



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

Issued by the Chief Inspector

Name of designated centre:	Aperee Living Conna
Name of provider:	Conna Care Home Ltd
Address of centre:	Conna, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	18 November 2024
Centre ID:	OSV-0004447
Fieldwork ID:	MON-0045240

About the designated centre

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

Aperee Living Conna was established in 2003. It is currently managed by the Aperee Living Group. It is a 50-bedded home situated on the edge of Conna and all accommodation is on one level. The home comprises 42 single rooms with toilet and shower facilities some of which are shared between two single bedrooms. There are two single rooms (not en-suite), three double bedrooms en-suite, a large sitting room, conservatory, dining room, oratory, library, hairdressing salon, assisted bathroom, assisted shower room and enclosed garden with seating provided. All rooms have access to a call bell system and residents are encouraged to personalise their rooms. The centre offers long-term and respite care as well as caring for residents with dementia. There is 24-hour nursing care available. There is medical and allied health services available and all dietary needs are catered for.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	44
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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
Monday 18 November 2024	09:15hrs to 17:40hrs	Siobhan Bourke	Lead
Monday 18 November 2024	09:15hrs to 17:40hrs	Niall Whelton	Support

What residents told us and what inspectors observed

This unannounced inspection, took place over one day, by two inspectors of social services. The purpose of this inspection was to monitor the care and welfare of residents living in the centre and to follow up on the completion of fire safety works required in the centre. The inspectors met with many of the 44 residents, and spoke with seven residents in more detail regarding their day-to-day experiences of living in the centre. Overall, residents told inspectors they were happy with the current staffing levels, quality of food and the care they received from staff in the centre. A number of residents, were living with a cognitive impairment, and were unable to fully express their opinions to inspectors. These residents appeared to be content, appropriately dressed and well-groomed.

On arrival to the centre, inspectors saw that signage was in place, indicating that visiting was restricted due to an outbreak of respiratory infection in the centre. Infection control precautions such as mask wearing was in place for staff. The inspectors were informed that visiting was restricted in the centre on the advice of public health and the inspectors saw that only residents' nominated persons were visiting the centre during the day.

Aperee Living Conna is a large single-storey building located in the scenic rural setting near Conna village. The centre had 44 single bedrooms and three twin bedrooms arranged in three main wings called Aghern, Douglas and Castle. All the twin rooms were occupied by only one resident on the day of inspection and were configured for single occupancy. The inspectors walked around the premises, accompanied by the person in charge, to meet residents and observe the premises and fire safety works that had been required. It was evident to inspectors that the person in charge was knowledgeable regarding residents' assessed needs.

In general, residents' bedrooms were personalised, warm and clean. Pressure relieving specialist mattresses, falls injury prevention mats and other supportive equipment was seen in residents' bedrooms. Some bedrooms had some wear and tear evident, such as chipped paint on bedroom walls and some furniture such as wardrobes and bed-frames were worn and required repair. The inspectors saw that a staff bathroom was closed off to use, as loose tiles were coming off the walls and tiles were also coming off one of the sluice room walls. While the centre was generally clean, a hand hygiene sink on a corridor and a communal shower were not, this is discussed further in the report.

There were a number of communal rooms and areas for residents' use throughout the centre such as a large dining room and day room, activities room, a sun room and an oratory. The activities room and oratory room had been de-cluttered since the previous inspection. The communal spaces were clean and warm throughout with the exception of the sun room, which was very cold on the day of inspection.

The outdoor courtyard was very well maintained and was easily accessible by residents.

Many of the residents were eating their meals in their bedrooms during the outbreak. Resident were very complimentary regarding the quality, choice and variety of food available to them and were enjoying the new menus, that the chef had recently implemented. Residents who required assistance were provided with it in an unhurried and respectful manner. Texture modified diets appeared appetising and wholesome.

The inspectors observed lovely person-centered interactions between staff and residents, and it was obvious that staff knew residents well. The person in charge and assistant director of nursing were also well known to residents. Many of the residents who spoke with the inspectors were full of praise for the kindness of staff. Many of the residents told the inspectors that call bells were answered in a timely manner since the installation of the new call bell system, but a small number still reported delays. Residents were encouraged to maintain their mobility and independence. Residents who required mobility aides were seen to have access to these as required, following assessments by relevant health and social care professionals.

There was a schedule of activities in place every day and residents were aware of the activities available in the centre. The inspector saw the activity staff attend to residents' rooms and did one-to-one and small group activities with residents, as they were mindful of the outbreak in the centre. Regular residents' meetings were held in the centre and from a review of minutes of these meetings, issues such as activities, food, laundry and staff communication were discussed and actioned.

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

Capacity and capability

This was an unannounced risk inspection carried out by two inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended). The inspection was conducted to follow up on information received from the provider that the required fire safety works had been completed in the centre. This inspection found, that while it was evident that fire safety works had been undertaken in the centre, there was no evidence that work completed to date, had been signed off by a competent professional to ensure that it was completed to the required standard.

The previous five inspections of Aperee Living Conna, undertaken on 26 April 2023, 7 September 2023, 9 November 23, 10 May 2024 and 21 August 2024 identified significant areas of concern, relating to the governance and management of the

centre, the protection of residents' finances and fire safety. Fire safety had also been identified as an issue in the report of the 22 September 2022 inspection, where significant improvements were required to ensure adequate precautions against the risk of fire. Following the failure of the provider to address serious fire risks; identified in their own external fire safety risk assessment undertaken in January 2022; and issues identified during the inspection of the centre on 22 September 2022 and 26 April 2023, a restrictive condition was attached to the registration of the centre in May 2023. This condition required the registered provider to have the fire safety works completed by 31 October 2023 to ensure the safety of the residents. The provider gave written assurances to the Chief Inspector that the outstanding fire safety works, evident during the August 2024 inspection, would be completed by end of October 2024. This inspection found that these works had yet to be signed off by a competent professional to ensure that it was completed to the required standard.

Aperee Living Conna is operated by Conna Care Home Limited, the registered provider. As identified in the previous inspection, concerns remained regarding the financial resources available to the provider. The Chief Inspector was informed that the registered provider company was in receivership since 31 July 2024 and that the appointed receivers were now responsible for the operational and financial management of the designated centre, with the powers of the current directors suspended. These and other findings are outlined under Regulation 23 governance and management.

The registered provider had appointed a person participating in management (PPIM) who attended the centre each week to support the onsite management team. Records of management meetings and clinical governance meetings between the person in charge and the PPIM were maintained, with associated action plans developed, and implemented. The inspectors were informed that the PPIM met with the provider on a regular basis to discuss the operational management of the centre and to ensure finances were available to complete the fire safety works required. However, these meetings were informal and therefore minutes of management meetings were not available to inspectors to review.

The person in charge for the centre was full time in position and was supported by an assistant director of nursing and a clinical nurse manager. The number and skill mix of staff working in the centre was appropriate to meet the assessed needs of residents living in the centre. There was an adequate number of nursing staff on duty, with two nurses rostered every day and night, supported by a team of health care staff. The person in charge ensured that an extra member of staff, in the role of night porter, was rostered at night, to mitigate identified fire risks in the centre as these had yet to be signed off as complete.

A training schedule was in place for all grades of staff. Staff were facilitated to attend training appropriate to their role and demonstrated an appropriate awareness of their training with regard to safeguarding, infection prevention and control and fire safety. There were arrangements in place to provide supervision for staff.

There was a system in place to ensure oversight of the quality of care provided to residents, through a schedule of clinical audits and close monitoring of clinical risks to residents.

Incidents occurring in the centre were recorded electronically and there was oversight and monitoring of incidents by the person in charge. All incidents had been reported to the Chief Inspector, as per regulatory requirements. A review of the complaints register found that complaints were recorded, acknowledged, investigated and the outcome communicated to the complainant.

Regulation 14: Persons in charge

The person in charge, at the time of inspection was full time in post since May 2024. They had the necessary qualifications and experiences as required in legislation. It was evident to inspectors that they were knowledgeable, regarding their roles and responsibilities, and residents care needs.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of staff was appropriate having regard to the assessed needs of the 44 residents living in the centre and the size and layout of the centre. There was a minimum of two registered nurses rostered 24 hours a day, seven days a week.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge ensured staff had access to training appropriate to their roles. From a review of training records in the centre, it was evident that staff were up-to-date with mandatory training on fire safety, safeguarding, responsive behaviour and infection control. Staff were appropriately supervised by the management team working in the centre.

Judgment: Compliant

Regulation 22: Insurance

There was evidence available that the registered provider had a current contract of insurance in place.

Judgment: Compliant

Regulation 23: Governance and management

Significant concerns remained with regards to the governance and management of the service as evidenced by the following;

The provider had failed to ensure that the service was sufficiently resourced.

- Inspectors remained concerned regarding the provider's management of the centre's finances, as the centre was in receivership since 31 July 2024.
- Sign-off by the competent person was not in place at the time of the inspection in relation to fire works in the centre. This is required to evidence that all orange and red rated fire safety risks, identified in the fire safety risk assessment dated 20 January 2022, have been addressed in full and the works to address those risks were completed to the required standard.
- There had been significant delays in the completion of these fire works, despite assurances from the provider in compliance plan responses of earlier completion times.
- A restrictive condition remained in place against the registration of the centre and could not be removed as the fire works in the centre had not been signed off by a competent person.

The management systems in place were not always effective to ensure that the service was safe and appropriately monitored;

- There was a lack of oversight of premises issues with a number of issues outstanding from the previous inspections.
- Communication systems between the registered provider and the PPIM remained informal and therefore were not sufficiently robust.
- Again, the findings of this inspection, were that the registered providers governance structure was not in line with commitments provided to the office of the Chief Inspector or the Statement of Purpose against which the centre is registered.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge recorded incidents and accidents electronically and these were reviewed by an inspector. All required notifications as outlined in Schedule 4 of the regulations had been submitted to the office of the Chief Inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider ensured that the complaints procedure was accessible and displayed in the centre. There was a nominated complaints officer and review officer available and a record of complaints made was maintained.

Judgment: Compliant

Regulation 4: Written policies and procedures

From a review of the written policies and procedures required under schedule 5 of the regulations, it was evident to the inspectors that a number of these were not updated in the previous three years as required in the regulation. This may result in the policies not being in line with current best practice.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors found that residents were provided with a good standard of health and social care from kind and caring staff. However, concerns remained regarding premises and ensuring required fire safety works were completed as outlined further in the report.

The inspectors reviewed a sample of residents' health and nursing care records. Residents living in the centre had good access to general practitioner services and were referred to allied health and social care professionals when required. It was evident that a range of evidence based assessments were completed in relation to residents' risk of developing pressure ulcers, falls risk, nutritional assessment, dependency, moving and handling and continence. Appropriate interventions and

treatment plans were implemented and reviewed. However, assessments did not always contain relevant information and not all care plans were updated, when the needs of residents changed, which is further detailed under Regulation 5. Individual assessment and care plan.

From observation and review of documentation, there were arrangements in place to safeguard residents from abuse. A safeguarding policy detailed the roles and responsibilities and appropriate steps for staff to take should a concern arise. Training records indicated that staff had completed safeguarding training. Improvements had been made to ensure systems in place for managing residents' finances in the centre had been strengthened. Residents' needs in relation to behavioural and psychological symptoms and signs of dementia were assessed and continuously reviewed. These were documented in the resident's care plan and supports were put in place to address identified needs.

The inspectors saw that there was adequate resources in place to facilitate daily and deep cleaning schedules in the centre. Residents' bedrooms were observed to be clean. The person in charge had implemented its outbreak plan at the time of inspection and two residents had appropriate transmission based precautions in place, on the day of inspection. Inspectors saw that a communal shower room was not clean and other findings are outlined under Regulation 27; Infection control.

The premises was designed and laid out to meet the needs of the residents living in the centre and there was adequate communal and outdoor space. Bedrooms were personalised and residents had adequate space for their belongings. The premises, overall, provided a homely environment for residents. However, further action was required in the general maintenance and upkeep of the premises as detailed under Regulation 17; Premises.

From a walk through of the centre and conversations with management, the programme of work to address fire safety risks identified in the provider's fire safety risk assessment dated 20 January 2022, was nearing completion. The inspectors were informed that the only outstanding action was to display updated evacuation floor plans. When complete, the provider is required to obtain sign off from the competent person to provide assurance that all risks identified in the fire safety risk assessment have been addressed in full and that work was completed to an appropriate standard.

Fire safety training was up to date for staff. The night porter role remained in place and continued with regular fire safety checks in the centre. An inspector reviewed the fire records in the centre and saw that appropriate certification was in place for servicing and maintenance of fire equipment, including the fire fighting equipment, emergency lighting and fire detection and alarm system. Means of escape had been improved; pathways externally had been widened and provided with additional emergency lighting to guide occupants to the assembly point. Fire doors were in good condition; some were fully replaced and others had been repaired.

In the Douglas corridor, there were three cross corridor doors along the length of the corridor, two of which were fire compartment doors. The third door was not

within a fire compartment boundary, however staff identified this as a fire compartment to inspectors. This may lead to residents being evacuated into an area of the building, not protected from the fire. It would be beneficial to differentiate fire compartment doors from those which are not, to inform evacuation procedures.

Residents had access to advocacy services and residents were consulted on the running of the centre, through regular residents' meetings. Residents had access to television, newspapers and radios. However, action was required to ensure that noise levels in the centre did not impact on residents' well being and in relation to visiting restrictions during an outbreak as outlined under Regulation 9; Residents rights.

Regulation 17: Premises

The following required action to ensure compliance with Regulation 17 and Schedule 6:

- paint on some bedroom walls, door frames and corridors was chipped and damaged.
- there were tiles in a few locations were loose and at risk of falling from the wall, for example a sluice room and a staff room
- the bathroom in The Douglas Suite, also had loose tiles creating a risk to residents. The shower area in this room was being used for storage. This was the only shower available for residents who don't have an en suite. The toilet in this room also required repair
- in a number of en suite bathrooms, a gap had formed between the tiles and the bedroom flooring trim; this was harbouring debris and was difficult to clean
- there was a malodour from a sluice room in the Douglas Suite. The source of the malodour was not known. This required further investigation and action to address the issue
- the communal sunroom at the end of the Douglas suite was not heated
- the position of light switches and bedside lights requires review to ensure they are functional and easily operated. For example, a bedside light was not working and a lighting unit in a bedroom was flickering
- the lighting on the corridor outside the activities room and oratory was not working
- the coving near the laundry room required repair; there was exposed plasterboard
- externally, there was no lighting in the secure garden area.

Judgment: Substantially compliant

Regulation 27: Infection control

The following required action to ensure procedures were consistent with the National Standards for infection prevention and control in community services (2018).

- A hand hygiene sink on one of the corridors and a shower room was not clean
- The electronic device used by nursing staff, for medication management, had a cracked screen therefore could not be effectively cleaned
- A pressure cushion was worn and cracked and therefore could not be effectively cleaned.
- The clinical hand wash sinks in the centre did not comply with the recommended specifications for clinical hand wash basins.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Notwithstanding the extent of work carried out to address the risks identified in the fire safety risk assessment, these works were not yet signed off by the competent person.

Improvements were required by the provider to ensure adequate precautions against the risk of fire and for reviewing fire precautions:

- there was inappropriate use of an extension cord in the hair salon, where it was located beneath the salon sink, creating a risk of water ingress to the socket. This did not align with the risk assessment for the hair salon and it was removed immediately. Extension cords were also used to power appliances such as the medication fridges in the treatment room. This is poor practice and presents a risk of fire.
- the position of some sockets adjacent to a resident's pillow on their bed required review
- notwithstanding that two electrical panels were within fire rated enclosures, the metal door covers to each panel had been removed and had not replaced; this is poor practice
- the periodic inspection report for the fixed wiring electrical installation identified five category 2 (meaning requires improvements) observations which had not been addressed
- there was a gap at the kitchen door which required adjustment, to ensure effective containment of smoke and fire.

The measures in place to safely evacuate residents and the drill practices in the centre required improvement:

- on one corridor, an incorrect fire door was identified to the inspector by staff as being the fire compartment boundary door, for horizontal evacuation, which may result in residents being moved into an area, not protected from the fire. The drill record for this area reflected the correct compartment size. (this is a repeat finding)
- the assessed evacuation requirements for residents is supported by the provision of a pictogram on the bedroom door, as a prompt to staff to identify the mode of evacuation for the resident; in two bedrooms the incorrect pictogram was displayed
- monthly evacuation drills and simulated scenarios in various areas of the centre, including completing an external evacuation were completed. The time to evacuate identified in some drill records was excessive and required review.

The fire notices displayed did not relay the evacuation procedure to be followed in the event of a fire, as required by the regulations

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspector found mixed findings in relation to assessments and care plans, whereby some information in a sample of care plans reviewed was person centred, while the following required action;

- A resident's medical history was not included to inform relevant assessments
- Residents' assessments and care plans were not consistently updated following a changed in a resident's condition for example, following a fall.

These could lead to errors in care delivery.

Judgment: Substantially compliant

Regulation 6: Health care

It was evident to inspectors that residents had timely access to medical services such as local GP services whereby a GP attended the centre once a week. Residents had access to out of hour services as required. Community services such as community palliative care services were also available. Residents who required assessments by speech and language therapists, occupational therapists, dietitians and physiotherapists were referred where appropriate.

Judgment: Compliant

Regulation 8: Protection

The provider had a safeguarding policy in place and staff were provided with training in relation to the detection and prevention of and responses to abuse. The systems in place to ensure monies and items handed in for safekeeping were recorded and safely managed had been strengthened, since the previous inspection.

Judgment: Compliant

Regulation 9: Residents' rights

Action was required to ensure residents' rights were being promoted or supported in relation to the following;

- Some residents reported concerns regarding the levels of noise from sensor alarms in the centre and how this impacted their well being.
- There were excessive restrictions on visiting during the outbreak, which did not support residents' rights.
- A small number of residents reported delays in having their call bells answered.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Aperee Living Conna OSV-0004447

Inspection ID: MON-0045240

Date of inspection: 18/11/2024

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	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ul style="list-style-type: none"> • The RPR and PPIM continue to communicate at a minimum on a weekly basis. Minutes of these meeting are recorded since this inspection. • The fireworks in the center are now complete. The sign off report from the fire engineer providing assurance that all previously identified fire risks have been addressed has been submitted and an application to remove the restrictive condition has been submitted. • The center is in the process of being sold and will remain in receivership until the sale is completed. • The maintenance plan for 2025 has been updated. • The Statement of Purpose has been updated. <p>The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.</p> <p>The registered provider failed to provide a date for achieving compliance with Regulation 23 (a) and (c).</p>	

Regulation 4: Written policies and procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:</p> <p>A new suite of written policies and procedures reflecting up-to-date practice were in progress of being implemented at the time of the inspection and have since been completed.</p>	
Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <p>There has been a staff change in the maintenance department. It is now hoped that the overall maintenance of the building will improve. A maintenance plan for the center for 2025 has been completed and some works have commenced:</p> <ul style="list-style-type: none"> • 4 Bedrooms have been painted • The loose tiles in the centre have been repaired. • The shower area in the Douglas corridor is no longer used as a storage area and the loose tiles have been repaired in this bathroom. • The toilet in the Douglas Corridor bathroom has been repaired. • The gap formed between the tiles and the bedroom flooring trim in the Castle corridor has been cleaned and filled in. • The malodour in the Douglas Sluice room has been investigated and the slop hopper has been identified as the source of the smell. A regular cleaning regime has commenced of the slop hoppers. • An electric heater has been purchased for the Sunroom at the end of the Douglas Corridor • All lights have been checked to ensure they are in working order and bulbs were replaced where necessary. As part of the maintenance plan the position of the light switches and the bedside lights will be reviewed. • The lighting on the corridor outside the activities room and oratory is repaired • The coving in the corridor near the laundry room has been repaired. • An electrician has been asked to price of cost of installing lighting in the secure garden area. These works are included in the maintenance plan. <p>The registered provider failed to provide a date for achieving compliance with Regulation 17 (2).</p>	

Regulation 27: Infection control	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Infection control:</p> <ul style="list-style-type: none"> • An audit template has used to assess cleanliness and hygiene in Home to help reduce the spread of infection. Corrective actions are taken when required depending on the results of the audit. • Electronic devices are no longer used by nursing staff, for medication management. • New resident pressure cushions have been purchased replacing the damaged ones. • Installation of 3 Clinical Sinks in accordance with HBN11 -01 are included in the refurbishment plan. 	
Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <p>Notwithstanding the extent of work carried out to address the risks identified in the fire safety risk assessment, these works were not yet signed off by the competent person. Improvements were required by the provider to ensure adequate precautions against the risk of fire and for reviewing fire precautions:</p> <ul style="list-style-type: none"> • The extension cable is no longer in use in the hair salon • An electrician has been asked to insert extra electrical sockets in the Hair Salon and in the treatment rooms. • The repositioning of some sockets adjacent to a resident's pillow on their bed in included in the maintenance plan. • The metal door covers of the two electrical panels within fire rated enclosures are in the process of being reattached. • An electrician has been asked to price the five category 2 observations noted in his periodic inspection report of the fixed wiring electrical installation which need to be addressed. • The gap between in the kitchen doors which required adjustment, to ensure there is effective containment of smoke and fire has been resolved. <p>The measures in place to safely evacuate residents and the drill practices in the centre required improvement:</p> <ul style="list-style-type: none"> • In the Douglas corridor a notice has been applied to the double fire doors to bring to the attention to all that these fire doors do not correspond with a fire compartment boundary. • The PEEP sheets and the pictogram placed on resident's bedroom doors to assist in identifying the correct mode of evacuation for each resident have been reviewed for all residents to ensure their correctness. • Fire drills continue to be carried out in the centre. The focus of these drills is to ensure 	

staff know how to repond to the fire alarm safely and in a more timely manner.

- The fire notices are updated by a Fire Safety Engineer to relay the evacuation procedure which should be followed in the event of a fire, as required by the regulation.

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

The registered provider failed to provide a date for achieving compliance with Regulation 28 (1) (a) and (e), 2 (v) and (3).

Regulation 5: Individual assessment and care plan	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

- All nursing staff have received person centred care plan training

All Care plans are in the process of being reviewed and updated again to ensure they are person centred and reflect the residents physical, psychological and social care needs

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

All staff are undergoing Residents's Rights training on HSELand:

- The Fundamentals of Advocacy in Health and Social Care
- Introduction to Human Rights in Health and Social Care. - Applying a Human Rights-based Approach in Health and Social Care: Putting national standards into practice.

- The amount of sensor mats in use has been reviewed
- There is a new visitors policy in the centre and a visiting leaflet has been compiled to explain the visiting policy, including any limitations that apply, and the reasons for the limitations. Residents are provided with a clear pathway to appeal against limitations on access if they consider them unreasonable. We will facilitate visits on compassionate grounds.
- Each Staff member attended a briefing on the importance of answering call bells in a

timely manner. There is a weekly call bell audit in place. Answering call bells in a timely manner is on the agenda of the residents' meeting to explore if residents have any issues with their call bells being answered in a timely manner.

The registered provider failed to provide a date for achieving compliance with Regulation 9 (3)(e).

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Not Compliant	Orange	

	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	12/02/2025
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	
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	

Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	12/02/2025
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	Substantially Compliant	Yellow	30/03/2025

	consultation with the resident concerned and where appropriate that resident's family.			
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Substantially Compliant	Yellow	