# Report of an inspection of a Designated Centre for Older People.

## Issued by the Chief Inspector

| Name of designated centre: | Aperee Living Galway |
|---|---|
| Name of provider: | Aperee Living Galway Limited |
| Address of centre: | Ballinfoyle, Headford Road, Galway |
| Type of inspection: | Unannounced |
| Date of inspection: | 10 May 2023 |
| Centre ID: | OSV-0000331 |
| Fieldwork ID: | MON-0040040 |

## About the designated centre

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

Aperee Living Galway is a purpose built facility located on the Headford Road, Co Galway. The centre admits and provides care for residents of varying degrees of dependency from low to maximum. The nursing home is constructed on three levels. There are four double bedrooms and 52 single bedrooms. There is adequate sitting and dining space to accommodate all residents in comfort. The second floor is dedicated to accommodate residents of high dependency. The provider employs a staff team consisting of registered nurses, care assistants, administration, housekeeping and catering staff.

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

| Number of residents on the date of inspection: | 55 |
|---|---|

## 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 10 May 2023 | 10:00hrs to 18:30hrs | Una Fitzgerald | Lead |
| Wednesday 10 May 2023 | 10:00hrs to 18:30hrs | Catherine Sweeney | Support |

## What residents told us and what inspectors observed

Overall, the findings of this inspection were that residents were satisfied with their daily interactions with staff and felt that the staff knew their individual likes and dislikes. Residents were satisfied with the length of time it took to have their call bells answered. Residents were happy with the food and the choices available. While residents reported that they felt safe in the centre, the evidence found on this inspection did not support regulatory compliance with regard to the management of resident finances, and the system in place to manage fire safety. The evidence to support these findings is discussed in detail throughout the report.

A Fire Safety Risk Assessment commissioned by the provider in November 2021, and an inspection carried out by inspectors of social services in June 2022 found significant issues of concern in relation to fire safety. A compliance plan submitted by the provider following this inspection was not in progress and minimal action had been taken to address the immediacy of the risks identified. Following significant engagement with the Chief Inspector, the provider had committed to taking action to address all identified fire risks, some of which has been identified as high risk to residents, staff and visitors. On the day of inspection, inspectors found the majority of issues identified in the fire safety assessment and on inspection, had not been addressed. There was no information available as to when the required works would commence. This was a risk that was not being managed effectively by the provider.

The fire risk assessment of November 2021 identified that the upper floor of the centre had limited compartmentation, with up to 20 residents being accommodated in one compartment, with the requirement for these twenty residents to be evacuated from this area in the event of a fire. The provider had committed to commencing fire safety works to reduce the size of the compartmentation within this area. This would allow for containment of smoke and fire, and the safe evacuation of residents in the event of a fire emergency. This work had not commenced and the risks associated with the current arrangement remained.

Following an introductory meeting, the inspectors walked through the premises with the person in charge. There was a large reception area on entering the building. The area was well furnished and was inviting and welcoming. Inspectors observed the residents in the centre using this area to sit and wait for their relatives to arrive, or to watch the comings and goings of staff and visitors to the centre. The bedroom accommodation was situated across three floors. Residents were satisfied with their bedroom size, en-suite bathrooms and the availability of storage space for personal items.

The design and layout of the centre supported the needs of residents to move freely and safely. Corridors were clear of obstructions. Storage cupboards were clutter-free, and laundry storage was easily accessible. On the second floor, there was a unit that accommodated residents with dementia. There was a small sitting room in this area that was observed to be in use by residents throughout the day. This unit

has a separate dining room. Inspectors observed that this dining room was kept in a poor state. The kitchen appliances were visibly unclean and the floors were heavily stained and marked. The cabinet that stored the cups and saucers was in a poor state of repair and not amenable to cleaning.

Inspectors spent time observing some of the residents living with dementia and their engagement with staff. While some of these residents were unable to tell the inspectors their views on the quality of the service, the inspectors observed that they were relaxed and comfortable in their surroundings. With the exception of a communal sitting and dining room on the ground floor, inspectors observed that communal rooms were supervised by staff.

Residents told the inspectors that they were familiar with the person in charge, and that they would not hesitate in bringing any concerns to their attention. When asked how they spend their day, residents reported that there was sufficient activities and choice available.

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 risk inspection carried out by inspectors of social services to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended)
- follow up on the actions taken by the provider to address issues of non-compliance found during an inspection of the centre in June 2022 in relation to the governance and management of the centre, and the management of fire safety
- review written representation regarding a notice of proposed decision to cease new admissions into the centre until the building was compliant with Regulation 28; Fire precautions
- follow up on concerns received by the Chief Inspector in relation to the management of resident finances

Inspectors found that the provider had failed to implement the compliance plan submitted to the Chief Inspector following the last inspection in June 2022. This meant that the provider had failed to take adequate steps to address the serious non-compliance found with Regulation 28: Fire precautions. In addition, during this inspection inspectors found serious non-compliance with both the overall management of resident finances, and the resources available to ensure an effective service. Resident finances and the management of pension arrangements in the centre were not in line with regulation requirements. Inspectors found that there

was no clear systems in place to ensure that the finances of the centre were appropriately managed.

Aperee Living Galway Limited was the registered provider of Aperee Living Galway. The Chief Inspector was concerned about the registered provider's ability to sustain a safe quality service. There had been ongoing regulatory engagement with the provider, including provider meetings and, cautionary and warning meetings in relation to governance and management and fire safety. The current governance structure was supported by a company external to the registered provider, comprising of two newly appointed regional managers, a human resource (HR) and finance team, and a chief operations officer. Within the centre, the management team comprised of a person in charge, an assistant director of nursing, nurses, care team, housekeeping team and an accounts manager.

Fire safety concerns had been identified in the centres own fire safety risk assessment, and during the previous inspection of the centre, and there was a significant lack of progress in addressing these areas of high risk. The level of risk in the centre was such that the Chief Inspector issued a notice of proposed decision to cease admissions into the centre until all the fire safety issues were addressed. Following this proposed decision, the provider submitted a representation to the Chief Inspector with a commitment that fire related works would commence on the 29 March 2023 with a completion date of 3 January 2024. On the day of inspection, this work had not commenced, and there was no information made available as to when the start date would be. This is further discussed in the Quality and Safety section of the report.

Following information of concern about residents' finances, inspectors reviewed the policies and procedures in place to ensure residents' funds were safeguarded. The provider was a pension agent for one resident, and also held a small amount of money belonging to the estate of two deceased residents. The provider held residents' money in the company's bank account. Inspectors were very concerned about the manner in which residents' funds were being managed, and were not safeguarded. An urgent compliance plan request was issued to the provider during the inspection to provide assurance to the Chief Inspector that the centre was adequately resourced to provide a safe and effective service to residents. The response from the provider failed to provide adequate assurances.

While inspectors found that the person in charge was committed to a programme of quality improvement to enhance and improve the daily lives of the residents, the implementation of this programme was impacted by insufficient management support. For example, an assistant director of nursing with responsibility for the supervision of direct care was redeployed to providing direct nursing care and so could not fulfil their monitoring and supervisory role. A review of the daily roster of the centre found that, due to a continued shortage of staff nurses, nursing management were supporting the service by delivering direct nursing care. This reduced the amount of time available for oversight and supervision of the service.

The staffing levels in the centre on the day of inspection were found to be adequate for the assessed needs of the residents. Staff training was found to be appropriate

and completed by all staff. Supervision of staff was found to be compromised by the reduced supervisory hours available to the nurse management team.

Notifiable events, as detailed under Schedule 4 of the regulations, were notified to the Chief Inspector of Social Services, as required by the regulations.

## Regulation 15: Staffing

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

The supervision of staff was compromised by inadequate levels of nursing staff. This impacted the oversight of nursing documentation.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The registered provider did not ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. For example, inadequate levels of nursing staff impacted on the ability to cover planned and unplanned leave. A review of the rosters found that nursing duties were regularly reallocated to the nurse management team, compromising the time available to supervise and monitor the service.

In addition, there were significant concerns in relation to the availability of sufficient resources in the centre. This was evidenced by

- a fire safety risk assessment, carried out by an external assessor in November 2021, had identified red-rated (requiring urgent action) risks which had not been addressed.
- in the event of some staff absence, this person was not always replaced with another staff member.
- the provider did not have appropriate banking and financial management systems in place.

The organisational structure of the centre was not stable, and not clearly defined.

The senior management team had seen a number of changes in the previous months, with further upcoming changes advised. The provider, Aperee Living Galway Limited, comprised of one director. The availability and access to the director was limited, and the current lines of authority and accountability were not clearly defined. Issues of serious regulatory concern had not been fully addressed, and additional issues were identified during this inspection, which further evidenced that the management structure in place was not sufficient to provide a safe service.

The systems in place for the management of residents' finances and pension agent arrangements were not in line with the centre's newly revised policy, or with regulatory requirements. The system did not ensure that the service provided was safe and appropriate. The current systems in place were wholly inadequate, and did not ensure residents were safeguarded from financial abuse. This was evidenced by

- resident pension arrangements, put in place by the provider, were not in line with national guidance, and did not meet their legal requirements
- the system in place to return monies to the estates of residents who had passed away was not robust
- the provider had not identified safeguarding concerns relating to the use of the resident monies that had remained in the company's current account.

Judgment: Not compliant

## Regulation 31: Notification of incidents

Notification of incidents to the Chief Inspector was completed in line with regulatory requirements.

Judgment: Compliant

## Quality and safety

The inspectors found that the interactions between residents and staff was patient and respectful throughout the inspection. Residents voiced satisfaction with the quality of care they received, and staff were observed to respond to residents requests for assistance in a timely manner.

Notwithstanding the positive feedback from residents in relation to their care, and the significant effort of the staff in the centre to ensure that resident enjoyed a good quality of life, inspectors found that the lack of action taken by the provider to address the significant risk of fire in the centre did not ensure that the residents were safe. Furthermore, the provider failed to ensure that residents' finances were protected. As stated in the capacity and capability section of this report, the

inadequate resourcing of nursing staff was impacting on the supervision of nursing documentation.

Inspectors followed up on the detail described in the providers representation in relation to action taken to address the fire issues in the centre. The provider had failed to commence the action required to address fire safety risks. Factoring in the seriousness the fire safety concerns identified during the June 2022 inspection, coupled with the clarity that, on the day of inspection, planned fire safety works had not commenced in the centre, inspectors were not assured that the provider's fire safety arrangements adequately protected residents from the risk of fire. Inspectors were not assured that residents could be safely and effectively evacuated to a place of safety in the event of a fire. The compartment size and the works required to reduce compartment sizes had not commenced. A review of fire evacuation drills evidenced that the drill times recorded were excessive. This, combined with an inadequate vertical evacuation strategy, unsuitable external means of escape and deficiencies in containment measures led to an unsafe environment for the residents living in the centre. This is a repeated non-compliance.

A review of the management systems in place to manage residents' finances found that the provider did not take all reasonable measures to protect residents from abuse. Inspectors were significantly concerned that residents' finances were not protected in the centre. Inspectors found that the provider did not have robust financial systems in place to ensure that residents' finances were protected and that their monies were not used for any purpose other than by the individual residents. In addition, the provider had not ensured that, in the event of a resident passing away, the money held by the company on behalf of the resident, was passed to the estate of the resident.

Inspectors found that the daily care delivered to residents was of a satisfactory standard. Inspectors acknowledged that staff were knowledgeable with regard to resident's individual care needs and preferences. However, a review of the electronic documentation system identified incomplete information in residents' assessments and care plan records. For example, guidance directed by external health and social care professionals was not updated into the care plans which meant that the care plans were not directing the most appropriate care. In addition, multiple residents told the inspectors that they were not consulted on their care plans and had not been included in the care plan process. A review of residents' records found that there was arrangements in place for residents to access the services of allied health and social care professionals. However, there was evidence that advice received from external allied health care professionals was not integrated into the residents care plan.

Open visiting was occurring in the centre and inspectors observed visitors in the centre throughout the day. Visiting arrangements were observed to be unrestricted. There were opportunities for residents to consult with management and staff on how the centre was run. Minutes of residents meetings dated February 2023 evidenced that residents were consulted about the activities held, the satisfaction with the food served, and the importance of hand hygiene. Residents had access to

television, radio, newspapers and books.

## Regulation 28: Fire precautions

The provider had failed to take action to address the significant non-compliance found on the last inspection. The commitment made by the provider outlining the works that were to commence in the centre on 22 March 2023 had not commenced. Inspectors found that no action had been taken to address known risks such as;

- uncertainty over fire-containment requiring upgrades to compartment walls and ceilings.
- inadequate detection requiring an upgrade of the fire detection system.
- inadequate means of escape including an upgrade to internal and external emergency lighting.
- visual deficiencies in the building fabric
- visual deficiencies in the fire doors
- poor staff knowledge of compartment areas

Judgment: Not compliant

## Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not in line with the requirements of the regulations. Care plans were not reviewed or updated when a residents condition changed. For example,

- care plans guiding the care of residents with diabetes were not accurate and did not contain the most recent recommendations made by specialist teams.
- care plans were not updated with the most recent recommendations made for a resident assessed at risk of malnutrition

Judgment: Substantially compliant

## Regulation 8: Protection

The provider did not take all reasonable measures to protect residents' finances, and the management of pension arrangements in the centre were not in line with residents' rights and protection.

Aperee Living Galway Ltd. was a pension agent for a resident in the centre. This residents' monies were transferred directly into the current account of the provider.

The resident did not have direct and immediate access to their money. A review of bank statements for this account showed that the amount retained in this account since December 2022 was not always sufficient to allow the resident to access their money.

Contrary to good practices and assurances given to the Chief Inspector by the provider in November 2022 about the protection of residents' monies, the above findings raise serious concern that Aperee Living Galway Ltd., are not appropriately managing money owned by residents of Aperee Living Galway, and may be using it for purposes other than for the resident it belonged to.

Judgment: Not compliant

## Regulation 9: Residents' rights

Staff ensured that residents' rights were upheld in the designated centre. Staff were observed to engage in positive, person-centred interactions with residents. Residents told the inspector that they were well looked after and that they had a choice about how they spent their day. There was an activity schedule in place. Residents were observed to be socially engaged throughout the day of the inspection. The registered provider had ensured that visiting arrangements were in place and were not restricted.

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 | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 31: Notification of incidents | Compliant |
| **Quality and safety** | |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 8: Protection | Not compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Aperee Living Galway OSV-0000331

## Inspection ID: MON-0040040

## Date of inspection: 10/05/2023

**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 16: Training and staff development | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Director of Nursing shall ensure that processes and responsibilities for supervision are planned in advance and only changed in exceptional circumstances.

Agency nurses will be utilized to prevent the necessity of the DON doing nursing shifts. Allowing her to remain in a supervisory capacity.

Supervision is enhanced by ADON while completing nursing shifts routinely to ensure positive outcomes and quality service is provided to residents. This will be further supplemented with the return of the center's CNM early August. Staff will be supervised through observation and support of staff daily by both DON and ADON.

Additionally, staff appraisals will be used to support staff to identify any learning needs.

DON and ADON/CNM have weekly clinical meetings to ensure governance over clinical areas continues. Head of department meetings will continue monthly for complete oversight of the service. Care team meetings will be held every second month to ensure a multidisciplinary approach.

Senior Healthcare staff are available in shifts to add additional supervision to the floors.

Advertised internally for a senior staff nurse to supplement the management team.

Continuous professional development is encouraged for all staff members, which will ensure all staff have the relevant skills, knowledge, and attributes to do the job.

Constructive feedback and observation of practice on a day to day basis is part of the learning process.

| Regulation 23: Governance and management | Not Compliant |
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Outline how you are going to come into compliance with Regulation 23: Governance and management:
The RPR and Director of Nursing will ensure a staffing contingency plan is in place in the event of a shortfall in staffing levels in the center. Shift shortages are generally covered with the center's internal care team and ADON where possible, agency shifts and the Director of Nursing in exceptional circumstances. It is not, however, always possible to cover all staff absence shifts due to late notification. The Provider is currently identifying any potential gaps between current and future workforce needs and an active recruitment campaign is ongoing.

The Director of Nursing and internal HR person are further engaging with a number of Recruitment Consultants to assist with RGN recruitment. All progress and efforts are monitored and documented by the Administrative Team.

To date 4 RGN's are on boarding with the below timeframe of start dates.
1 expected to start no later than 30th August.
1 will commence by 30th of September.
1 By the 30th October and
1 by the 30th November.
1 CNM will be returning from maternity leave early August.

This will ensure that by November 30th the nursing roster will have 10 WTE with 2 staff nurses on Maternity leave which will be complying and in excess of what the SOP outlines.

The lines of accountability and authority in Aperee Living Galway will be clearly defined at individual, team and service level, all staff will be informed of the management structure and facilitated to communicate regularly with management. The organizational structure will be outlined in the Statement of Purpose.

The COO is currently holding the role of PPIM. The PPIM and DON meet monthly, and have weekly calls, demonstrating better oversight of issues in the home as they arise. Development of the meetings include a standing agenda that includes all aspects of the service, consistent analysis and action plans are developed to inform improvements that may be needed in the service.

Resident pension and deceased funds arrangements in Aperee Living Galway have been updated in line with National Guidance and the homes policy for management of personal property, personal finances, and possessions by the Provider.

Residents' funds will not be used for any other purpose than the resident's own use,

remaining balance less their weekly personal contribution will be safe guarded in a recently opened separate client resident account and balances monitored frequently by the Accounts Department. Monthly statements will be provided to each resident.

All deceased residents' monies have been returned to the Residents estate.

The Provider shall evaluate its safeguarding practices, its approach to identifying, responding to, managing, and learning from safeguarding concerns and the resulting outcomes.

| Regulation 28: Fire precautions | Not Compliant |
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The management of fire safety, and the systems associated with Fire Safety will be enhanced to ensure the service provided is safe. The Registered Provider is committed to ensure all outstanding risks identified in the homes fire safety risk assessment shall be addressed no later than November 30th.

As the required works are implemented, The RPR in conjunction with the Director of Nursing shall take steps to mitigate the issues and implement any controls or improvements identified.

Weekly fire education sessions are completed to reinforce and educate on the fire risks, compartment sizes, evacuation process and safety awareness. A designated person is assigned this role. This person also completes a secondary check of all fire equipment, SKI sheets and PEEPS, this is in addition to the daily and weekly inspections carried out by maintenance man.
Routine practice sessions for evacuation of the largest compartment are carried out with a view to reducing times.
Night porter employed for the purpose of patrolling at night to monitor for fire risks and ensure all safety measures are in place. The night porter is trained in evacuation and is an additional person on duty should an evacuation be needed.
Fire and risk are discussed at all head of department meetings and care team meetings.
All staff have up to date fire training.
All fire equipment has up to date servicing and testing.
New head lamps and High vis jackets have been purchased to enable the staff to work in the bedrooms where emergency lighting is needed. Emergency lighting is available in all other areas of the home.
Emergency door releases have been installed at external doors in the event that the main systems would fail.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

| Regulation 5: Individual assessment and care plan | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Full risk assessment in place highlighting care plan deficiencies and where actions were needed.
Full care plan review was completed following the inspection and Staff nurses responsible for updating all care plans.
Full review of systems in the management of diabetes and management of reviews with Diabetic nurse specialist were completed. GP to be included in all correspondence with Diabetic nurse specialists and care plans updated to reflect same.
All prescriptions updated in liaison with GP to highlight that doses will change according to Diabetic nurse specialist recommendations following the weekly review of blood sugar readings.
Full review of all residents in receipt of Dietician input completed immediately after the inspection to ensure all recommendations are up to date in the care plan.
Full review of existing recommendations to ensure all current guidance is implemented.
Food and nutritional needs were at the time segregated across three different care plans.
All requirements now condensed to one care plan to avoid conflicting advice in different care plans.
Full review and new plan for how care plans are documented currently in process.

| Regulation 8: Protection | Not Compliant |
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Outline how you are going to come into compliance with Regulation 8: Protection:
The policy for management of personal property, personal finances and possessions has been updated in line with National Guidance to include the process for managing pension arrangements in the centre.

Residents’ pension funds will not be used for any other purpose than the resident’s own use, remaining balance less their weekly personal contribution will be safe guarded in a separate client resident account and balances monitored frequently by the Accounts Department. Monthly statements will be provided to each resident.

## 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 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 28/07/2023 |
| 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 | 30/08/2023 |
| Regulation 23(b) | The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision. | Not Compliant | Orange | 28/07/2023 |
| Regulation 23(c) | The registered | Not Compliant | Red | 12/08/2023 |

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| | provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | | | |
| 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. | Not Compliant | Orange | 30/11/2023 |
| Regulation 28(1)(b) | The registered provider shall provide adequate means of escape, including emergency lighting. | Not Compliant | Orange | 30/11/2023 |
| 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, | Not Compliant | Orange | 30/08/2023 |

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| | first aid, fire 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. | Not Compliant | Orange | 15/08/2023 |
| Regulation 28(2)(i) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 30/11/2023 |
| 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 | 30/11/2023 |
| Regulation 5(4) | The person in charge shall formally review, at | Substantially Compliant | Yellow | 30/09/2023 |

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| | 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. | Not Compliant | Orange | 07/07/2023 |