspection. Nonetheless, inspectors found the quality and safety of resident care was impacted by the failure of the provider to identify potential risks to resident safety. Furthermore, individual assessment and care planning, premises, infection prevention and control and fire precautions, did not fully meet the requirements of the regulations.

The provider had implemented some systems to safeguard residents from abuse. The procedure to safeguard residents was underpinned by a safeguarding policy that provided guidance and support to staff on the appropriate actions and measures to take to protect residents should a safeguarding concern arise. Staff were facilitated to attend safeguarding training. However, a review of adverse incidents in the centre found that a number of unexplained injuries, had not been identified as potential safeguarding concerns. These incidents were therefore not assessed and managed using the centres' safeguarding policy and procedures, to ensure that the residents were appropriately safeguarded.

Infection prevention and control measures were in place and monitored by the person in charge. Inspectors identified some examples of good practice in the prevention and control of infection. For example, sluice room facilities were clean and tidy. However, inspectors noted poor standards for infection prevention and control in some areas of the centre, such as in the cleanliness of some items of resident equipment.

Overall, the design and layout of the premises was suitable for its stated purpose and met the residents' individual and collective needs. The centre was found to be well-lit and warm. Resident's accommodation was individually personalised. However, some areas were observed to have visible wear and tear. Furthermore, the residents' designated visitor room was unavailable for use as it was reassigned and this arrangement did not ensure that there was sufficient private space for resident to meet with their visitors, other than in their bedrooms.

There were measures in place to protect residents against the risk of fire. These included regular checks of means of escape to ensure they were not obstructed, and checks to ensure that equipment was accessible and functioning. However, inspectors found that all staffing working in the centre did not participate in simulated evacuation drills. This posed a risk to the safe and timely evacuation of residents in the event of a fire emergency.

Residents had access to medical and healthcare services. Residents were reviewed by their general practitioner (GP) as required or requested. Systems were in place

for residents to access the expertise of health and social care professionals, when required.

There were a number of residents who required the use of bedrails and records reviewed showed that appropriate risk assessments had been carried out. There was appropriate oversight and monitoring of the incidence of restrictive practices in the centre.

Residents had access to an independent advocacy service and details regarding this service were advertised on the resident information board, displayed in the reception area of the centre. Residents' meetings were convened regularly to ensure residents had an opportunity to express their concerns or wishes. Minutes of residents meetings indicated that residents were consulted about the quality of activities and planned outings. Residents' feedback was also sought with regard to the quality and safety of the service, the quality of the food, laundry services and the staffing. Residents had access to television, radio, newspapers and books. Internet and telephones for private usage were also readily available. Residents had access to religious services and resources and were supported to practice their religious faiths in the centre.

Visiting was taking place and that residents were facilitated to meet with their families and friends in a safe manner.

Regulation 11: Visits

Visits by residents' families and friends were encouraged and practical precautions were in place to manage any associated risks to ensure residents were protected from risk of infection.

Judgment: Compliant

Regulation 17: Premises

A review of the premise found that some areas were not maintained in line with the requirements of Regulation 17:

- The wall covering in one resident ensuite bathroom was observed to be lifting from the wall surface.
- Floor covering, applied to form skirting at the base of the walls in one assisted bathroom, was peeling away from the wall surface.

Inspectors found that the function of a visitors room had been reassigned, this did not ensure that residents has adequate private space to meet with residents,

outside of their own bedrooms.

Judgment: Substantially compliant

Regulation 26: Risk management

The registered provider maintained policies and procedures to identify and respond to risks in the designated centre. The risk management policy met the requirements of Regulation 26.

Judgment: Compliant

Regulation 27: Infection control

A number of issues were identified which had the potential to impact the effectiveness of infection prevention and control within the centre and posed a risk of cross infection. This was evidenced by:

- Unclean nebuliser masks and compressor machines were observed in several residents' bedrooms.
- Clean equipment was found to be stored in a storeroom along with residents hoists, which increased the risk of cross-contamination.
- The floor surface in one resident communal toilet was visibly unclean.
- The floor and mattress surface in one resident bedroom was visibly unclean.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider did not have adequate precautions against the risk of fire in place. For example:

- Fire safety training was not up-to-date for all staff working in the centre. Furthermore, simulated fire evacuations were not practiced by all staff working in the designated centre. This may impact the resources available to assist the timely evacuation of residents, in the event of a fire emergency in the centre.
- Two fire doors were observed to be held open with furniture on the second day of inspection. This practice may impact the effectiveness of the door to contain fire, smoke or fumes in the event of a fire emergency.

- Access to some electrical supply cupboards was by a keycode which which was not known by all staff. This may pose a delay in accessing this areas in the event of a fire emergency.
- One electrical supply room was unlocked and accessible to residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A sample of residents' assessments and care plans reviewed by inspectors, found that they were not in line with the requirements of the regulations. For example, care plans were not consistently developed, based on an assessment of need, within 48 hours of the residents admission to the centre, as evidenced by;

- Two residents, who were assessed on admission as being at risk of falling, and sustained falls in the centre, did not have appropriate care plans developed. One resident care plan was initiated eight months after their admission to the centre, and the other resident did not have a care plan in place.

Care plans were not consistently review or updated when a resident's condition changed. For example:

- The care plans for a number of residents with skin integrity issues were not updated in a timely manner to reflect the care interventions required to support their needs.
- The care plan for one resident who returned from hospital with weight loss was not reviewed or updated. This did not ensure the care plan contained the most up-to-date information, to direct staff regarding the interventions required to ensure the residents nutritional needs were met.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to appropriate medical and allied health care professionals and services to meet their assessed needs.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

A restraint-free environment was promoted in the centre, in line with local and national policy. Each resident had a risk assessment completed prior to any use of restrictive practices. The use of restrictive practices was regularly reviewed to ensure appropriate usage.

Judgment: Compliant

Regulation 8: Protection

Inspectors found that the registered provider did not take all reasonable measures to protect residents from abuse. For example;

- A review of incident records found that there were a number of unexplained injuries reported, which had not been recognised as potential safeguarding concerns. This meant that the management team had not considered all factors which may have contributed to the unexplained injuries, and preliminary screening investigations were not completed to rule out potential safeguarding concerns, in order to ensure the protection of residents.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' rights were upheld in the designated centre. The inspectors observed that residents' privacy and dignity was respected. Residents told the inspector that they were well looked after and that they had a choice about how they spent their day.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ennis Road Care Facility OSV-0005768

Inspection ID: MON-0046248

Date of inspection: 05/03/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All staff files have been audited and the gaps identified on inspection have been addressed – complete. Ongoing audit and review of all staff files will take place monthly to ensure continued compliance. The company is currently upgrading to a new electronic HR software system which will aid compliance – commencing from 06/06/25.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A full review of all resident's experiencing bruising was conducted post-inspection. A new policy on unexplained bruising was developed, communicated to staff and implemented in practice. Residents with known conditions or medications that increased the risk of bruising were identified and a dedicated care plan was developed to alert staff of their increased risk and preventative measures to take. All unexplained bruises are escalated to senior nurse managers on a daily basis, recorded on the KPI dataset and reviewed and discussed at management and clinical governance meetings weekly – complete and ongoing. An analysis and audit of care plans is completed quarterly however post-inspection these audits have been increased to monthly audits – complete and ongoing.	

Full care plan review and audit completed by ADON and actions and learning shared with Nursing staff on 11/04/25. Findings were discussed individually with all nurses at nurses meeting on 22/04/25. All care plan actions identified on inspection have now been completed and care plans have been reformatted to ensure that they are more person-centred and more concise yet contain adequate information to guide staff. Daily reviews of individual care plans by the senior nurse management team continue when reviewing incidents/ accidents or any significant changes in a resident's status – complete and ongoing.

A call bell audit is completed daily by the management team. A new call bell champion is in place daily since 06/01/25 and a full analysis has shown that this has reduced the average call bell time by half since its introduction. No patterns have emerged in regard to times of the day, staff or residents involved for lengthy call bell response times. Where there are isolated incidences of lengthy call bell times these are now thoroughly investigated (including the use of CCTV footage where required) to examine the rationale behind the delay and used as a staff performance tool – completed and ongoing.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Repairs identified were reported to the maintenance team on the day of inspection and fully completed by 07/03/25. A full audit was completed by the management team of all residents' ensuites/ communal bathrooms on 11/03/25 and all additional repairs fully carried out by 21/03/25.
2. This area was assigned during covid as 'a temporary visiting area isolated' however the area is no longer required for this purpose as we have ample alternative areas and spaces for private visits. The residents choose to use this room for different activities such as the men's shed and painting or making bird houses etc as well as for visiting. Additional furniture has been installed to reflect the varied use of this room – complete.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. Nebulizer masks are changed weekly and cleaned daily by nursing staff. From 10/03/25 a nursing oversight template was put into place daily and this is reviewed by management daily at the beginning of each shift – complete and ongoing.

2. The hoover was removed from the hoist room immediately and housekeeping informed of the correct storge of the hoover in the housekeeping cleaning room - complete.

3. The floor surface was cleaned immediately by housekeeping on the day of inspection. There are regular checks and oversight in place for communal toilets to ensure that they are cleaned and checked at regular intervals throughout the day by housekeeping, SHCA staff (when housekeeping are not on shift) and on management walkabouts. Room audits are conducted daily and environmental hygiene audits are conducted monthly. Findings of these are communicated to individual staff involved and at regular staff and departmental meetings - complete and ongoing.

4. The resident's area was deep cleaned immediately on the day of inspection and learning shared with all staff. Process in place with management oversight that following discharge resident areas are terminally cleaned by housekeeping as soon as possible following discharge and the room is locked to avoid reentry – complete and ongoing.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Fire safety training is completed yearly by all staff. Refresher fire training for the two staff members due is scheduled for 22/05/25.

2. Whilst fire drills included all staff, the simulation of the evacuation element of these drills previously did not include non-clinical staff who had not been trained in moving and handling residents. All non-clinical staff now receive moving and handling training and actively participate in simulated fire evacuation drills – complete and ongoing.

3. Daily management oversight and walkaround has increased in frequency post the inspection the practice of holding open fire doors has been discussed at all team meetings – complete and ongoing.

4. The code in use was the same code for all other restricted areas throughout the building. This information has been communicated to all staff at team meetings and is now known to them - complete.

5. The electrical supply unit is now locked with a key which is located on the nurse's set of keys should access be required by maintenance - complete.

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:
Full care plan review and audit completed by ADON and actions and learning shared with Nursing staff on 11/04/25. Findings were discussed individually with all nurses at nurses meeting on 22/04/25.

All care plan actions identified on inspection have now been completed and care plans have been reformatted to ensure that they are more person-centred and more concise yet contain adequate information to guide staff.
Daily reviews of individual care plans by the senior nurse management team continue when reviewing incidents/ accidents or any significant changes in a resident's status – complete and ongoing.

Care plan review is part of weekly clinical governance meeting and weekly KPI review. All care plans currently under review by PIC. Training given to nurses on 14/05/25 in relation to immediate assessment and care plan changes after any change in circumstance for the resident on a daily basis – complete and ongoing.

Care plan audits have increased in frequency and now occur monthly – effective from Apr 2025.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A full review of all resident's experiencing bruising was conducted post-inspection. A new policy on unexplained bruising was developed, communicated to staff and implemented in practice. Residents with known conditions or medications that increased the risk of bruising were identified and a dedicated care plan was developed to alert staff of their increased risk and preventative measures to take.

All unexplained bruises are escalated to senior nurse managers on a daily basis, recorded on the KPI dataset and reviewed and discussed at management and clinical governance meetings weekly. These are screened for potential safeguarding concerns, preliminary screening investigations completed and notified to the relevant Authorities were relevant – complete and ongoing.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	21/03/2025
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	30/06/2025
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	Substantially Compliant	Yellow	31/05/2025

	effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	31/03/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	30/06/2025
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	Substantially Compliant	Yellow	30/06/2025

	fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/06/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/06/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	30/06/2025
Regulation 5(4)	The person in charge shall formally review, at	Not Compliant	Orange	30/06/2025

	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.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	06/03/2025