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:	Nenagh Manor Nursing Home
Name of provider:	Foxberry Limited
Address of centre:	Yewston, Nenagh, Tipperary
Type of inspection:	Unannounced
Date of inspection:	12 April 2023
Centre ID:	OSV-0000422
Fieldwork ID:	MON-0038713

About the designated centre

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

Nenagh Manor nursing home is located a short walking distance of the town of Nenagh. It is set out over three levels and provides 24 hour nursing care. It can accommodate 50 residents over the age of 18 years and includes a dementia specific unit which accommodates 10 residents. It is a mixed gender facility catering from low dependency to maximum dependency needs. It provides short and long-term care, convalescence, respite and palliative care. There is a variety of communal day spaces provided including dining rooms, day rooms, conservatory, hairdressing room and residents have access to landscaped secure garden areas. Bedroom accommodation is offered in single and twin rooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	46

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 12 April 2023	09:30hrs to 18:25hrs	Bairbre Moynihan	Lead
Wednesday 12 April 2023	09:30hrs to 18:25hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

Inspectors arrived to the centre in the morning to conduct an unannounced inspection to monitor ongoing regulatory compliance against the regulations and national standards. From the inspector's observations and from speaking to residents, it was clear residents received good care from staff that were kind and caring. Residents were complimentary about the food and the staff.

On arrival inspectors were greeted by the person in charge. Following an introductory meeting inspectors were guided on a tour of the premises. Nenagh Manor is laid out over three floors. The centre had a 10 bedded, single, en-suite dementia unit called the Butterfly unit. An open plan sitting and dining room was located within this unit. A conservatory was located at the end of the unit which was cold and uninviting. The conservatory led out into an enclosed garden. Inspectors were informed that there was a plan to upgrade the paving in the garden as the sloped nature of it posed a falls risk to residents. The main house on the lower ground floor contained nine bedrooms, one of which was a double room with no en-suite. Residents in this room shared toilet and shower facilities. The upper ground floor contained 16 rooms, 14 of which were single en-suite. Communal rooms for the main house included an open plan sitting/dining room and lounge. The majority of residents were in the open plan room on the day of inspection. In addition, a temporary staff room was located in what was the library. This will be discussed later in the report. The first floor contained nine rooms, four of which were single en-suite, one twin en-suite and four twin rooms where residents shared toilet and showering facilities.

The registered provider had two activities co-ordinators that covered six days a week. One activities co-ordinator per day. Activities were observed taking place on the day of inspection. For example; residents were playing a game with a ball while other residents observed. Bingo was taking place on the afternoon of inspection with good participation from the residents. However, given the size and layout of the centre, it was difficult for one person to engage in meaningful activities for all residents. Residents were observed reading newpapers and an inspector was informed that WIFI was available throughout the centre and that residents had smart TVs in their rooms and could access an online streaming service for movies and music.

Inspectors' found that residents were free to exercise choice about how they spent their day. Residents were assisted to get up in the morning at a time of their choosing. All residents spoken with were complimentary of staff and of the care they provided. Residents were consulted about their care needs and about the overall service being delivered. Resident meetings were held every two to three months. Records indicated that a range of issues were discussed such as fire safety, activities, food and outings.

The dining experience was observed in both the dining room/sitting room on the

upper ground floor and in the Butterfly unit. Residents were provided with a choice at mealtimes including modified diets. The menu was displayed on a board in the dining room/sitting room. Staff were available to provide assistance to residents at mealtimes if required. A small number of residents chose to have their meals in their rooms and this choice was respected.

The next two sections of the report present the findings of this inspection in relation to governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk based inspection to monitor ongoing compliance with the regulations and standards. Overall, effective governance and management systems were evident in the centre, ensuring good quality person centred care was delivered to residents. Some areas had been addressed following the infection prevention and control inspection in August 2022. For example; the new laundry was completed and had opened on the week prior to inspection. In addition, wall mounted hand gels had been placed throughout the centre. However, outstanding areas for action remained. For example; the sink in the dining room was not compliant with the required specifications. Areas for improvement were identified on inspection under the domain of Capacity and Capability in Regulations 15: Staffing, 16: Training and staff development and 23: Governance and management.

The registered provider of the centre was Foxberry Limited which consisted of three company directors. The registered provider owned and managed a number of centres throughout Ireland. The person in charge, reported to the chief operating officer, was supported in the role by an assistant director of nursing who was supernumery, three clinical nurse managers who had no supernumery role, staff nurses, healthcare assistants, catering, household, laundry, activities, administration and maintenance staff. Inspectors were informed that there was one wholetime equivalent (WTE) staff nurse vacancy and seven healthcare assistant vacancies. Staff had been recruited for these vacancies however, management stated that there was a delay in securing work visas.

The registered provider had a training matrix in place. Staff had access to mandatory training for example; fire safety training, manual handling and safe guarding. The majority of training was up to date for example cardio pulmonary training and medication management. However, gaps were identified in training on managing behaviours that challenge.

A sample of staff personnel files reviewed by inspectors indicated that they were maintained in compliance with regulatory requirements. These files provided evidence of robust recruitment and retention of staff and staff reported feeling supported in their roles. There was a comprehensive induction and probation programme in place and all staff had annual performance appraisals where there

were opportunities to identify any training needs and to develop skills and knowledge. Garda vetting was in place for all staff before commencement of employment. The registered provider had insured the centre in line with the requirements of the regulation.

The annual review of quality and safety of care was completed for 2022 aligned to the National Standards for residential care settings for older people in Ireland. 14 of the 35 standards reviewed required an action and an action plan accompanied the annual review with a person responsible for each action identified. Systems of communication were in place. Staff meetings and nurses meetings took place approximately monthly. Agenda items in the staff meeting included monthly statistics and review of falls and incidents from the previous month and incident reviews completed. The agenda for the nurses meeting included policies, medication training, care planning and complaints. Audits provided to inspectors included an infection control audit which was completed against a COVID-19 audit tool, medication audit and an audit of the dining experience. In line with findings from the inspection in August 2022, the infection control audit was not sufficiently comprehensive enough to identify the issues. A time bound action plan accompanied the audits viewed. Inspectors were informed that there was a plan to introduce a new online system of auditing and it was currently being rolled out in other centres within the company. Incidents were reported to the office of the chief inspector in line with regulatory requirements.

Regulation 14: Persons in charge

The person in charge had been the person in charge of the centre since 2013, is a registered nurse with the required managerial and nursing experience in keeping with statutory requirements. The person in charge was actively engaged in the governance, operational management and administration of the service.

Judgment: Compliant

Regulation 15: Staffing

The inspectors were informed one activities co-ordinator was on-duty per day six days a week. While activities were observed to be taking place during the day it was a challenge for one person to meet the social and recreational needs of the residents given the size and layout of the centre. This matter was brought to the attention of the registered provider at a previous inspection in January 2022.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A small number of gaps were identified in staff training:

- 12 staff had not completed training in managing behaviours that challenge.
- One staff member employed directly by Nenagh Manor, safeguarding training was out of date.
- The mandatory training completed by external contractors required greater oversight from management. For example; safeguarding training.

Judgment: Substantially compliant

Regulation 21: Records

The records outlined in schedules 2, 3 and 4 of the regulations were stored securely in the centre and made available for an inspector to review. Residents' records evidenced daily nursing notes with regard to the health and condition of the residents and treatment provided.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had a contract of insurance in place against injury to residents which was provided to an inspector for review. An inspector saw that this was renewed yearly and was up-to-date.

Judgment: Compliant

Regulation 23: Governance and management

Areas requiring action were identified to ensure the service provided is safe, appropriate and effectively monitored:

- Risks highlighted on the inspection in August 2022 had not been risk assessed and if required placed on the risk register. For example; the lack of hand hygiene sinks in the centre.
- Enhanced oversight of mandatory staff training from external contractors was required.

- The registered provider had failed to address a number of emergency lights throughout the building that were not in working order. Quarterly maintenance certification records had also identified these issues.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

An inspector reviewed a sample of residents' contracts of care. These were seen to be agreed on admission to the centre and detailed the services provided to each resident whether under the Nursing Home Support Scheme or privately. The type of accommodation was stated along with fees, including for services which the resident was not entitled to under any other health entitlement.

Judgment: Compliant

Regulation 31: Notification of incidents

All incidents were notified to the office of the chief inspector in line with regulatory requirements.

Judgment: Compliant

Quality and safety

The inspector's found that residents' had a good quality of life in Nenagh Manor nursing home and where possible, were encouraged to live their lives in an unrestricted manner according to their capabilities. Residents had good access to medical, nursing and health and social care providers. However, areas for action were identified in relation to regulations 17: Premises, 27: Infection control, 28: Fire precautions, 29 Medicine and pharmaceutical services and Regulation 5: Individual assessment and care planning.

Visitors were observed in the centre on the day of inspection. It was evident that visitors were welcome. Visitors were required to sign a visitors book, complete a temperature check and wear a mask. Visitors confirmed this and confirmed that there was no restrictions on them visiting their relative/friend. The visiting policy was up-to-date and was in line with the practices observed in the centre.

Nenagh Manor was originally a house and it was upgraded and extended over time

to accommodate 50 residents. Since the inspection in January 2022 and the infection control focused inspection in August 2022 a small number of areas had been actioned. For example; the area surrounding the dementia unit was reviewed and secured with fencing installed. However, this area required further review to reduce the falls risk to residents due to the sloped nature of the paving. Inspectors were informed that this area was next on the maintenance list to be addressed. The laundry room had been completed and opened on the week prior to inspection. This area supported the functional separation of the clean and dirty phases of the laundering process. This area was well-ventilated, clean and dry. New industrial washing machines and dryers had been installed in the new facility. The centre was generally clean on the day of inspection, however, in line with findings from the inspection in August 2022 the placement of hand hygiene sinks and a review of the sluice rooms was required. Inspectors were informed that there was a plan in place to convert the old laundry room to a domestic storeroom. At the time of inspection the registered provider had not identified an infection control link nurse practitioner with protected hours. Additional areas for action are discussed under Regulations 17 and 27.

The registered provider had systems in place for the management of medicines. Staff spoken to were knowledgeable about the systems and processes in the centre. Medications were stored securely including medications requiring strict control measures (MDAs). Staff had access to advice from a pharmacist and an inspector was informed that the pharmacist was available to speak to a resident if they requested it. Management stated that medication reviews of all residents were completed three monthly with the person in charge and general practitioner. All staff who administered medications had completed online training in medication management within the last year. An inspector was informed that the registered provider is moving to new electronic medication management system imminently. Notwithstanding the many good practices in relation to medicines and pharmaceutical services an area for action was identified which will be discussed under the regulation.

The registered provider had recently commenced using a new electronic system for care planning. Care plans and relevant assessments were in place for residents however, in line with the findings from inspection in January 2022 a number of care plans reviewed were not person centred and did not adequately provide guidance on the care that was required on an individual basis.

The use of restrictive practices in the centre were low and were supported by assessments. A small number of residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The registered provider had an up-to-date policy in place on managing behaviours that challenge which supported the practices in place on the day of inspection.

Staff were knowledgeable on the different types of abuse and the actions to take. A sample of staff files reviewed indicated that staff had the required Garda (police) vetting prior to commencing employment in the centre. Additional areas of good

practice are discussed under the regulation.

The provider had taken precautions against the risk of fire. The provider had ensured that fire exit routes were well maintained with unrestricted access to emergency exits and adequate emergency lighting throughout the centre. Records of fire alarm maintenance were available on the day and were up to date. Staff had received appropriate training in fire safety and training in this area was up to date. Staff also displayed a good knowledge of the evacuation procedures in the centre in conversation with inspectors. This included staff working in the kitchen and laundry who demonstrated a good knowledge of how to shut-off the gas in the event of an emergency. Fire safety was discussed at staff meetings as noted in the minutes of these meetings. The provider maintained records in relation to fire evacuation drills that had taken place within the centre. In addition, each resident had a personal evacuation plan that detailed the level of support they required in the event of an emergency evacuation.

Residents' rights were protected and promoted in the centre. Choices and preferences were seen to be respected. Regular resident meetings were held which provided a forum for residents to actively participate in decision-making and provide feedback in areas regarding social and leisure activities, advocacy and empowerment and influencing standards of care. Minutes of these meetings were documented, with action plans assigned and followed up on. For example, outings were discussed and plans put in place to make these happen.

Regulation 11: Visits

The centre had an opening visiting policy. Visitors were not required to make a booking prior to visiting.

Judgment: Compliant

Regulation 17: Premises

Improvements were required in order to ensure compliance with schedule 6 of the regulations. For example:

- Wheelchairs and hoists were stored on a corridor on the upper ground floor and in the conservatory in the Butterfly unit.
- The conservatory was noticeably cold and would not be conducive to residents using the area. A number of wheelchairs were being stored in this area. This area was not conducive to a homely environment.
- A small number of rooms in the centre were not in use for which they are registered for. For example;
    - A room registered as a treatment room was in use as a hairdressing

salon. Inspectors were informed that this room had always been a hairdressing salon and was designed as such.
    - The library was registered as a temporary staff room during the early waves of the COVID-19 pandemic, however, it remained as such and had not reverted back for resident use.

Judgment: Substantially compliant

Regulation 27: Infection control

Improvements were required in order to ensure that procedures are consistent with the national standards for infection prevention control in community services. For example;

- The number and type of hand hygiene sinks remained unchanged since the inspection in August 2022. Furthermore, there was no dedicated clincial handwash sink in the Butterfly unit. Staff were observed using the sink in a resident toilet to perform handwashing. This posed a risk of cross contamination.
- Sluice rooms remained unchanged since the last inspection. These were small, contained no racking for storage of bedpans and urinals and no clinical waste bin. In addition, the Butterfly unit and first floor contained no sluice rooms.
- The placement of clinical waste bins required review. An inspector observed multiple instances of placement of clinical waste bins in resident bathrooms.
- Infection control audits were COVID-19 focused and were not identifying issues identified on inspection.
- Multiple resident slings were observed hanging on the wall in communal areas. An inspector was informed that they were only used during emergencies however, it was not clear if slings had been cleaned after resident use. Management stated that the slings were numbered when cleaned however, a sample reviewed contained no numbering.
- A dressing trolley was located in the oxygen storage room. The trolley contained a number of open but unused dressings. This posed a risk of cross contamination.
- The COVID-19 contingency plan required review to ensure that it was in line with current guidance.

Judgment: Not compliant

Regulation 28: Fire precautions

Overall adequate arrangements were in place to protect against the risk of fire

including fire fighting equipment, means of escape, and regular servicing of the systems. However actions were required as follows:

- The inspectors noted a number of emergency lights throughout the building were not in working order. Quarterly maintenance certification records dated 19 December 2022 and 28 March 2023 for the emergency lighting system were issued while noting that a number of emergency lights throughout the building had failed the 3 hour test or were not lighting under test.
- The inspectors observed inappropriate storage practices in the upstairs storage areas that potentially created a fire risk where files were stacked up. The person in charge gave assurances that all items would be removed from these areas to reduce the fire risks.
- Inspectors noted emergency evacuation maps that showed the conservatory on the ground floor as an evacuation route, the layout of the building was not clear. This had not been detected by the provider but assurances were provided that this would be addressed and reprinted.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

While overall medication management procedures were good, an inspector identified the following which required action:

- Subcutaneous medication stored in the fridge were observed to be out of date.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A sample of care plans and validated risk assessment tools were reviewed. Care plans reviewed, while in date did not contain information that was up-to-date. For example; COVID-19 care plans referenced the cocooning of residents in their room. This information is dated and not in line with current COVID-19 guidance. In addition, a number of care plans observed were not person centred. For example: one care plan contained the name of another resident.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to medical care. Residents retained their own general practitioner (GPs) and seven general practitioners attended the centre when required and carried out three monthly reviews. Outside of these hours an out of hours service was available and attended if required. Speech and language therapy, dietitian and tissue viability nurse were provided through a private company at no cost to the resident. A physiotherapist attended onsite once weekly for two hours. The physiotherapist did a group exercise class with residents and reviewed residents following a fall. If a resident requested a private session with the physiotherapist this was at an additional cost. Occupational therapy was accessed privately if required. Old age psychiatry attended onsite when required.

Residents weights and observations were completed monthly or more frequently if the residents' condition necessitated it. Twice daily temperatures were completed.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The use of restrictive practices in the centre was low with 8% of residents using bedrails. Risk assessments were in place for these residents.

A small number of residents had responsive behaviours. These residents were supported by a consistent approach to managing responsive behaviours. Behavioural assessments were completed and informed an holistic approach to managing residents' responsive behaviours. Staff were knowledgeable on how to respond to residents with behaviours that challenge.

Judgment: Compliant

Regulation 8: Protection

The registered provider took all reasonable measures to protect residents from the risk of abuse. Staff spoken with were knowledgeable regarding what constitutes abuse and the appropriate actions to take should there be an allegation of abuse. The provider was pension agent for four residents living in the centre and adequate systems were in place for the management of these finances. The majority of staff employed by the centre had up-to-date training in safeguarding. This was discussed under Regulation 16: Training and staff development.

Judgment: Compliant

Regulation 9: Residents' rights

Overall, residents' right to privacy and dignity was well respected. Residents were afforded choice in the their daily routines and had access to individual copies of local newspapers, radios, telephones and television. Independent advocacy services were available to residents and the contact details for these were on display. There was evidence that residents were consulted with and participated in the organisation of the centre and this was confirmed by residents meeting minutes, satisfaction surveys and from speaking with residents on the day. Social assessments were completed for each resident and individual details regarding a residents' past occupation, hobbies and interests was completed. This information informed individual social and activity care plans. A schedule of diverse and interesting activities was available for residents, however there were challenges in adequate provision of activities due to limited availability of activity staff and the challenges presented by the design and layout of the centre. This was discussed under Regulation 15 Staffing above.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Nenagh Manor Nursing Home OSV-0000422

Inspection ID: MON-0038713

Date of inspection: 12/04/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance the RPR will have the following in place and implemented and actioned as required: • Ongoing recruitment plan in place to recruit an additional Activity Coordinator to support the residents social and activity plans.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance the PIC will have the following in place and implemented and actioned as required: • Training has been scheduled for all staff outstanding to receive training in managing behaviors that challenge. • Safeguarding training for the 1 staff member has been completed. • The training matrix is reviewed on a regular basis by the PIC and RPR support team to alert when training is due to expire. • External contractors are required to ensure their personnel have completed all mandatory training. A review of this will be overseen by the Group Facilities Manager.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure compliance the RPR will have the following in place and implemented and actioned as required:
• The risk register has been updated to include all risk identified.
• External contractors are required to ensure their personnel have completed all mandatory training. A review of this will be overseen by the Group Facilities Manager.
• The Group Estates and Engineering Manager will review any issues noted after the Quarterly review and maintenance of all fire equipment including lighting. Once issues noted and action plan to resolve will be drawn up and completed before the next review.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure compliance the RPR will have the following in place and implemented and actioned as required:
• The inappropriate storage of wheelchairs and hoists is discussed daily at handover and reviewed by the home's maintenance personnel when on duty to ensure all items stored correctly.
• The heater in the conservatory will be turned on each morning if room found to be cold.
• The home floor plans submitted to the inspector on the 12th May as part of the re-registration pack now correctly identify all rooms as per their use.
• The library has reverted back to its original use.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
To ensure compliance the RPR will have the following in place and implemented and actioned as required:
• A full review of all common areas in the home is underway to identify the most appropriate location to position the hand hygiene sink for each floor and butterfly unit. Once completed the sinks will be installed.
• The location of the sluice room will be determined following an assessment to determine the most efficient space with in the centre to house a fully compliant sluice

room.
• The placement of clinical bins has been reviewed to ensure appropriate placement.
• The IPC audits have been reviewed and amended to reflect current requirements and are completed by the PIC on ViClarity.
• Each resident who requires the use of a hoist sling has their own individual one. A stock is kept and when one is put into use it is named and only used for that resident.
• The dressing trolley has been removed from the oxygen storage room and open unused dressings discarded.
• COVID plan updated to reflect current guidance and communicated to all staff.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
To ensure compliance the RPR will have the following in place and implemented and actioned as required:
• All emergency lights are working in the centre. The Group Estates and Engineering Manager will review any issues noted after the Quarterly reviews and maintenance of all fire equipment including lighting. Once issues noted and action plan to resolve will be drawn up and completed before the next review
• Daily at handover the storage of items in inappropriate areas is discussed with all staff. This is reviewed by the homes maintenance personnel and supported by the Group Estates and Engineering Manager.
• The emergency evacuation maps are being updated to ensure all evacuation routes are clear to follow.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
To ensure compliance the PIC will have the following in place and implemented and actioned as required:
• All medicines reviewed and out of date medicines returned to the pharmacy. A weekly review is now in place to ensure out of date medicines are removed from use.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
To ensure compliance the PIC will have the following in place and implemented and actioned as required.
• All COVID care plans have been archived and will only be put in use if a residents is suspected or confirmed COVID.
• The care plans are now under review to ensure the correctly reflect the care needs of the residents and are resident specific.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/08/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	29/05/2023
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	29/05/2023
Regulation 23(c)	The registered	Substantially	Yellow	29/05/2023

	provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Compliant		
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	31/01/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	29/08/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	29/08/2023
Regulation 29(6)	The person in	Substantially	Yellow	29/05/2023

	charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Compliant		
Regulation 5(4)	The person in charge shall formally review, at 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.	Substantially Compliant	Yellow	31/08/2023