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

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| Name of designated centre: | Willowbrook Lodge |
| Name of provider: | NSK Healthcare Limited |
| Address of centre: | Mocklershill, Fethard, Tipperary |
| Type of inspection: | Unannounced |
| Date of inspection: | 14 December 2022 |
| Centre ID: | OSV-0000302 |
| Fieldwork ID: | MON-0038587 |

## About the designated centre

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

Willowbrook Lodge is located just three miles from Cashel on the Fethard Road. The centre is a two storey facility with accommodation for 27 residents. There is accommodation for 12 residents on the ground floor and 15 residents on the first floor. Accommodation comprises 17 single bedrooms, two twin rooms and two, three bedded room on each floor. Some rooms have en suite facilities. The communal rooms are mainly on the ground floor and there is a large communal room on the first floor which offers vistas of the surrounding countryside. The service caters for the health and social care needs of residents both female and male, aged 18 years and over. Willowbrook Lodge provides long term care, dementia care, respite care, convalescent care and general care in the range of dependencies low / medium / high and maximum. The service provides 24-hour nursing care.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 20 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

**1. Capacity and capability of the service:**

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

**2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Wednesday 14 December 2022 | 09:00hrs to 16:30hrs | Mary Veale | Lead |

## What residents told us and what inspectors observed

This was a pleasant centre where residents for the most part enjoyed a good quality of life and were supported to be independent. Resident's rights and dignity were supported and promoted by kind and competent staff. Care was led by the needs and preferences of the residents who were happy and well cared for in the centre. The overall feedback from residents was of satisfaction with the care and service provided. Residents' were very positive about their experience of living in Willowbrook Lodge. The inspector greeted all the residents on the day of inspection and spoke at length with five residents. The inspector spent time observing residents daily lives and care practices in order to gain insight into the experience of those living there.

On arrival the inspector was met by a member of the nursing team. Following a brief introductory meeting with the nurse in charge, the inspector was accompanied on a tour of the premises. The inspector spoke with and observed residents in communal areas and their bedrooms. Following the tour of the premises the inspector met the person in charge of the centre.

The centre was homely and clean and the atmosphere was calm and relaxed. The centres entrance area and communal rooms were decorated with festive Christmas trees, Christmas decorations and nativity cribs. Areas of the centre had been redecorated, fire doors had been replaced and the laundry had relocated since the previous inspection. Alcohol hand gels were available throughout the centre to promote good hand hygiene practices. The design and layout met the individual and communal needs of the residents. The centre was laid out over two floors which were accessible by a platform lift. There was a choice of communal spaces that residents could access, for example, the ground floor contained an open plan living room, a conservatory, a visitors room, and a separate dining room.The first floor had a sitting room which was not in use on the day of inspection. Communal rooms were spacious and comfortable.

The resident's bedroom accommodation was mostly single rooms, with three twin rooms and two multi-occupancy three-bedded room. 11 bedrooms had en suite toilet and wash hand basin facilities, and five bedrooms had ensuite showers. Bedrooms were personalised and decorated in accordance with resident's wishes. Lockable locker storage space was available for some residents and personal storage space comprised of single or double wardrobes. Pressure reliving specialist mattresses, low to floor beds and other supportive equipment was seen in resident's bedrooms. At the time of inspection the centre was operating at a reduced occupancy.

The centre had a large outdoor area to the front of the centre. This area had an outdoor pergola and canopied area with garden tables, chairs and benches. There

was an outdoor smoking area which was seen to be used throughout the day by residents.

Personal care was being delivered in many of the resident's bedrooms and observation showed that this was provided in a kind and respectful manner. The inspector observed many examples of kind, discreet, and person- centred interventions throughout the day. The inspector observed that staff knocked on resident's bedroom doors before entering. Residents very complementary of the staff and services they received. Residents said they felt safe and trusted staff. Residents told the inspector that staff were always available to assist with their personal care.

Residents spoken to said they were happy with the activities programme in the centre. The weekly activities programme was displayed in the conservatory area and group activities were observed taking place in the lounge area throughout the day. The inspector observed staff and residents having good humoured banter during the activities. The inspector observed the staff chatting with residents about their personal interests and family members.

Residents' enjoyed home cooked meals and stated that there was always a choice of meals and the quality of food was very good. Some residents told the inspector that they had a choice of having their breakfast in bed or could have their breakfast later in the dining room. The inspector observed the dining experience for residents in the dining room at lunch time. The meal time experience was quiet and was not rushed. Staff were observed to be respectful and discreetly assisted the residents during the meal times.

The centre provided a laundry service for residents. All residents who the inspector spoke with on the day of inspection were happy with the laundry service and there were no reports of items of clothing missing.

The inspector did not observe visitors during the day of inspection but the residents told the inspector that there was no booking system in place and that their visitors could call to the centre anytime. Residents said that their visitor were not calling on the day of inspection due to the extreme cold and icy weather.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

## Capacity and capability

This was an unannounced inspection carried out to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 as amended. Overall this was a well-managed service with established management systems in place to monitor the quality and safety of the

care and services provided to residents. The provider had progressed the compliance plan following the previous inspection in September 2021. Improvements were found in relation to Regulation 7: managing behaviour that is challenging, Regulation 9: resident's rights, Regulation 17: premises, Regulation: 27 infection prevention and control, and Regulation 28: fire precautions. On this inspection, actions were required by the registered provider to address areas of Regulation 17: premises, Regulation 21: records, Regulation 27: infection prevention and control and Regulation 31: notification of incidents.

The centre had two restrictive conditions attached to its registration. One restrictive condition was in relation to works to be completed to comply with Regulation 28: fire precautions and the second restrictive condition related to the centre having a full time person in charge. The programme of works to come into compliance with regulation 28: fire precautions had been completed and confirmation of completion of works had been submitted to the Chief Inspector of Social services. The registered provider representative was requested to submit an application to the Chief Inspector of Social services to remove both restrictive conditions.

The registered provider is NSK healthcare Limited. The current provider had operated the centre since July 2021. The company had two directors both of whom were involved in the operations of the centre. The governance structure operating the day to day running of the centre consisted of a person in charge who was supported by an assistant director of nursing, a team of registered nurses and health care assistants, catering, housekeeping, administration and maintenance staff.

There were sufficient staff on duty to meet the needs of residents living in the centre on the day of inspection. There had been a high turnover in staffing in the centre since July 2021 and the centre had ongoing recruitment efforts in place to maintain safe and consistent staffing levels. Staff were supported to perform their respective roles and were knowledgeable of the needs of older persons in their care and respectful of their wishes and preferences.

There was an ongoing schedule of training in the centre and management had good oversight of mandatory training needs. An extensive suite of mandatory training was available to all staff in the centre and training was up to date. Staff with whom the inspectors spoke with, were knowledgeable regarding fire evacuation procedures and safe guarding procedures.

There was good oversight of clinical care and key performing areas which was evident in the comprehensive and ongoing schedule of audits completed in the centre. Audits were objective and informed ongoing quality improvements. The centre had an extensive suite of staff meetings for example; catering meetings, staff, infection prevention and control, and management meetings. Agenda items were evident but meeting documentation required clear minutes and action plans. However, the insufficiency detail of meeting records did not impact on the quality or safety of the services provided. The provider was undertaking to review the documentation of meetings to ensure quality improvements were clearly monitored and completed in the centre. The annual review for 2021 had been completed. The

review was undertaken against the National Standards. It set out an improvement plan with time lines to ensure actions would be completed.

Records and documentation, both manual and electronic were well presented, organised and supported effective care and management systems in the centre. Requested records were made available to the inspector throughout the day of inspection and records were appropriately maintained, safe and accessible. Improvements were required in staff records and this is discussed further under Regulation 21: records.

Incidents and reports as set out in schedule 4 of the regulations were mostly notified to the Chief Inspector within the required time frames. One incident had been omitted in error and was submitted immediately following the inspection. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

The inspector followed up unsolicited information that had been submitted to the Chief Inspector since the previous inspection. The unsolicited information received related to resident's rights, protection, training and staff development, staffing and governance and management. All these regulations were reviewed and found to be compliant.

There was a complaints procedure in the centre which was displayed in the main entrance area. There was a nominated person who dealt with complaints and a nominated person to oversee the management of complaints. Records of complaints viewed found evidence of effective management of complaints, however the satisfaction of the complainant was not always recorded.

## Regulation 14: Persons in charge

The person in charge worked full time in the centre and displayed good knowledge of the residents' needs and a good oversight of the service. The person in charge was well known to residents.

Judgment: Compliant

## Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the day of the inspection.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in infection prevention and control, manual handling, fire safety , safe guarding, and responsive behaviour. There was an ongoing schedule of training in place to ensure all staff had relevant and up to date training to enable them to perform their respective roles.

Judgment: Compliant

## Regulation 21: Records

Improvements were required with staff records. In a sample of four staff files viewed, two of the files did not have a satisfactory history of gaps in employment in line with schedule 2 requirements.

Judgment: Substantially compliant

## Regulation 23: Governance and management

Management systems were effectively monitoring quality and safety in the centre. Clinical audits were routinely completed and scheduled, for example, falls, nutrition, and quality of care and these audits informed ongoing quality and safety improvements in the centre.

Judgment: Compliant

## Regulation 31: Notification of incidents

Actions were required to ensure that the person in charge shall give the Chief Inspector notice in writing of an incident within 3 working days of its occurrence. For example;

- A notice of an unexplained absence of a resident from the designated centre had not been notified in line with schedule 4 requirements.

Judgment: Substantially compliant

## Regulation 34: Complaints procedure

There was an effective complaints procedure in the centre which was displayed at the main entrance area. There was a nominated person who dealt with complaints and a nominated person to oversee the management of complaints. Complaints viewed by the inspector did not consistently record if the complainants were satisfied with the outcome.

Judgment: Substantially compliant

## Quality and safety

The inspector found that residents had a good quality of life in Willowbrook Lodge and were encouraged to live their lives in an unrestricted manner according to their capabilities. Residents had good access to medical, nursing and health and social care providers if required. Improvements were required in relation to Regulations17: premises, and Regulation 27: infection prevention and control.

There was no restriction to visits in the centre and visiting had returned to pre-pandemic visiting arrangements in the centre. Residents could receive visitors in the visitors room, their bedrooms where appropriate, and the centres communal areas. Visitors could visit at any time and there was no booking system for visiting. Their was evidence in the centres visiting log book that relatives and friends of residents were calling almost daily.

The centre was bright, clean and general tidy. The overall premises were designed and laid out to meet the needs of the residents. Improvements had been made to the premises since the previous inspection, for example; the centres laundry, waste management area and boiler had been relocated to external buildings to the rear of the centre. Some of the centres windows had been replaced. Many of the centres corridors had been repainted and some of the bedrooms had been redecorated, and had flooring replaced. The centre had updated its bedroom numerical layout and directional sigange. There was an on-going plan of preventative maintenance works which included painting, upgrading to bathroom facilities and decorating the remaining bedrooms. The centre was cleaned to a high standard, alcohol hand gel was available outside all bedroom corridors. Bedrooms were personalised and residents in shared rooms had privacy curtains and ample space for their belongings. The centre was mostly free of clutter. Overall the premises supported the privacy and comfort of residents. However, some improvements were required in relation to the centres premises this will be discussed further under Regulation 17.

Improvements were found in fire safety since the previous inspection. The provider had completed building works to contain fire boundaries to the ceiling on the first floor level and stairwell, all fire compartments had evacuation equipment aids and evacuation maps displayed. All fire doors in the centre had been adjusted and repaired to ensure that they closed effectively. All staff had completed fire training in the centre. Effective systems were in place for the maintenance of the fire detection, alarm systems, and emergency lighting. The centre had automated door closures to bedrooms and compartment doors. All fire doors were checked on the day of inspection and all were in working order. There was evidence of an on-going schedule for fire safety training. There was evidence that fire drills took place regularly. There was evidence of fire drills taking place in each compartment with simulated night time drill taking place in the centres largest compartment. Fire drills records were detailed containing the number of residents evacuated, how long the evacuation took, and learning identified to inform future drills. There was a system for daily and weekly checking, of means of escape, fire safety equipment, and fire doors. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. All fire safety equipment service records were up to date. The PEEP's identified the different evacuation methods applicable to individual residents. Staff spoken to were familiar with the centres evacuation procedure. There was evidence that fire safety was an agenda item at meetings in the centre. On the day of inspection there were two residents who smoked and detailed smoking risk assessments were available for both residents. A fire blanket, fire extinguisher, suitable ashtrays and a call bell were in place in the centres designated outdoor smoking area.

Staff were observed to have good hygiene practices and personal protective equipment (PPE) storage dani-centres were available throughout the centre. Sufficient housekeeping resources were in place. Housekeeping staff were knowledgeable of correct cleaning and infection control procedures. The cleaning schedules and records were viewed on inspection. Intensive cleaning schedules had been incorporated into the regular weekly cleaning programme in the centre. The centre had a curtain cleaning schedule. Used laundry was segregated in line with best practice guidelines and the centres relocated laundry had a work way flow for dirty to clean laundry which prevented a risk of cross contamination. There was evidence that infection prevention control (IPC) was an agenda item on the minutes of the centres staff meetings. IPC audits which included COVID 19 were evident and actions required were discussed at the centres management meetings. There was an up to date IPC policies which included COVID 19 and multi-drug resistant organism (MDRO) infections. The person in charge had completed a post Covid-19 outbreak report which identified learning from the outbreak, such as improvement in communication and clearer isolation zones. Improvements were required in relation to infection prevention and control, this will be discussed further in the report.

The inspector saw that the resident’s pre- admission assessments, nursing assessments and care plans were maintained on a paper based system. Residents’ needs were comprehensively assessed prior to and following admission. Resident’s assessments were undertaken using a variety of validated tools and care plans were developed following these assessments. Care plans viewed by the inspector were comprehensive and person- centred. Care plans were sufficiently detailed to guide

staff in the provision of person-centred care and had been updated to reflect changes required in relation to incidents of falls, infections and wound care. Care plans were regularly reviewed and updated following assessments and recommendations by allied health professionals. There was evidence that the care plans were reviewed by nursing staff. Consultation had taken place with the resident or where appropriate that resident's family to review the care plan at intervals not exceeding 4 months.

Residents were supported to access appropriate health care services in accordance with their assessed needs and preferences. General Practitioners (GP's) attended the centre and residents had regular medical reviews. Residents also had access to a consultant geriatrician, a psychiatric team, nurse specialists and palliative home care services. A range of allied health professionals were accessible to residents as required an in accordance with their assessed needs, for example, physiotherapist, speech and language therapist, dietician and chiropodist. There was evidence that residents had attended a physiotherapist and occupational therapist to provide individual assessments. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

The centre had reduced bed rail usage since the previous inspection, with four of the 20 residents using restrictive bed rails on the day of inspection. There was policy in place to inform management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort with their social or physical environment) and restrictive practices in the centre. There was evidence that staff had received training in managing behaviour that is challenging. Residents' had access to psychiatry of later life. For resident's with identified responsive behaviours, nursing staff had identified the trigger causing the responsive behaviour using a validated antecedent- behaviour- consequence (ABC) tool. There was a clear care plan for the management of resident's responsive behaviour. It was evident that the care plans were being implemented. Risk assessments were completed, a restrictive practice register was maintained, and the use of restrictive practice was reviewed regularly. Less restrictive alternatives to bed rails were in use such as sensor mats and low beds. The front door to the centre was locked. The intention was to provide a secure environment, and not to restrict movement . Residents' were seen assisted by staff to leave the centre throughout the day.

The centre had arrangements in place to protect residents from abuse. There was a site-specific policy on the protection of the resident from abuse. Safeguarding training had been provided to all staff in the centre and staff were familiar with the types and signs of abuse and with the procedures for reporting concerns. All staff spoken with would have no hesitation in reporting any concern regarding residents' safety or welfare to the centre's management team. The provider assured the inspector that all staff had valid Garda vetting disclosures in place.

There was a rights based approach to care in this centre. Residents rights, and choices were respected. Most residents were actively involved in the organisation of the service. There was evidence that resident meetings and informal feedback informed the service. The centre promoted the residents independence and their

rights. The residents had access to an independent advocate and a SAGE advocate in the centre. The advocacy service details and activities planner were displayed in the main entrance area and conservatory area. Residents' were complimentary of the activities provided by the centres staff. Residents confirmed that their religious and civil rights were supported. Mass took place fortnightly in the centre. Group activities of card games and bingo took place on the day of inspection. Residents has access to daily national newspapers, weekly local papers, WIFI, books, televisions, and radio's.

The centre had a risk management policy that contained actions and measures to control specified risks and which met the criteria set out in regulation 26. The centre's risk register was reviewed in September 2022 and contained information about active risks and control measures to mitigate these risks. There were up to date COVID -19 risk assessments in place including the centres contingency plans for a COVID- 19 outbreak. The risk registered contained site specific risks such as risks associated with individual residents, and risks associated with manual handling equipment.

## Regulation 11: Visits

Indoor visiting had resumed in line with the most up to date guidance for residential centres. The centre had arrangements in place to ensure the ongoing safety of residents. Visitors continued to have temperature checks and screening questions to determine their risk of exposure to COVID-19 on entry to the centre.

Judgment: Compliant

## Regulation 17: Premises

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example;

- Lockable storage required review as residents in rooms 2, 3, 4,11,14,15,16, 20, and 21 did not have lockable storage space.
- Flooring in room 16 and a toilet area required review as the flooring was curling from the wall edges.
- Storage rooms on the first floor required review as these rooms had incontinence wear, cleaning products stored together and another had resident clothes and manual handling hoists stored together .This posed a safety risk to staff working and residents living in the centre.

Judgment: Substantially compliant

## Regulation 26: Risk management

Arrangements were in place to guide staff on the identification and management of risks. The centre had a risk management policy which contained appropriate guidance on identification and management of risks. A register of live risks was maintained which included additional risks due to COVID-19, these were regularly reviewed with appropriate actions in place to eliminate and mitigate risks.

Judgment: Compliant

## Regulation 27: Infection control

Some actions were required to ensure the environment was as safe as possible for residents and staff and in line with IPC. For Example;

- A review of the bedroom wash hand basin units was required as a number of cabinets were damaged with exposed (medium density fibreboard) MDF. This posed a risk of cross contamination as staff could not effectively clean the residents wash hand basin units.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

The provider had good oversight of fire safety. Annual training was provided and systems were in place to ensure fire safety was monitored and fire detection and alarms were effective in line with the regulations. Bedroom doors had automatic closing devices so that residents who liked their door open could do so safely. Evacuation drills were regularly practiced based on lowest staffing levels in the centre's largest compartment.

Judgment: Compliant

## Regulation 5: Individual assessment and care plan

The standard of care planning was good and described person-centred care interventions to meet the assessed needs of residents. Validated risk assessments were regularly and routinely completed to assess various clinical risks including risks

of malnutrition, bed rail usage, pressure sores and falls. Based on a sample of care plans viewed appropriate interventions were in place for residents' assessed needs.

Judgment: Compliant

## Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. GP's routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professional as appropriate.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

There was a centre-specific policy and procedure in place for the management of behaviour that is challenging. A validated antecedent- behaviour- consequence (ABC) tool, and care plan supported the resident with responsive behaviour. The use of restraint in the centre was used in accordance with the national policy. Staff were familiar with the residents rights and choices in relation to restraint use. Alternatives measures to restraint were tried, and consent was obtained when restraint was in use. Records confirmed that staff carried out regular safety checks when bed rails were in use.

Judgment: Compliant

## Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns.

Judgment: Compliant

## Regulation 9: Residents' rights

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| Residents' rights and choice were promoted and respected within the confines of the centre. 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 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 21: Records | Substantially compliant |
| Regulation 23: Governance and management | Compliant |
| Regulation 31: Notification of incidents | Substantially compliant |
| Regulation 34: Complaints procedure | Substantially 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 | Compliant |
| Regulation 5: Individual assessment and care plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Managing behaviour that is challenging | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Willowbrook Lodge OSV-0000302

## Inspection ID: MON-0038587

## Date of inspection: 07/12/2022

**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:<br>Contacted staff members and requested them to update their CVS and forward to the office.<br><br>Noted and will be completed by 15/02/2023 | |
| Regulation 31: Notification of incidents | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 31: Notification of incidents:<br>Noted and will follow hereafter. | |
| Regulation 34: Complaints procedure | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 34: Complaints procedure:<br>Noted and made changes, will follow up on complaint procedures. | |

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| Regulation 17: Premises | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Storage room will be fitted with more shelves.
2. Hoist will be removed from storage room.
3. Locks will be added to personal storage for residents.

Will be completed by 28/02/2023

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| Regulation 27: Infection control | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 27: Infection control:
Will be completed according to the tradesman's availability

Will be completed by 28/02/2023

## 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 | 28/02/2023 |
| Regulation 21(1) | The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector. | Substantially Compliant | Yellow | 15/02/2023 |
| Regulation 27 | The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated | Substantially Compliant | Yellow | 28/02/2023 |

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| | infections published by the Authority are implemented by staff. | | | |
| Regulation 31(1) | Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence. | Substantially Compliant | Yellow | 14/01/2023 |
| Regulation 34(1)(f) | The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied. | Substantially Compliant | Yellow | 14/01/2023 |