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:	Claremount Nursing Home
Name of provider:	Claremount Nursing Home
Address of centre:	Claremount, Claremorris, Mayo
Type of inspection:	Unannounced
Date of inspection:	07 February 2025
Centre ID:	OSV-0000329
Fieldwork ID:	MON-0043572

About the designated centre

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

Claremont Nursing home is a purpose-built, two-storey centre which provides 24-hour nursing care for up to 69 residents requiring continuing care, convalescence, respite, dementia and palliative care. The centre is well laid out. Residents are accommodated on the ground floor. Bedroom accommodation comprises of 31 single and 19 twin bedrooms. All bedrooms have accessible en-suite toilet and showering facilities. There is a choice of different communal areas for residents to relax and a separate visitors' room, physiotherapy room and oratory are available. The centre is located approximately 1km outside the town of Claremorris in County Mayo. It has a large internal garden for residents and is set in landscaped grounds.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	56

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
Friday 7 February 2025	08:00hrs to 16:00hrs	Celine Neary	Lead
Friday 7 February 2025	08:00hrs to 16:00hrs	Helena Budzicz	Support

What residents told us and what inspectors observed

Overall, inspectors observed that while some residents enjoyed a good quality of life and their rights were respected, overly restrictive practices did not ensure that residents could make choices about their daily routines and their ability to seek assistance and support. In addition, their were limited opportunities for some residents who had significant cognitive impairment to engage in meaningful social activities in line with their preferences and capacities.

This was an unannounced inspection and on arrival to the centre, the inspectors were greeted by the general manager and the person in charge. The provider attended and met with the inspectors later that morning. An introductory meeting was held followed by a walk around of the centre with the general manager and person in charge. This gave the inspectors the opportunity to meet with residents and staff, to observe residents in their home environment and to observe staff practices. The inspectors noted that there was a relaxed and calm atmosphere in the centre. Residents were being assisted to get up from bed and were being supported by staff with their breakfast and to mobilise around the centre on their way to the various communal rooms.

Claremount Nursing Home provides long term care for both male and female adults with a range of dependencies and needs. The designated centre is a purpose built nursing home that can accommodate a maximum of 69 residents. There were 56 residents living in the centre at the time of this inspection. The centre was bright, airy, welcoming, and pleasantly decorated throughout with photographs, paintings and wall ornaments. Residents had a choice of communal areas to use and these were well used on the day of the inspection.

The centre is located on the outskirts of Claremorris town. The majority of residents living in the centre had a known diagnosis of dementia. Those residents who could not communicate their needs to staff appeared comfortable and content.

While walking through the centre, inspectors saw that staff were attentive to residents needs and were assisting residents in an unhurried manner. It was evident to the inspectors that the management and staff knew the residents well as they were seen to adapt their approach in line with the residents' individual needs. However, inspectors observed several occasions throughout the day were staff did not always engage with or seek consent from residents when providing care. Furthermore, inspectors observed that some staff were communicating with each other and not with the resident, when providing them with care. This did not support a person-centred approach to care or promote the dignity and respect of the residents.

The centre was warm throughout and there was a homely atmosphere. Residents were observed sitting in a number of communal rooms throughout the centre. These rooms included a large reception area, a spacious dining room and large bright

lounges for residents to enjoy. Each communal area provided comfortable seating options. Some seating had been reupholstered since the last inspection in communal area's, and there was a schedule in place to refurbish any remaining seats in need of repair. In addition the flooring in a number of en suite toilets had been replaced with new flooring and this refurbishment plan was ongoing with the remaining en suite bathrooms where flooring was damaged. The centre also had a decorative courtyard garden which was well maintained and safely enclosed.

Overall the centre was clean and tidy. Additional hand wash basins had been installed since the last inspection, and there were wall-mounted alcohol hand gels readily available throughout the centre, to promote good hand hygiene.

Although there was a schedule of activities available, inspectors found that these activities did not occur on the day. There was an over reliance on the use of television to entertain residents and the inspector observed that many residents were seated in a row in front of the television, for long periods, in between mealtimes with little engagement or stimulation provided. While the activity coordinator was present in the room the inspector observed, on several occasions, that their time was spent completing paperwork or assisting with personal care, instead of providing activities for residents. This was a repeat finding from previous inspections.

Residents who spent the majority of their day in their bedrooms were not observed to have any social interactions or access to meaningful activities other than television or radio on the day of the inspection. Residents who spoke with the inspector's said that they enjoyed receiving visitors in the centre and that it often broke up the day for them.

There were not enough tables in the day rooms for residents to place their drink or a cup of tea, so it was left by their feet on the ground. This meant that residents did not have easy access to a drink if required and was not acceptable. Furthermore, inspectors observed that drinks and jugs of water were not left within easy reach of residents when they were resting in their bedrooms.

The inspectors observed two sittings of residents' mealtimes. Residents who spoke with the inspectors praised the quality and quantity of the food served and confirmed that their personal preferences were catered for. The food served on the day of the inspection was well presented and residents appeared to enjoy it. Residents had a choice of meals. However, the inspector's observations indicated that the mealtime experience could be improved upon. For example, nurses brought the medication trolley into the dining room to administer medications and this caused interruption to residents during their meals and did not support an enjoyable dining experience.

While there were sufficient staff available to support residents to eat and drink, a number of staff were observed failing to speak or interact with the residents that they were assisting with their meals. In addition staff were observed to interrupt a resident during their meal to momentarily attend to another task or speak with

colleagues. These observations did not support person-centred care, and did not provide a sociable atmosphere or a pleasant dining experience for all residents.

During the early morning walk around inspectors identified that more than 10 emergency call bells were missing from residents bedrooms. This did not promote the safety and well being of these residents if they needed assistance. As a result, during the walk around the person in charge had to seek staff to attend to some residents, looking for or in need of assistance, who did not have access to a call bell to alert staff that they needed them.

Visitors were observed coming and going on the day of the inspection. There were no restrictions on visiting and residents were observed meeting their visitors both in private and in the communal areas of the centre.

The inspectors observed that residents could only access the pleasant outdoor areas via emergency fire doors. These doors had a key code lock in place and residents had to seek the assistance of staff if they wanted to go out into their enclosed courtyard garden. This was an overly restrictive practice that did not enable residents to access their outside space without the assistance of staff and is a repeat finding from the last inspection.

The next two sections of the report will present the findings in relation to governance and management in the centre and how this impacts on the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed under the relevant regulations.

Capacity and capability

This was an unannounced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in designated Centres for Older People) Regulations 2013 as amended. Inspectors followed up on the compliance plan from the previous inspection in March 2024. The registered provider had addressed many of the outstanding actions from the previous inspection and improvements were found on this inspection. However, improved focus and oversight were now required to achieve full compliance with the regulations. The findings are set out under the relevant regulations.

Claremount Nursing Home Limited is the registered provider for this designated centre. The management structure as set out in the centre's statement of purpose, was in place and, consists of the provider, a general manager, a person in charge and two clinical nurse managers. A team of nursing staff provide clinical support along with health care assistants, household, catering and maintenance staff. A physiotherapist is also based in the centre five days per week.

Inspectors followed up on the actions taken by the provider to address the non-compliance in relation to Regulation 23: Governance and Management, Regulation

27: Infection Prevention and Control and Regulation 28: Fire Precautions, found on the last inspection in March 2024. The provider had submitted an application to vary the time frame of a restrictive condition, which had been attached by the Chief Inspector to ensure regulatory compliance. This condition related to fire safety issues identified in the centre on inspections in 2024. The information submitted in the application was reviewed as part of this inspection.

The provider had ensured that staffing resources were effectively organised and managed in the centre, to ensure that care was provided to residents, in accordance with the centre's own statement of purpose. A review of the staffing rosters evidenced that staffing resources were available to cover planned and unplanned leave. The provider had recently recruited three health care assistants and two staff nurses to ensure base line staffing levels were met. They were also actively recruiting for an administrator.

A review of staff training records evidenced that all staff had up-to-date training appropriate to their role. Staff demonstrated an awareness of their training with regard to the safeguarding of vulnerable people, and the procedure to commence in the event of a fire emergency. However, many staff had not completed training in responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment), restrictive practices or human rights.

The provider had management systems in place to monitor the quality of the service provided to residents. Key aspects of the quality of residents care were collected in relation to falls, weight loss, nutrition, complaints, and the incidence of wounds. However, there was little evidence that this information was used to inform quality improvement initiatives. For example, while the management had identified residents that were a high risk of malnutrition, there was no evidence that this information was used to improve outcomes or the quality of care provided for these residents. Furthermore, there was no analysis of the information collected in respect of the incidence of unwitnessed falls that had occurred in the centre to identify contributing factors and develop a quality improvement action plan. These findings are discussed further under Regulation 23; Governance and Management.

Inspectors found that not all notifiable incidents had been notified to the office of the Chief Inspector within the required time frames. This information had to be requested by the inspector. These notifiable incidents had occurred in November and December 2024 and were submitted retrospectively by management, when requested.

The centre had a policy and procedure in place for the management of complaints. Inspectors reviewed a sample of complaints and found that these had been managed in accordance with the centre's policy. A review of the complaints records showed that the satisfaction of the complainant was documented following the record of the outcome of the complaint investigation and actions taken.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The registered provider had submitted an application to vary Condition 4 of the designated centre's registration. In addition to the application, the provider also submitted all of the required information to comply with Schedule 1 and Schedule 2 of the registration regulations. The required registration fee had been paid.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staff on duty on the day of the inspection to provide care in line with the residents' assessed needs and the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

A review of the training records showed that 25 staff had not completed the training for responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) and 32 staff did not complete the training for restrictive practices even though the provider's own training/restricitve practices policy stated that all staff should be trained in dementia care and the management of responsive behaviours.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems that were in place did not always ensure that the service provided was safe, appropriate and effectively monitored. For example;

- While there was an auditing system in place, there was no clear action plan documented and outlined to inform a quality improvement plan. For example, there was no evidence in the monitoring of the falls that the trending analysis was completed to review the effectiveness of the measures in place to prevent falls and also did not provide an adequate quality improvement plan to ensure the safety of residents and a reduction of falls in the centre.

- While six residents were identified as being at high risk of malnutrition in the monthly MUST (Malnutrition Universal Screening Tool) audit in December 2024, there was no quality improvement plan developed to ensure residents' nutritional care needs and nutritional risks were appropriately identified, monitored, and managed.
- Some of the audits, such as Safe and Effective Services, achieved 100% compliance and did not identify the findings from this inspection. They stated that all staff received responsive behaviour training (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). However, this inspection findings were that 25 staff members had not attended this training, compromising the adequate oversight of staff practices in the centre.

While the annual review of the quality and safety of care delivered to residents in 2024 was completed, and quality improvement plans were outlined for 2025, it did not include the level of engagement of advocacy services with residents and an overview of complaints received, including reviews conducted.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The management team in the centre did not submit the required notifications to the Chief Inspectors office relating to a significant influenza outbreak in December 2024. This is a repeat finding from previous inspections.

Judgment: Not compliant

Regulation 34: Complaints procedure

A complaints policy was in place, and the complaints procedure was displayed in the centre. A review of the records found that complaints and concerns were promptly managed and responded to in line with the regulatory requirements.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that residents' clinical and nursing care needs were being met to a satisfactory standard. This inspection identified that the provider and

their staff team had worked hard to ensure the findings from the previous inspection in 2024 were being addressed. This inspection found significant improvements had been completed in respect of the premises and the oversight of fire safety, however, more focus and effort were now required to ensure that all residents had access to meaningful activities in line with their preferences and capacities.

Whilst staff knew residents well, the inspectors observed that care provided for residents was not person centred, and did not ensure that their quality of life was enhanced and that their rights were adequately considered and respected.

For example, key code locks on the doors to the courtyard garden, were restricting residents living in this centre, to access their own garden freely. In addition, inspectors observed that on one occasion staff did not seek the resident's permission before they commenced a moving and handling maneuver. This startled the resident and did not uphold the resident's right to dignity and choice in their care.

Residents were provided with timely access to health care from their general practitioner (GP) and allied health professionals and psychiatric services who attended the residents in the centre as necessary. The provider employed a physiotherapist who provided treatments for residents on five days each week.

A number of residents with dementia experienced responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Some staff were observed by the inspectors to fail to appropriately respond to residents' responsive behaviours on the day of the inspection. For example, the inspectors observed two residents walking around the centre with purpose and displaying exit seeking behaviours. Although staff did provide reassurance, there was no meaningful interactions to support the residents in order to de-escalate these behaviours. As a result, they continued to walk around the centre for the day.

The inspector reviewed a number of residents' assessments and care plan documentation and found that they were adequately detailed to guide staff. Care plans were regularly up-dated in line with the regulations and where their were changes in the residents condition this information was included in the care plans. Residents with responsive behaviours did have appropriated care plans in place, however, these were not being implemented by some staff, on the day. Furthermore, one resident who had recently had a fall, and had been assessed as being a high risk of further falls and required the assistance of staff and a mobility aid, was observed by inspectors walking around the centre without assistance or a mobility aid, to support them.

Policies and procedures were in place to protect residents from risk of abuse. The provider ensured that staff were facilitated to attend safeguarding residents from abuse training. Residents confirmed to the inspectors that they felt safe living in the centre.

Residents had access to local and national newspapers and radios. However, there was limited meaningful social activities available on the day of the inspection for

many of the residents, including residents with dementia and responsive behaviours. The activities schedule on the day of inspection had outlined that a game show, fitness class, mass and bingo would take place. From the inspectors observations throughout the day, the only scheduled activity that took place was mass on the television. Furthermore, staff informed the inspectors that those residents who engaged in one-to-one activities were facilitated in the morning, during a short period of time. The inspectors were not assured that the activity coordinators could facilitate meaningful engagements and activities for residents, who chose to remain in their rooms, or could not participate in group activities. This was not a realistic time frame for providing meaningful on-to-one activities for a number of residents. The inspectors visited the communal rooms at various times throughout the day and, observed that residents in the communal rooms were watching television or sleeping with little provided in the way of meaningful activities or social interactions. These findings are set out under Regulation 9.

The overall environment was homely and well decorated and there was a comfortable atmosphere in the centre. Inspectors observed that many residents had brought in personal items and photographs from home to decorate their bedrooms. Significant refurbishment and redecoration had been completed since the last inspection however, a number of soft furnishings were torn or worn and needed repair or replacement. There was a plan in place to replace the damaged flooring in some en-suite bathrooms.

The storage of equipment also required review to ensure that resident equipment was cleaned and stored appropriately and that there was adequate segregation of clean and dirty items to prevent cross contamination.

The inspectors found that the registered provider had installed a number of hand hygiene sinks that met the required specifications since the last inspection. Infection prevention and control measures were in place and monitored by the senior management team. However, further improvements and greater oversight of housekeeping and infection prevention and control measures, were still required.These findings are discussed further under Regulation 27: Infection control.

The laundry facility was clearly segregated into clean and dirty zones and clean items were stored separately. Cleaning schedules were updated daily and there was adequate staffing resources daily to maintain a consistent service. The laundering of clothes was of a high standard and overall residents were satisfied with this service.

It is acknowledged the provider had completed a significant quantity of fire safety works in order to fulfil the commitments of their conditions of registration, and to bring the centre into full compliance with Regulation 28: Fire Precautions. The inspectors found that the provider had completed the vast majority of the required fire safety works, with some items still in progress and due for completion within the next three months.

Regulation 10: Communication difficulties

Residents who had communication difficulties and special communication requirements had these recorded in their care plans and were observed to be supported to communicate effectively.

Judgment: Compliant

Regulation 17: Premises

Although works were ongoing and the provider had made significant improvements to the premises some areas of the premises did not fully conform to the requirements set out in Schedule 6 of the regulations as follows;

- Flooring in some en-suite bathrooms were visibly stained and in need of repair or replacement.
- Some furniture was visibly worn and in need of repair or replacement.
- Emergency call bell facilities for all residents were not in place.

Judgment: Substantially compliant

Regulation 27: Infection control

The infection prevention and control processes that were in place did not adequately address risks associated with the transmission of health care-associated infections and the environment and equipment was not managed in a way that minimised the risk of transmitting a health care-associated infection. This was evidenced by the following findings;

- There was no process in place for staff to clean health care equipment or chairs used by residents. Inspectors observed several comfort chairs, safety mats and wheelchairs that were visibly dirty, on the day of inspection.
- Incontinence wear for residents personal use was open in a communal store room and this posed a risk of cross contamination.
- Health care equipment which had been used by residents was being stored alongside clean/sterile supplies in the same room.
- Medications in blister packs were placed on the floor in the medication room.
- Inspectors observed one residents urinary catheter bag was touching the floor.
- There was a poor quality infection prevention and control auditing system to drive quality improvement.
- Open-but-unused portions of wound dressings were observed in the treatment room. This practice should cease as once the package is opened it can no longer be considered sterile.

- The fabric on some items of furniture was worn which prevented them from being adequately cleaned. This was an ongoing non compliance from the last inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had completed a significant amount of fire safety works to the centre and was working towards bringing the centre into compliance. Substantial progress had been made on the remediation of the fire safety deficiencies outlined in the fire risk assessment completed in June, 2024, and further work to resolve the outstanding issues are in progress.

Notwithstanding this, the registered provider is required to carry out essential remedial works to the following:

1. The completion of fire-stopping works to the walls penetrated by the galvanised ducting above the kitchen.

2. Attic access hatches that do not have the same fire-rating as the ceilings.

3. Fire-stopping of the ceiling fans in the bedroom en-suites.

When these works are completed the provider is required to submit confirmation to the Office of the Chief Inspector.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Comprehensive care plans were based on validated risk assessment tools. These care plans were reviewed at regular intervals, not exceeding four months, or earlier if required. There was evidence of consultation with the resident and, where appropriate, their family when the care plans were revised.

Judgment: Compliant

Regulation 8: Protection

Measures were in place to ensure residents were safeguarded from risk of abuse and the procedures to be followed by staff were set out in the centre's policies and procedures. These measures included arrangements to ensure all incidents, allegations or suspicions of abuse were addressed and managed appropriately to protect residents at all times.

All staff were facilitated to complete training on safeguarding residents from abuse. Staff who spoke with the inspectors clearly articulated their responsibility to report any allegations, disclosures or suspicions of abuse and were familiar with the centre's reporting structures.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were not supported to exercise choice in their daily routines. This was evidenced by:

- Access to the courtyard garden of the centre was restricted due to a keypad lock on the doors. This meant that residents could not choose to access this outdoor space as they wished without a member of staff being available to open the doors for them.
- Not all residents were offered the same opportunities to participate in activities in accordance with their interests and capacities. There was an over reliance on television as an activity, and one to one activities for residents who chose to spend time in their bedrooms, did not always take place.
- The inspectors observed that residents were not consulted prior to care taking place and therefore could not exercise choice. The inspector observed staff transferring a resident from their chair to a wheelchair, but staff did not ask consent or explain to the resident why this was taking place.
- Many residents did not have access to call bells in their bedrooms and therefore could not seek help or assistance if required.

Although there were regular resident meetings held, there was no evidence found on inspection that resident feedback was being used to improve the service, for example;

- Residents meeting records reviewed on inspection did not include comments from residents regarding how they viewed the service or on what aspects of the service they particularly liked or would like to see changed.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Claremount Nursing Home OSV-0000329

Inspection ID: MON-0043572

Date of inspection: 07/02/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: BPSD will be completed by all staff Four sessions of BPSD training have been completed on the 14.02.2025 & 14.03.2025 All staff will complete the training BPSD by the 31/03/2025 Restraint will be completed by all staff Two sessions of restrictive practice training will be booked and completed by 09.05.2025	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The management of, recording, analysis and preventative action for falls will be reviewed monthly with the MDT to ensure a robust strategy for the prevention of, and reduction in falls is achievable. A full review of the year to date will be completed by the 31.03.2025 The quality management system and local practice will be reviewed to ensure a clear link and pathway between auditing and identifying non-compliance through to rectification	

and review.

1)Corrective action reports will be generated for all identified non compliance
2)An action plan generated
3)Discussed at QM Meetings
4)Reviewed and closed
Implemented; 11.03.2025

Residents identified in audits with a high must score had a detailed care plan and action plan in place to ensure malnutrition and weight loss were appropriately managed. However, this wasn't followed through and duplicated onto the audit action plan. Going forward the audit findings will reflect the care plans in place to ensure a clear pathway of identification, action and review.
Completed; 14.02.2025

The annual report has been reviewed to include advocacy & complaints
Completed; 01.03.2025

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All notifiable incidents will be notified to the chief inspector within the specified time frames – with immediate effect

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
amaged bedroom floors are currently been replaced and will be replaced by 31.07.2025

Damaged bathroom floors are currently been replaced and will be replaced by 31.07.2025

Paintwork is ongoing and will be completed by the 31.07.2025

Furniture is always steam cleaned in line with our local policy, however stains due to age are present. These chairs are on our renovation program and currently been recovered. Date for completion 31.07.2025

A review of all call bells has been completed. Broken/missing or out of reach call bells have been replaced.
Additional checks and governance of the call bells have been implemented with immediate effect. 07.03.2025

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Reinforcement of the local policy and protocol has been communicated to health care staff & housekeeping. All wheel chairs and equipment are to be cleaned after each use and prior to storage, 'im clean' labels will be applied for accountability. This will be monitored by the senior carer & CNMS. Date for implementation 10.03.2025

Infection prevention and control refresher training will be completed to ensure all staff are aware of the best practice for the cleaning, storage and use of equipment.
To be completed by 30.04.2025

All staff have been reminded of the best practice in relation to the storage of continence wear. Continence wear is not to be opened in the store room and must be taken to the individual resident room for use. This will be monitored by the senior Carer and CNM's.

Cleaning equipment; the hoover and sanitizing machine storage has been reviewed and is now stored in the cleaning store.
Completed 10.03.2025

Blister Packs were stored on the floor in a plastic container following the delivery of medication the night before. Nurses have been reminded that nothing should be stored directly on floor. All items are to be stored on the shelving provided.
Completed 10.03.2025

Catheter bags will be placed so to ensure the bag is not in contact with the floor.
Implemented 10.03.2025

The quality management system and local practice will be reviewed to ensure a clear link and pathway between auditing and identifying noncompliance through to rectification and review.

1)Corrective action reports will be generated for all identified non compliance
2)An action plan generated
3)Discussed at QM Meetings
4)Reviewed and closed

Implemented; 11.03.2025

Single use dressings will be discarded once opened.
Implemented 10.03.2025

Furniture is always steam cleaned in line with our local policy, however stains due to age are present. The chairs marked are on our renovation program and currently been recovered.
Date for completion 31.07.2025

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Compartmentation and fire stopping of the galvanized kitchen ducting.
Completed; 07.03.2025

Attic assess hatches; fire stopping has commenced with the direction of our fire engineer.
Date for completion; 30.04.2025

A contractor has been enrolled to complete the Fire stopping of the ceiling fans & the compartment walls under the direction of our fire engineer.
Completion date 31.05.2025

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The courtyard entrance access has been reviewed. The key coded access and alarm have been removed to ensure residents can access the gardens without staff help.
Date Completed; 03.03.2025

The activity plan and routine has been reviewed with the activity staff to identify shortfalls in the activity plan and schedule. Activity staff will be offered the opportunity to attend training specific to their role to ensure quality of a meaning full experience.
Date for completion; 30.06.2025

All staff have been reminded of the importance and need for good communication and the need to ensure consent is gained before any care is provided.
All staff will complete the training 'Human Rights' module 1, 2, 3 & 4.

Date for completion; 14.04.2025

Going forward we will ensure residents are consulted with in regards to aspects of the service they particularly like & would like to see changed. This will be documented in resident meeting minutes.
Date for Completion; 31.03.2025

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)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	09/05/2025
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	31/07/2025
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2025
Regulation 23(e)	The registered provider shall ensure that the	Substantially Compliant	Yellow	01/03/2025

	review referred to in subparagraph (d) is prepared in consultation with residents and their families.			
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.	Not Compliant	Orange	31/07/2025
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/05/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Yellow	28/03/2025
Regulation 31(2)	The person in charge shall ensure that, when the cause of an unexpected death has been established, the Chief Inspector is	Not Compliant	Yellow	28/03/2025

	informed of that cause in writing.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/06/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	03/03/2025
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	03/03/2025