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:	Glebe House Nursing Home
Name of provider:	Cowper Care Centre DAC
Address of centre:	Kilternan Care Centre, Glebe Road, Kilternan, Dublin 18
Type of inspection:	Unannounced
Date of inspection:	06 February 2025
Centre ID:	OSV-0000039
Fieldwork ID:	MON-0046322

About the designated centre

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

The centre is located on the outskirts of Dublin and is close to local amenities such as bus routes, local shops and close proximity to the M50. It is a purpose built single storey building that opened for business in 1994. The service provides general nursing and dementia care as long term care, respite or convalescence for residents with maximum, high, medium, and low needs. They are registered to offer 54 beds to male and female residents primarily over the age of 65. There is a mixture of single and twin en-suite bedrooms provided over four units. There is a hub in the middle of the centre with a seating area and dining space, and this is well used by the residents and their visitors. There are also other communal areas on each of the units, and one unit has been designed to provide accommodation for residents living with dementia. There is access to the gardens and internal courtyards from each unit.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	50

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 6 February 2025	09:20hrs to 17:30hrs	Lisa Walsh	Lead

What residents told us and what inspectors observed

The overall feedback from residents was that they were happy living in Glebe House Nursing Home. There was a friendly and welcoming atmosphere in the centre, and staff were observed to be helpful and respectful towards residents. Residents spoken with were highly complimentary of the staff, with one resident saying "staff are terrific and very kind" and another resident saying "the place is top notch". Another resident spoken with said that "you couldn't improve on them [staff], they do their absolute best". Residents also said staff were always checking on them to see if they needed anything.

This unannounced inspection, conducted by one inspector over one day, involved speaking with residents, staff, and visitors to gain insight into the residents' lived experience in the centre. The inspector also observed the environment, interactions between residents and staff, and reviewed a range of documentation.

Following an introductory meeting with the person in charge and assistant care manager, the inspector was accompanied on a tour of the premises by the person in charge. It was clear that they were very well known to the centre's residents and visitors and aware of residents' needs.

The centre is set out across one floor, with three wings and a dementia unit off a central large lounge/dining room area which is a hive of activity and where the majority of residents' were observed to spend their time. The centre is divided into wing 1, wing 2, wing 3 and wing 4. Residents' bedrooms were located on each wing with wing 3 being the dementia specific unit with a keypad on the entrance. The keypad code was displayed for residents who were able to use this to access and exit the unit if they wished. Communal space in wing 3 consisted of a sitting room, a quiet room and a dining room. There was also an internal courtyard which residents in wing 3 could access.

As well as the large lounge/dining, communal space in wing 1, wing 2 and wing 4 consisted of a sitting room in each wing and a prayer/quiet room in wing 4. The prayer/quiet room was not accessible for residents' use on the day of the inspection as, there were boxes stored in the room to be archived. There was also a hair salon located in wing 4. Residents from these wings could freely move throughout this part of the centre. Doors in the communal areas also opened out onto secure garden areas which were pleasantly decorated and well-maintained with pathways clear from debris so residents could easily walk throughout.

The inspector observed that the registered provider had made changes to the footprint of the centre since the last inspection. The baths located in assisted bathrooms in wing 1, wing 2, and wing 3 had been removed. The chemical store room in wing 4 had also been moved to a garage on the grounds of the centre. In

addition, there was another garage next to this which was used for storage also and another building, which was used as a staff canteen.

There was two dining rooms, a small one in the dementia unit in wing 3 and a larger dining room for residents in wing 1, wing 2 and wing 4. Dining room tables were set in both dining areas and a menu was available for residents to choose from with two options available to them. Tables were dressed with fresh flowers and the mealtime experience was observed to be relaxed with some residents' enjoying a glass of wine with dinner. Other residents' choose to eat in their bedrooms, which was their preference. There was mixed feedback about the food served in the centre. While many spoken with said that the food was good, with one resident saying the food served was "excellent", some residents' expressed their view that the quality of the food was poor, "vegetables were overcooked" and the beef served in the centre was very "tough to eat". The residents spoken with who were unhappy with the food said they had raised this issue but felt like it had not improved.

On the day of inspection, there was one activity staff for the 50 residents' with the majority of residents' engaging in activities in the main lounge area. In the large communal area on the morning of the inspection, some residents were doing one-to-one physiotherapy and some residents had a hand massage. In the afternoon, there was an exercise class and then a sing-song. For residents in the dementia wing, some had a hand massage early in the morning and a sing along in the afternoon which the residents joined in with. The inspector observed that there were limited activities available for residents in the dementia unit with an over reliance on the television as the only source of activation. On the day of inspection one of the planned activities also did not take place as healthcare assistants were busy providing personal care for residents until 11.30am and the activity staff was in the large communal area delivering activities. A small number of residents' spoken with also said they were not happy with some of the activities provided and said they would like more to do.

Residents' were observed to receive visitors in the centre within communal areas, or in the privacy of their bedrooms. Many families and friends were observed during the inspection day, visiting. Visitors spoken with also reflected the residents' positive feedback about staff, with one saying staff are "excellent" and describing how the resident "lights up" when the staff are talking with them.

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

Capacity and capability

While there were established management structures to support staff in this centre, the inspector found that some improvements were required in the management systems for the effective oversight of fire safety, protection, residents rights, premises, infection control and notification of incidents.

This was an unannounced inspection which took place over one day in Glebe House Nursing Home, to assess compliance with the regulations and review the registered provider's compliance plan from the previous inspection in June 2024. The inspector also followed up on a concern received and reviewed information, submitted to the Chief Inspector, in advance.

Cowper Care Centre DAC, the registered provider, operates Glebe House Nursing Home. The person in charge reported to the chief executive officer (CEO) and worked full time in the centre. It was evident that the person in charge was well-known to the residents and they demonstrated a commitment to providing a good quality service for the residents. They were supported in their role by one assistant care manager, one service manager and a clinical nurse manager. The person in charge also had oversight of a team of nurses, healthcare staff, an activity staff, chefs, a catering and domestic team, administration, and maintenance staff. On the previous inspection the assistant care manager was working part-time, they were now working full-time in line with the statement of purpose.

Regular management meetings were taking place between the person in charge and the CEO, which discussed clinical and non-clinical matters. There were clinical meetings held regularly with the person in charge and nursing staff to discuss residents' and their specific care needs. Monthly falls, mobility and restrictive practice meetings were held, which was attended by a multi-disciplinary group who reviewed restraints in use in the centre and it was evident efforts were being made to reduce the use of restraints.

The provider had a schedule of audits in place using an electronic auditing system, covering areas such as falls and infection control, which were audited monthly. These identified areas for improvement and effected change. However, some systems in place had not identified areas of non compliance identified on the day of inspection.

The annual report for 2024 was completed and it was evident that residents and their families input was sought in the development of this. Before the annual review was finalised, the draft report was brought to the residents' group for their input. A residents' survey was completed to seek residents views alongside a family survey. These were reviewed and a quality improvement action plan was developed following feedback.

Since the last inspection, significant improvements were observed with mandatory training. All staff had completed safeguarding training. A staff member had been up-skilled to deliver fire safety training within the centre. Records reviewed identified five staff who required fire safety refresher training, however, these were scheduled to be completed in the coming days.

Improvements were required in relation to Regulation 31: Notification of incidents. The inspector had identified that two notifiable incidents had occurred, however, the Chief Inspector had not received the appropriate notifications.

There had been students, on a short placement, volunteering in the centre. Volunteer files showed that the provider had obtained a Garda Siochana (police) vetting disclosure for all volunteers and that they received an induction and fire safety training.

Regulation 16: Training and staff development

Staff had access to training and there was a training schedule in place. All staff had completed mandatory safeguarding training. Five staff required a refresher for fire safety training which was scheduled for the coming days.

Judgment: Compliant

Regulation 23: Governance and management

While the registered provider had assurance systems in place, these were not fully robust to be assured of the quality and safety of the service. For example:

- The registered provider had removed three baths from the assisted bathrooms without informing the Chief Inspector, meaning the centre was not operating in line with condition 1 of their certificate of registration.
- Current arrangements for the auditing and oversight of fire precautions did not adequately identify areas that did not comply with the requirements of the regulations. This is detailed in Regulation 28: Fire Precautions.
- A review of the schedule of activities was required to ensure that all residents across the centre had opportunities to participate.
- The systems that were in place to protect residents from abuse had failed to recognise two incidents as safeguarding concerns. As a result these incidents were not followed up in line with the provider's own safeguarding policy to ensure residents were protected.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed within the last year and this updated copy was available for review. Overall, it contained all the information outlined in Schedule 1.

Judgment: Compliant

Regulation 30: Volunteers

All volunteers had An Garda Siochana (police) vetting disclosures on file. Volunteers had their roles and responsibilities set out in writing. The volunteers had only been on a very short placement so there was no records of volunteers receiving supervision and support. However, there was a policy in place which ensured that volunteers should receive supervision and support.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had not reported two notifiable incidents which had occurred. These were retrospectively submitted following the inspection.

Judgment: Not compliant

Quality and safety

Overall, residents were supported to have a good quality of life. The inspector observed kind and compassionate staff, treating the residents with dignity and respect, as described above. However, this inspection identified areas where improvements were required to ensure a high standard of care and support was provided to residents. Specifically in relation to, protection, resident's rights, fire safety, premises and infection control.

Records showed that residents' had access to medical care in line with their assessed needs. Residents had access to a general practitioner (GP), with some remaining with the GP of their choice. Residents were seen as required for appointments and a locum GP also attended the centre monthly and completed a full assessment of each residents' medications. Residents' had access to allied healthcare professionals as required on a referral basis, such as, occupational therapy, dietitian, speech and language therapy, tissue viability nurse, psychiatry of old age, palliative care and geriatrician. Residents had access to an in-house

physiotherapist which attended the centre once a week. If residents wanted to access private physiotherapy assessments this could also be organised. A clinical nurse specialist also attended the centre once every two weeks to review all residents with cognitive impairment and their medications.

All staff had completed safeguarding training. However, during the inspection, the inspector became aware of potential safeguarding incidents that had not been identified as possible safeguarding concerns. This meant that the safeguarding concerns had not been responded to appropriately, meaning that no investigation of the incident had occurred and safeguarding care plans had been put into place to protect the residents involved. The registered provider was not a pension agent for any residents and all valuable belongings were given to residents' family for safekeeping.

In general, residents' choices and preferences were seen to be respected. The inspector saw that staff engaged with residents in a respectful and dignified way. Residents had access to independent advocacy services, with the advocacy service details on display throughout the centre in a variety of areas. Residents also had access to newspapers, radio, television and internet services. Residents meetings were held quarterly, with a good level of attendance by residents'. Residents' discussed topics such as, activities, the complements and compliant procedure, infection control, health care, food and the quality of care they received. While there was a varied schedule of activities for residents in the large communal area, there was limited activity options available for the residents in the dementia unit and some of the scheduled activities on the day of inspection did not take place.

The centre was warm and homely and some improvements had been observed since the last inspection. For example, a new clinical sink had been installed in wing 1 and the inspector was informed that new sinks were planned for wing 2, wing 3, and wing 4. In addition, some storage practices had improved and sitting rooms were free from additional items being stored within them. However, residents could not access the prayer room due to items stored in it. The registered provider had also failed to engage with the Chief Inspector in respect of proposed changes to the premises and had removed three baths from the centre.

While the centre was generally clean and tidy on the inspection day, some storage practices required review to minimise the risk of transmitting a healthcare-associated infection. This will be discussed under Regulation 27.

The inspector reviewed the arrangements at the centre to protect residents from the risk of fire. There was a fire safety policy in place. Each resident had a personal emergency evacuation plan (PEEP) in place, which was regularly reviewed. All fire extinguishers had recently been inspected by an external fire safety company and satisfied requirements. Daily fire panel checks were completed, as well as daily inspections of the means of escape, however, these had not identified the non compliance's found on the day of inspection. Some areas of improvements were required in relation to fire safety to ensure adequate precautions were in place, which included fire drills and evacuation signage.

Regulation 17: Premises

Some improvement was required by the provider to ensure that the premises were appropriate to the number and needs of the residents of the designated centre and in accordance with the statement of purpose prepared under Regulation 3. For example;

- A prayer/quiet room for residents' use, was not available to residents' as it was had multiple archive boxes stored within it and training materials. This was a registered communal space that should be available to residents at all times.
- Two storage rooms and a staff canteen, for the use of the centre was not included on the floor plans.

Some areas required review to ensure the provider also complied with Schedule 6 of the regulations. The registered provider did not ensure that the premises had a sufficient number of baths on the premises to meet the needs of the residents'.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27: Infection control and the National Standards for infection prevention and control in community services (2018). However, some storage practices posing a risk of cross-contamination required review. For example:

- In some shared toilets, toiletries were not clearly labelled with the name of individual resident. This posed a risk of communal use and potential cross-infection.
- A dirty urine bottle was left on a grab rail in a shared toilet This also posed a risk of communal use and potential cross-infection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The following improvements were required to ensure the safety of residents, staff and visitors:

- The fire escape routes through the secure gardens were locked, preventing residents', staff and visitors having an adequate means of escape.
- On the external escape routes to the fire assembly point, there was no clear signage to direct residents', staff and visitors to this location in the event of an emergency.
- While fire drills were being undertaken in the centre, these were not conducted in line with the centres' own policy and did not reflect the possible fire scenarios. The fire drills did not simulate full compartment evacuation with the appropriate staffing levels.
- Upgrade and repair works were required to fire doors. For example, a number of fire doors did not close fully when the released, leaving a gap. The inspector was informed, by the person in charge, that the registered provider had contracted an external company to complete a review of the fire doors within the centre, to complete any maintenance and repairs, and replace doors as required; this was due to commence in February 2025.

Judgment: Substantially compliant

Regulation 8: Protection

While the management team had responded appropriately to some safeguarding incidents, and followed their policy, a review of records identified a potential safeguarding concern that had not been recognised or responded to as a safeguarding concern in line with the provider's safeguarding policy and procedures. This a repeat finding from the last inspection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provision of activities observed, on the day of inspection, did not ensure that all residents had an opportunity to participate in activities in accordance with their interests and capacities. The inspector observed that there was an over reliance on passive activities such as having music on the television and watching television for the residents in the dementia unit.

Judgment: Substantially compliant

Regulation 6: Health care

A general practitioner attended the designated centre. There was on-site support from a physiotherapist once a week. Appropriate medical and health care referrals were made to specialist services such as psychiatry of old age, speech and language therapy, and dietitian. Records evidenced that referrals were timely and residents received prompt support form these specialist services when needed. The inspector was informed that eligible residents were facilitated to access the services of the national screening programme.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 6: Health care	Compliant

Compliance Plan for Glebe House Nursing Home OSV-0000039

Inspection ID: MON-0046322

Date of inspection: 06/02/2025

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The residents were consulted and agreed in the removal of baths as it has not been used in the last 7 years. A new bath will be installed in Wing 3 assisted toilet. All residents will be informed once the installation is completed, on or before June 30, 2025. 2. A review and cross-check of staffing rosters were conducted to ensure that all staff and areas of the facility are covered during fire drills. To date, all areas were covered and all staff members assigned to their respective areas are trained and familiar with their specific duties during an emergency evacuation. The Service Manager will conduct debriefing sessions after each fire drill to gather feedback from staff on the drill's effectiveness and any areas for improvement. Furthermore, a system for biannual checks is in place, and the relevant audit template has been updated to meet the requirements. Identified staff members have been assigned to ensure that all staff complete the necessary updates, and the documents are available for inspection if needed. 3. Individual resident care plans and baseline abilities (cognitive abilities, physical abilities, hobbies, past interests, and current preferences) were reviewed. Then a comprehensive review of Dementia Unit activities planner was conducted and revised with the Care's team input and in consideration of current residents' baseline abilities. The PIC also scheduled a separate monthly meeting with the activity coordinator to review the activity program and adjust according to new insights, changes in residents' conditions and interests. In addition, a new sensory stimulation activity, Virtual Reality, was recently added to the range of activities facilitated in the care centre which commenced on February 27, 2025. The activities coordinator also attended a training on Cognitive Stimulation Therapy and Imagination Gym to enhance her knowledge and skills in planning appropriate activities for residents with sensory and cognitive challenges. 4. In addition to the local policy and procedure in management of safeguarding incidents, the local manager on duty in a day-to-day basis will review responsive behaviour occurrences to enhance detection of any possible safeguarding incidents. Weekly updates will be communicated to the PIC including status of any incidents, their	

resolution, and the effectiveness of interventions and practices. The PIC will also review training and offer refresher courses to staff on safeguarding policy and best practices as required, incorporating lessons learned from incidents. All incidents will be overseen by the PIC making certain that they are effectively handled, and that local management follows through with all necessary actions and protocols. It includes maintaining clear and detailed documentation for all safeguarding incidents, reports, actions taken, and outcomes. These additional measures will ensure appropriate oversight for any possible safeguarding concern.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

A comprehensive review of the local procedure in identifying and reporting incidents were conducted. A step-by-step guide was established by the PIC to streamline the process to enhance staff awareness and managers on duty review any reported concerns within 24 hours and document their findings. This will ensure that any possible safeguarding occurrences are addressed promptly and all notifiable incidents are communicated in a timely manner, in accordance with regulatory and organisational requirements.

Regulation 17: Premises	Substantially Compliant

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

1. An alternative working space for filing or archiving historical records has been identified, preventing the prayer/quiet room from being used for this purpose. A weekly check by the local managers has also been implemented to monitor the use of residents' communal spaces.
2. A revised floor plan of the care centre and premises, incorporating the recent change in number of bathing facilities, external cabin for staff breaks, and external storage facility will be finalised and submitted by July 31, 2025. The floor plan will include detailed architectural specifications to ensure compliance with the regulation. The staff cabin will be designed to meet safety and functionality requirements, such as proper ventilation, seating capacity, and accessible access routes. The storage facility will be designed to store materials for daily operations. The storage area will be securely located outside the building, ensuring accessibility for staff.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

1. Individual resident toiletries in shared rooms will be labelled with their names using a moist resistant printed labels. These items will be stored in a small basket and kept in their bedside locker. A weekly check by the team leader will be conducted and the local managers will conduct random checks to ensure compliance.
2. A monthly audit of bathrooms and toilets will be conducted by the Housekeeping Supervisor and random checks in a daily basis will be conducted by the Team Leaders on duty. All findings from the audits and checks will be reported to the PIC during regular in-house management meeting to ensure standards are met and any issues are identified for improvement.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

1. A combination locks will be installed for all fire escape routes, particularly those through the secure gardens. The combination code will be displayed to ensure adequate means of escape in case of an emergency. Weekly inspections are being conducted to ensure that fire escape routes are accessible and clear of obstructions.
2. Additional signage was put in place to provide clear and visible direction for the designated exits to enhance safety, improve navigation, and streamline the flow of foot traffic during an emergency evacuation. Weekly inspections are being conducted to ensure that fire escape routes are accessible and clear from obstructions.
3. A review and cross-check of staffing rosters were conducted to ensure that all staff and areas of the facility are covered during fire drills. To date, all areas were covered and all staff members assigned to their respective areas are trained and familiar with their specific duties during an emergency evacuation. The Service Manager will conduct debriefing sessions after each fire drill to gather feedback from staff on the drill's effectiveness and any areas for improvement. Furthermore, a system for biannual checks is in place, and the relevant audit template has been updated to meet the requirements. Identified staff members have been assigned to ensure that all staff complete the necessary updates, and the documents are available for inspection if needed.
4. A service level agreement was formalised with an external contractor to oversee and maintain all fire doors across the premises. As part of the initial assessment, high-risk areas within the facility were identified and addressed promptly. These areas include the

kitchen, laundry room, electrical cabinets, and service doors. All of which had already undergone necessary repairs to ensure compliance with fire safety standards. The contractor is also scheduled to visit the premises twice a month. During these visits, the contractor will perform regular inspections, maintenance, and repairs as required, ensuring that all fire doors are fully operational and meet the required fire safety standards.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

In addition to the local policy and procedure in management of safeguarding incidents, the local manager on duty in a day-to-day basis will review responsive behaviour occurrences to enhance detection of any possible safeguarding incidents. Weekly updates will be communicated to the PIC including status of any incidents, their resolution, and the effectiveness of interventions and practices. The PIC will also review training and offer refresher courses to staff on safeguarding policy and best practices as required, incorporating lessons learned from incidents. All incidents will be overseen by the PIC making certain that they are effectively handled, and that local management follows through with all necessary actions and protocols. It includes maintaining clear and detailed documentation for all safeguarding incidents, reports, actions taken, and outcomes. These additional measures will ensure appropriate oversight for any possible safeguarding concern. A risk management and incident training will also be conducted by the Quality and Safety Manager for all nurses with the goal of completion by 1st of May 2025.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Individual resident care plans and baseline abilities (cognitive abilities, physical abilities, hobbies, past interests, and current preferences) were reviewed. Then a comprehensive review of Dementia Unit activities planner was conducted and revised with the Care's team input and in consideration of the current residents' baseline abilities. The PIC also scheduled a separate monthly meeting with the activity coordinator to review the activity program and adjust according to new insights, changes in residents' conditions and interests. In addition, a new sensory stimulation activity, Virtual Reality, was recently added to the range of activities facilitated in the care centre which commenced on February 27, 2025. The activities coordinator also attended a training on Cognitive

Stimulation Therapy and Imagination Gym to enhance her knowledge and skills in planning appropriate activities for residents with sensory and cognitive challenges.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	07/02/2025
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	Substantially Compliant	Yellow	27/02/2025

	that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	15/04/2025
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	03/02/2025
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/03/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1)	Not Compliant	Orange	07/02/2025

	(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.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	01/05/2025
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	07/02/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	27/02/2025