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:	Greystones Nursing Home
Name of provider:	Greystones Nursing Home Limited
Address of centre:	Church Road, Greystones, Wicklow
Type of inspection:	Unannounced
Date of inspection:	03 January 2024
Centre ID:	OSV-0000045
Fieldwork ID:	MON-0040464

About the designated centre

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

The centre is based in a town and is close to shops, and local public transport networks. The designated centre provides care and accommodation to male and female residents over the age of 18. It provides a service to residents with a wide range of needs including palliative care, dementia care, acquired brain injury and physical disability. The provider offers long-term and short-term accommodation, respite and convalescence care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	49

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 3 January 2024	08:00hrs to 17:00hrs	Helena Budzicz	Lead
Wednesday 10 January 2024	09:00hrs to 16:20hrs	Helena Budzicz	Lead
Wednesday 3 January 2024	08:00hrs to 17:00hrs	Frank Barrett	Support
Wednesday 10 January 2024	09:00hrs to 16:20hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

Overall, the inspectors found that the person in charge and staff were working to enable residents to have a good quality of life. Feedback from residents and visitors regarding the service they received and their quality of life in Greystones Nursing Home was positive. However, there were significant findings in respect of residents' care and the quality and safety aspects identified on the first day of inspection. Inspectors identified several issues relating to care for residents with high-dependency needs, including respecting residents' rights, provision of activities and the dining experience. In addition, the registered provider was required to take action in respect of fire safety concerns, infection control practices in the centre, and improvements to the premises.

This was an unannounced inspection which was carried out over two days. Upon arrival at the centre, the inspectors were greeted by the person in charge (PIC). The inspectors were informed by the person in charge that there was a COVID-19 outbreak in the centre. In total, four residents and three staff members were confirmed to have COVID-19. As a result of the staff's unplanned leave, there were two nursing shifts not covered on the morning of the inspection. The person in charge was working as a staff nurse in the centre. Two agency staff nurses arrived between 10.00hrs and 11.00hrs. The person in charge was also accompanying the general practitioner (GP) on the day of the inspection, as no other management personnel supported the person in charge locally. There was no other management personnel available to support the person in charge locally on the morning of the inspection. The regional manager from the group arrived around midday. As a result of the person in charge being occupied with the residents' care, the introductory meeting did not take place in the morning, but a progress meeting took place at 14.00hrs.

The inspectors noted that the COVID-19 outbreak and the shortage of staff negatively impacted the atmosphere in the centre, including overall residents' care and welfare experience on the first day of the inspection. Inspectors found that residents spent a significant amount of time with little in the way of meaningful activities to occupy them on the first and ground floor of the Sea Patrick wing on the first day of the inspection. Call-bells were available throughout the centre, and the inspectors observed that these were not responded to in a timely manner due to staff shortages; however, significant improvement was noted on the second day of the inspection when the full staffing complement was available.

Greystones Nursing Home provides long-term care for both male and female adults with a range of dependencies and needs. The centre consists of two distinct buildings, the Main house and the Sea Patrick wing. The building is situated in the village of Greystones, Co Wicklow. On the day of these two days of inspection, there were 52 residents living in the centre. Resident accommodation was provided over two floors. Access between floors was by stairs and passenger lift.

The centre had undergone renovation of the front part of the centre in the Main House, including the reception area and the communal and dining areas on the ground floor. The main living room was bright and comfortable, with a large television screen and books and paintings on display. There was a comfortable seating area at reception where residents could sit and relax. However, other areas of the designated centre were not well-maintained as detailed under Regulation 17: Premises with some ceilings showing evidence of water damage and visible wear and tear in the older part of the building. There was living room space, dining rooms, a quiet room and a hairdressing room in the Sea Patrick wing. Inspectors observed that the Quiet room was used as a storage room for various items of residents' equipment and was not available for residents' use on the first day of the inspection.

There were also dining room tables and two pots of large green plants, which were seen blocking the evacuation routes. Inspectors also observed that a number of armchairs and two tables were in the staircase lobby on the first floor, blocking another evacuation escape route. An immediate action plan was given on the first day of the inspection to clear the evacuation escape route and exits.

The inspectors saw that most of the bedrooms were spacious, and all contained appropriate seating and storage for residents. The inspectors observed one twin-occupancy bedroom on the first floor of the Main House had been converted to single occupancy. They also noted that another twin-occupancy bedroom on the ground floor of the Main House did not meet the S.I. 293 of 2021 criteria in that it did not afford a minimum of 7.4 m2 space to each resident.

The impact of the COVID-19 outbreak on the lives of all residents was noticeable as inspectors observed limited interactions between staff members and residents and saw that not all communal areas were appropriately supervised throughout the first day of the inspection, especially in the Sea Patrick wing where only two residents were seen using the sitting area. Two other residents in large specialised wheelchairs and of high dependency needs were observed unsupervised and without any form of engagement for prolonged periods in the staircase lobby. The organised activities for residents were mainly provided in the Main House on the first day of the inspection. Improvements were noted by the second day of the inspection, where the residents were offered a variety of activities in both units.

While a positive dining experience was observed in the Main House, the inspectors observed a dining experience on the first day of the inspection and saw that there was a more task-orientated rather than person-centred atmosphere in the Sea Patrick wing, as detailed under Regulation 18: Food and Nutrition.

The dining experience on the second day of the inspection was observed to be a relaxed, sociable occasion in both units, and inspectors saw that the food was appetising and well-presented. All dining tables were appropriately set with table decor and condiments. Soft music was playing on the television, and staff members offered choices to residents. The inspectors observed that residents requiring assistance were seen to be helped in a respectful manner, and there was sufficient staff in the dining room to provide assistance to all residents. However, further

improvement in the serving experience was required, as detailed under Regulation 18: Food and Nutrition.

The next two sections of the 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

Governance and management arrangements were not sufficient to ensure that the service was consistently operating in line with the regulations and standards. While residents reported their satisfaction, inspectors noted some practices in the centre that required improvement and immediate action was given to the provider in respect of fire safety risks identified.

This was an unannounced inspection, carried out over two days by inspectors of social services, to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The provider had a long history of non-compliance with Regulation 28: Fire safety, and a restrictive condition had been attached to the registration certificate requiring the provider to achieve compliance with this regulation by 30 November 2023. The provider had submitted an application to vary Condition 4 of the registration of the centre with a new proposed extended timeline, and the inspection informed decision-making in this regard. The inspectors also followed up on the actions taken by the provider to address issues identified on the last inspection of the centre in May 2023.

The inspectors found that the provider had taken some action on remedial works relating to fire containment measures and premises to address fire safety non-compliances that had been identified on the last number of inspections. Improvements to the premises were also found, specifically to the Main House building, which had been recently refurbished. Inspectors were not able to review some information on the first day of the inspection due to delays in accessing the records and documents requested as a result of the outbreak of COVID-19 and its effect and pressures on the staffing levels in the centre. A review of records took place on the second day of inspection.

The inspection found that while the provider had a plan in place for actions needed to ensure residents were protected from the risk of fire, some of the management systems related to oversight of fire safety, cleanliness and staff practices related to regulations such as infection control, premises, residents' rights, food and nutrition and governance and management of the centre were not effectively implemented to ensure appropriate monitoring and compliance with the associated with regulations.

Greystones Nursing Home is registered for 64 beds. The provider had identified a number of bedrooms that did not meet regulatory requirements and had decreased

the occupancy of the centre to 59. The inspectors reviewed the layout of these bedrooms and found that the layout of one other bedroom on the ground floor did not meet the criteria of S.I. 293/2021. Following the inspection, the provider committed to reduce the occupancy to 58 and to submit the application to vary Conditions 1 and 3.

The registered provider is Greystones Nursing Home Limited, which is part of the Evergreen Care Group. The person in charge was appointed in July 2023 and was present in the centre on a daily basis, Monday to Friday. The deputy Person in Charge was also new in the post since November 2023 and was on planned leave at the time of inspection, with no arrangements in place to replace them. On the first day of inspection, it was noted that there were no other management personnel identified locally as part of the contingency plan to support the person in charge in unplanned events such as the outbreak of COVID-19. Additional resources had been put in place by the second day of inspection to support the person in charge, such as a Regional Manager who attended the centre regularly after the first day of inspection.

The provider used a range of oversight tools to monitor performance in the centre. A schedule of clinical and environmental audits evaluated key areas such as weight loss, pharmacy audit, infection control and prevention, call-bell and bedrails audit. However, inspectors saw that some of the presented audits were checklists and did not inform further quality improvements in the centre. The provider had in place audits and checklists to oversee the fire safety systems at the centre and to monitor the condition of these systems. However, covered fire detectors, which posed a significant risk, were not identified on these audits, and there was no checking in place to ensure that contractors who were working in areas of the centre were ensuring that fire safety systems were not left obstructed or ineffective. Findings in respect of fire precautions are detailed under Regulation 28: Fire precautions.

Inspectors observed that staff members, mainly in the Sea Patrick wing, were not appropriately supervised to carry out their duties to promote the care and welfare of residents on the first day of the inspection. For example, the inspectors observed prolonged waiting times to answer call-bells, inadequate staff practices during meal times or during environmental cleaning, inappropriate communication with residents and a lack of social stimulation. As a result, the inspectors were not assured that there was adequate supervision of staff from senior management to note these issues and to implement improvements to ensure that appropriate practices were used to provide high-quality and person-centred care for residents.

Staff files reviewed contained all the items listed in Schedule 2 of the regulations. An Garda Siochana (police) vetting disclosures, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012, were available in the designated centre for each member of staff. However, there were gaps in four staff files in respect of the references provided by the previous employers.

Regulation 14: Persons in charge

The person in charge worked full-time in the centre. They held the required qualifications and experience required under the regulations. They demonstrated good knowledge regarding their role and responsibility and were well-known to staff, residents and families.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels were not in line with the centre's statement of purpose (SOP). For example:

- In the statement of purpose, the registered provider had committed to have 9.9 WTE (whole-time equivalent) staff nurses. The centre had a deficit of approximately 3.4 whole-time equivalents (WTE). During both inspection days, the centre had 6.5 WTE staff nurses. Inspectors were informed that three staff nurses were waiting for their PIN number from The Nursing and Midwifery Board of Ireland (NMBI) and were due to commence employment. In the interim, the registered provider was using agency staff to cover vacancies.
- There was also one vacancy for kitchen staff. Inspectors were informed that the provider was actively recruiting to fill this position.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Inspectors found that a number of staff were not up-to-date with their mandatory training requirements as per the centre's own policy on Staff training and development. For example, four staff members had not received refresher training in safeguarding vulnerable adults, two were out-of-date in fire training, three were in manual handling training, and six were in infection control and prevention training.

Inspectors observed on the day of the inspection that there was a lack of supervision of the staff during the first day of the inspection. Inspectors observed long waiting times of up to 10 min for the residents' call-bells to be answered. The lack of staff supervision is further evidenced under Regulation 9: Residents' rights, Regulation 29: Medicines and pharmaceutical services and Regulation 18: Food and nutrition.

Furthermore, during the second day of the inspection, inspectors observed that the

supervision of the housekeeping staff practices was not robust, as the housekeeping staff were not using appropriate cleaning methods and personal protective equipment (PPE).

Judgment: Not compliant

Regulation 21: Records

Some of the requested documents were not accessible on the first day of the inspection as a result of the impact staff shortages had on the availability of the person in charge.

The management of records was not fully in line with regulatory requirements, and records were not all kept in an accessible manner. For example, staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations, as four staff files did not contain written references. This is a repeat finding from the previous inspection.

Judgment: Not compliant

Regulation 23: Governance and management

Notwithstanding the improvements made to the quality of the lived environment in the Main House since the last inspection, inspectors found that the provider was in breach of Condition 1 of its registration certificate as areas in the centre designated for residents' use had changed their designated purpose and were used as a storage room on the first day of the inspection. An immediate action plan was issued to the provider in this respect, and the Quiet room was reverted back to its purpose on the second day of the inspection.

The registered provider did not ensure that the centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose (SOP). The contingency planning with respect to unforeseen events such as an outbreak of COVID-19 did not work, which was compounded by a weakened local governance and management structure.

Management systems were not adequate to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- Some of the quality improvement audits and checklists reviewed on the inspection did not evidence a quality improvement focus. For example, where poor findings were identified, there was no action or timebound plan for improvement to drive improvements in the quality and safety of the service. Furthermore, a person responsible for the actions being implemented and

follow-up reviews was also not identified.

- Managerial oversight of the staff training matrix, staff supervision, and staff practices required strengthening as detailed under Regulation 16: Training and Staff Development, Regulation 9: Residents' Rights and Regulation 29: Medicines and Pharmaceutical Services.
- There were inadequate systems in place to ensure residents' meal times were managed appropriately as outlined under Regulation 18: Food and Nutrition.
- Management systems in place did not ensure that the cleaning procedures in the centre were completed to recommended standards to protect residents from the risk of infection, as evidenced under Regulation 27: Infection control.
- Fire safety audits were not picking up fire safety concerns highlighted on this inspection. For example, weekly fire safety audits were being carried out on the fire alarm but did not identify that fire detector heads had been covered. The provider did not have a system in place to monitor the activity of contractors in areas of the centre to ensure that fire safety systems were operational at all times and, if covered, that they were uncovered on completion.
- Although daily escape route audits were being completed, immediate action had to be taken by the provider on the day of inspection to clear escape routes. Housekeeping practices required full review as significant clutter and storage were observed on day one of inspection, with an adverse impact on fire precautions. This was addressed by the second day of inspection.
- Management at the centre had made some improvements to fire safety concerns but failed to take action on the more significant risks known to the provider. The risk of the lack of compartmentation between floor areas was not prioritised in upgrade works. Inspectors were not assured that there was adequate oversight of fire safety precautions in the centre. Further information is detailed under Regulation 28: Fire Precautions.
- Notwithstanding the positive improvements made to the Main House of the centre's premises, inspectors found that further improvements were required to address several outstanding issues discussed under Regulation 17: Premises.

Judgment: Not compliant

Regulation 30: Volunteers

The inspectors reviewed files for volunteers involved in the centre on a voluntary basis and found that not all information as required by regulation was described; for example, the supervision and support arrangements were not in place.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had a directory of residents available, which outlined all specified information required in paragraph (3) of Schedule 3.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was on display in the centre; however, the complaint procedure displayed in the Sea Patrick wing was not updated with correct details, such as the name of the complaint officer, and other elements of the complaint procedure were not in line with the changes required under S.I. 628 of 2022.

Judgment: Substantially compliant

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

An application to extend the completion time-line of works to comply with Condition 4 of the centre's registration was submitted to the Office of the Chief Inspector of Social Services. The application was complete and contained all of the required information.

Judgment: Compliant

Quality and safety

Overall, the inspectors acknowledged that the quality of life and care in the centre was affected by the outbreak of COVID-19 at the time of inspection. The inspectors observed that, in general, staff were familiar with residents' preferences and choices; however, this was not always delivered in a person-centred way and promptly, especially on the first day of the inspection. Improvements were noted on the second day of inspection. However, the provider is required to take several actions to improve infection control in the centre, premises, medication management, and dining experience and to promote residents' rights. Significant additional actions to strengthen the centre's fire precautions are also required.

A review of care plans for a small number of residents colonised with Multi Drug

Resistant Organisms (MDROs) found that all resident files reviewed contained residents' current healthcare-associated infection status and history. Accurate information was recorded in resident care plans to guide and direct the care delivery effectively. However, some care plans, such as wound, mobility, communication and social and recreational care plans, were not appropriately updated with resident-specific, most up-to-date information to guide and inform individualised care. These discrepancies were also identified by the person in charge and are further discussed under Regulation 5: Individual Assessment and Care Plan.

On the first day, inspectors observed an institutional approach and limited communication interactions between some staff members and residents, as discussed under Regulation 9: Residents' Rights. This was also evidenced under Regulation 18: Food and nutrition, where further improvements in staff approach and knowledge were needed to make the dining experience an enjoyable social everyday event.

The inspectors identified some examples of good practices in the prevention and control of infection. For example, staff were observed to apply basic infection prevention and control measures known as standard precautions to minimise risk to residents. However, not all staff used the PPE in line with the current guidance with respect to with the management of COVID-19 infections, and enhanced cleaning was not in place. This is set out under Regulation 27: Infection control.

Overall, significant improvement was required in the upkeep of the facilities and premises. Inspectors noted that a room designated as a Quiet room on the first floor was used as a store room on the first day of the inspection. Other spaces in the centre that were being used by residents were not appropriate for their use, such as the landing at the top of the stairs, where residents were observed sitting without supervision for prolonged periods on the first day of inspection. Other areas of the centre were used for storage in an inappropriate way. A lower ground floor storage area adjacent to the staff corridor was overfilled with boxes of material, such as face masks and gowns, which appeared to be out-of-date. Other materials stored in this area were clothing, disused clothing, and new linen. There was no arrangement of the space, and the boxes were stacked high from the ground, which resulted in some of the boxes collapsing at the bottom. This area had concrete floors and concrete walls with no other finishing, which meant that it could not be adequately cleaned. Other storage spaces along corridors had maintenance issues noted on inspection, as further detailed under Regulation 17: Premises.

Inspectors reviewed procedures in place to protect residents in the event of a fire. The provider had a history of non-compliance with Regulation 28: Fire safety. While a fire safety risk assessment had been completed and remedial works had commenced, the provider did not prioritise their actions to ensure that the most serious risks had been addressed first.

During the inspection, inspectors were not assured of the effective compartmentation within the centre to protect residents in the event of a fire. The first-floor Quiet room in the Sea Patrick wing was not compartmented from the ground-floor dining area below it. Furthermore, the Quiet room opened onto a

bedroom corridor. In addition, there were no fire-rated doors at the stairway linking the ground floor to the first floor or on the bedroom corridors in the Sea Patrick wing. This meant that some residents on the ground floor were effectively living within the same fire compartment as some residents on the first floor. The procedure for evacuation was not reflective of this situation. Inspectors noted issues with fire doors on escape routes and service penetrations in service risers with insufficient fire stopping of services through compartments. This would mean that in the event of a fire, containment of fire and smoke could not be assured.

Means of escape in the event of fire were partially blocked in some areas. An exit route from the Sea Patrick wing first-floor bedroom corridor to escape stairs was blocked by plants and furniture. Other obstructions of the escape routes were identified, such as gates on link stairs and a wooden gate on a bedroom corridor. Inspectors also noted that some fire detectors were covered in the centre. This would mean that they were ineffective in detecting and giving warning of fires. Staff at the centre were unclear who had covered the detectors or how long they had been covered for. These covers were removed on the day. These issues are detailed under Regulation 28: Fire precautions.

Regulation 17: Premises

A number of bedrooms in the designated centre that were registered as twin bedrooms did not meet regulatory requirements in terms of size or layout to afford each of the residents a minimum of 7.4 m2 of floor space, which area shall include the space occupied by a bed, a chair and personal storage space. The provider had identified this and had maintained an occupancy below 58 residents and confirmed that an application to vary was to be submitted.

The registered provider did not, having regard to the needs of the residents at the centre, provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- Some areas of the premises required maintenance attention internally:
    - A toilet on the ground floor had damaged skirting, which was peeling off the wall behind the toilet, and damaged paint.
    - The first-floor bathroom was in poor condition, with broken wall tiles and a countertop which was water damaged.
    - A linen room on the first floor had damage to walls and ceilings. There were holes in the walls, and the floor boards were lifting when walked on.
    - Ceiling tiles in several areas of the centre were damaged and stained.
    - There was water damage on the wall on the first floor landing near the window above the nurses's station. The wall in this area was disintegrating as a result of water ingress.
    - Two storage areas on the basement level of the building were found to be dusty, without appropriate floor or wall covering, and not

sufficiently maintained.
    - Damage from wear and tear continued to impact the centre negatively; some furniture, such as tables and armchairs, appeared to be damaged.
    - A radiator in the bathroom near room 33 was rusted.

Judgment: Not compliant

Regulation 18: Food and nutrition

Inspectors observed differences in the dining experiences between the units on the first day of the inspection. By way of example:

- The dining experience in the Sea Patrick unit on the ground floor appeared to be task-orientated rather than person-centred. Inspectors saw that the food was served pre-plated for the residents; however, the residents with mainly high-dependency needs did not have choices offered, for example, extra sauce or different drinks.
- Some staff communication with the residents was limited, and the staff was observed mainly standing beside the residents rather than sitting with the residents at eye level to support better communication.
- The inspectors observed a significantly improved dining experience during the second day of the inspection; however, inspectors observed that while the meals with pureed consistency were presented in an appealing manner, some staff members were mixing together the pureed texture of the food on the plate. Serving such food was not aligned with residents' wishes, did not look appetising and failed to support an enjoyable experience from the different tastes of the food served.

Judgment: Substantially compliant

Regulation 27: Infection control

Infection prevention and control governance arrangements did not ensure the sustainable delivery of safe and effective infection prevention and control practices and antimicrobial stewardship. For example;

- The was no appropriately qualified infection prevention and control link practitioner in place to increase awareness of infection prevention and control and antimicrobial stewardship issues locally.
- Disparities between the findings of local infection prevention and control audits and the observations on the days of the inspection indicated that there were insufficient assurance mechanisms in place to ensure compliance with

the National Standards for Infection Prevention and Control in Community Services. For example, local audits had not identified the issues with the inappropriate storage and use of personal protective equipment (PPE) or the out-of-date supplies of PPE, including face masks or face shields.

The environment and equipment were not managed in a way to minimise the risk of transmitting a healthcare-associated infection. This was evidenced by;

- The clinical hand-wash sinks in the treatment room in the designated centre did not comply with the current recommended specifications.
- In addition to the inappropriate use of the Quiet room as a storage area, there was a lack of effective segregation that increased the risk of cross-infection. For example, there was inappropriate storage of a linen trolley with unclean laundry, two unclean fridges, hoists, wheelchairs and other pieces of equipment in this room. Inspectors acknowledge that the provider had taken prompt, appropriate action in respect of the Quiet room by the second day of inspection.
- Some items of residents' equipment and household cleaning equipment were not appropriately segregated in a number of storage areas, which posed a risk of contamination. For example, mattresses were stored on the floor, a household mop was stored on top of the vacuum cleaner, a full bed frame was stored together with cleaning equipment, there was unclean carpet on the floor, or the floor was only partially covered. Inspectors observed overfilled store rooms with boxes stacked on the floor, items stored out-of-boxes in the lower ground floor storage areas, and in activities store on the ground floor.
- The walls covering behind some hand-washing sinks around the centre could not be effectively cleaned due to surface damage. In addition, the inspectors noted gaps between the skirting board and the lining of the floor and damaged floor coverings on the corridors. As a result, the staff could not perform effective cleaning.
- Some parts of the environment had not been cleaned to an acceptable standard. For example, the canteen on the ground floor was visibly unclean with stained flooring, sink and unclean cutlery tray.
- A hazardous waste bin was seen to be overfilled on the corridors in front of the bedrooms of residents confirmed to have COVID-19 infection. This posed a risk of cross-contamination and further spread of the infection.
- During the second day of the inspection, poor practice was observed with regard to the appropriate use of personal protective equipment (PPE) such as gloves, aprons, and face masks with respect to the cleaning of residents' bedrooms with confirmed infectious status.

The inspectors observed that the person in charge addressed most of the environmental and cleaning issues to an appropriate standard by the second day of the inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider did not take adequate precautions against the risk of fire and did not provide suitable fire-fighting equipment, for example:

- The storage of materials in the lower ground floor storage areas impacted on fire safety at the centre, as it was impossible to identify what exactly was in all the boxes stored in this area. The arrangement of the storage area meant that flammable items were not separated from combustible items such as clothing or cardboard.
- Excessive storage of flammable items alongside other combustible materials was found in the maintenance lower ground floor plant room. This issue was also identified in the maintenance workshop area on the lower ground floor. The policy at the centre is to keep flammable storage separate from other storage, and was not implemented in practice.

The registered provider did not provide adequate means of escape, including emergency lighting, for example:

- The stairs and exit near the ground floor dining room in the Main House were not in use. This is the closest means of escape for some areas of the dining room. The first floor entrance to this stairway was not in use, and had a sign on the door preventing its use. Stair gates were fitted at the bottom of these stairs, further restricting their use. The evacuation plans displayed in the centre showed this as an active escape route, which could pose confusion and delay in evacuation.
- Emergency lighting was modified with the removal of the directional pictogram from the emergency light over the entrance door to a first floor stairs. This stairs was not being used by staff or residents at the centre, but was noted in the floor plans. There was no record available to indicate that this work had been assessed and completed in line with the fire safety design of the centre and certified by a competent person.
- Emergency lighting directional signage was not evident in all escape corridors in the centre, for example, the ground floor lift lobby, the ground floor bedroom area bedrooms 26 to 28 area or bedroom 31.
- A first-floor exit route was blocked by plants and furniture. These items also blocked the fire alarm call point and the fire extinguishers. An immediate action plan was given on the first day of the inspection; however, this was not fully rectified on the day of inspection.
- There was a wooden half-gate on the end of a bedroom corridor. While this was open, it had a locking mechanism and presented an obstruction to evacuation.
- A table was obstructing the first-floor escape route in the corridor, linking the older section of the centre to the newer extension.

The registered provider did not ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and, in so far as is reasonably practicable, residents are aware of the procedure to be followed in the

case of a fire. For example:

- Inspectors were not assured that specific risks at the centre were being reviewed and mitigated using fire drills and training to alert staff to the specific issues. This issue was identified during the inspection in October 2022. For example, training did not reflect the nature of the compartmentation issues, which meant that two bedrooms on the ground floor in the Sea Patrick wing were in the same evacuation compartment as the first floor, which could have a negative effect on residents in the event of the fire.
- There were no fire drills reflecting evacuation of the largest compartment under times of low staff numbers, such as at night. This meant that the provider could not be assured that staff would be able to evacuate those residents safely and in a reasonable time in the case of a fire.
- Fire evacuation floor plans posted on the walls at the centre did not reflect the fire fighting points available on the escape routes or did not identify the alternative means of escape from the position of the reader. This could cause confusion or delays in the event of a fire.

The registered provider did not make adequate arrangements for detecting or containing fires. For example:

- Fire detectors were found covered in the ground floor lift lobby and in the staff area on the lower ground floor.
- No fire detection was in place in a store room on the ground floor near bedroom 9.
- Fire detection was inadequate in the lower ground floor storage areas.
- An under-stairs store room within the ground floor sluice room did not have fire detection.
- Fire doors in some areas of the centre were not equipped with appropriate fire-rated ironmongery. For example, fire-rated hinges and handles were not in place on many bedroom doors, and non-fire-rated ironmongery was on store room doors and compartment doors.
- Large gaps were found around some compartment doors, and some smoke and fire seals were incomplete. For example, the first floor linen room and the cross corridor compartment doors in the escape route outside the linen room, which would mean they would not be effective in a fire.
- Bedroom doors throughout the centre had acoustic-activated door closers fitted, which activate on the sound of the fire alarm. These devices were found to fail to close when tested in some areas, such as rooms 35, 38, and 39. This would mean that a fire in a room with an open door could spread to other areas of the centre, and smoke and fumes would not be contained for a period in the protected corridors. The closing of doors in the event of a fire did not form part of the procedure outlined by staff to inspectors.
- Service risers on protected corridors did not have evidence of fire sealing around the frames. This would impact on the fire rating of the door-set, and could result in fire smoke and fumes spreading to the escape routes from the risers in the event of a fire. These risers extend through the floors of the centre, which could provide a route for fire, smoke and fumes to travel

throughout the centre in the event of a fire.

- An electrical services cupboard on the first floor near the quiet room, had no appropriate containment measures in place at the door. The door had vents fitted to it, and there was a significant amount of cabling and sockets plugged into outlets within this cupboard. The door itself did not have any features of a fire rated door and did not close.
- A store room adjacent to the lift on the ground floor was not fire-sealed from the lift lobby or the escape corridor. The door to this room was also not sealed around the frame, and there was a space above the door head, which was open on both sides.
- An attic hatch was open in bedroom 39. Inspectors could not be assured of containment measures above the ceiling level in this area.
- The Quiet room area on the first floor was not separated with fire-rated material from the dining area below it. The ceiling space was shared between both levels. Inspectors could not be assured that containment measures in place at the quiet room wall along the bedroom corridor would contain fire smoke or fumes from the area below.
- There were no containment measures in place within the lower ground floor storage area. Inspectors could see services and structural penetrations that were not fire-sealed. The area inside this was directly below ground floor bedrooms.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The process for medication administration and storage followed by staff nurses was not reflective of the centre's own medication management policy and required review to ensure that medications were prepared and administered by registered staff nurses in line with best practice guidelines. For example:

- The medication trolley was left open and unsupervised during medication rounds in the communal area of the centre. Inspectors observed on a number of occasions that medications were left on the medication trolley while the staff nurse did not supervise the trolley. This posed a risk of potential harm in case some residents could access these medications.
- Opened bottles of liquid medicines in the medication trolley did not include an opening date in line with best practice.
- Four boxes of medicinal products assigned to be returned to the pharmacy were left open and unsupervised in the open area at the nursing station. This was rectified during the inspection.
- There were gaps in the recording of the medicine fridge temperature, and no records of temperature monitoring of one of the rooms where medicinal products were stored were available. The person in charge ensured that the thermometer was installed in the store room, and the nurses were informed

to record the temperature of the room on the first day of the inspection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

On the first day of the inspection, inspectors observed that not all residents were provided with opportunities to participate in activities in accordance with their capacities and capabilities. For example:

- While there were activities going on in the Main House, inspectors observed residents with high-dependency needs left with no attention from staff members for a long time, and there were no activities provided for residents who stayed in other sitting rooms. However, a significant improvement was noted on the second day of the inspection as residents with high-dependency needs and in all communal areas were also involved in the activities.
- On the first day of the inspection, inspectors observed inappropriate staff interaction between staff and residents when a resident requested to go to bed after a meal. The staff members on duty did not appropriately and timely address this request. As a result, the resident was left waiting in the dining room for a long while until another staff member attended to the resident's needs.

Judgment: Substantially compliant

Regulation 20: Information for residents

Inspectors reviewed the 'Information Guide' available in the centre for residents. It was observed that some of the information outlined in the guide was not correct. For example, the complaints procedure was not updated, reflecting the centre's current complaints procedure; there was a different name for the management personnel, and the weekly service charge did not match the current service charge.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

The inspectors reviewed residents' records and saw that where the resident was temporarily absent from a designated centre, relevant information about the resident was provided to the receiving designated centre or hospital. Upon residents'

return to the designated centre, the staff ensured that all relevant information was obtained from the discharge service, hospital and health and social care professionals.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed a sample of residents' records and found that the care plans recorded did not consistently reflect the current care needs of residents. For example:

- Wound care plans were not regularly updated to reflect current wound status and treatments.
- Care plans such as mobility and recreational social care plans reviewed were not updated to reflect the current resident's condition, needs, and present preferences, abilities and interests in how the resident would like to spend their day.

Judgment: Substantially compliant

Regulation 10: Communication difficulties

The inspectors found that residents who required assistance with their communication needs were supported by staff; however, residents' requirements were not always reflected in residents' communication care plans, which could pose a risk for a new staff not being able to communicate with residents effectively.

Judgment: Substantially compliant

Regulation 13: End of life

End-of-life care plans were examined. Inspectors found that in accordance with the resident's assessed needs and consent, referrals were made to specialist palliative care services so that an integrated multidisciplinary approach to end-of-life was provided.

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	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 30: Volunteers	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 10: Communication difficulties	Substantially compliant
Regulation 13: End of life	Compliant

Compliance Plan for Greystones Nursing Home OSV-0000045

Inspection ID: MON-0040464

Date of inspection: 10/01/2024

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • As noted on the day of the inspection, we were awaiting pin numbers for 3 RGN – these have been received. Our wte is 9.1 – we are recruiting for 1 part-time rgn. • We are continuing to recruit contingency staff for the home.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • We will ensure that our training matrix is up to date with documentation to enable ease of review. • The training matrix is reviewed monthly with the PIC,DPIC & ROM. Since the inspection training in manual handling and safeguarding has been completed with the following topics and dates booked for the coming months: • IPC:20.03.2024 • Fire Safety: 26.03.2024 • Safeguarding: 09.04.2024 • Dementia Care: 09.05.2024 • Restrictive Practice: 07.06.2024 • Our DPIC & PIC will continue with their supervisory walkarounds to support our staff nurses to manage their care teams each shift. • Regular staff meetings for each department will continue to guide and support all staff. • The roster will be planned to ensure that there is a senior staff member on duty on each shift.	

• Our HCA supervisor has run and will continue to run call bell response & placement audits regularly and will give feedback on the findings to all staff at handovers, to improve on response. • We have implemented mealtime supervision & orientation processes for both dining areas to ensure the dining experience for the Residents is consistent and pleasant for all. • For our Household department we will ensure that all staff members are up to date and have refresher training on the vital aspects of correct wearing of PPE & the products in use for same. The hseland ipc training has been refreshed for particular members of staff in the household department and ongoing safety pauses are being held to further reenforce this learning.

Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • We have commenced a full review of documentation within our staff files to ensure that all Schedule 2 documents are received. This review is due to be completed by the 15.03.2024.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A new audit suite is being rolled out – these include responsible person, action required & follow up date as a mandatory requirement. These are computer based which will allow pic & rom to have oversight at all times on the information being gathered and the need for appropriate action. • The training matrix has been reviewed and is up to date. This will be reviewed on a monthly basis by PIC,DPIC & ROM to determine the ongoing training needs of the home and staff and plan for same. • A mealtime coordinator post will be appointed for each shift to ensure the smooth and Resident orientated delivery of meals & the whole mealtime experience. • A full review has been undertaken between PIC and Household supervisor in relation to cleaning practices within the home. Training in products & practices will be provided as required to ensure that all staff are aware of and compliant with the national guidance. • IPC training has been completed for some staff since the inspection and further training has been booked for 20.03.2024. • Our H&S officer & PIC will conduct a weekly walkthrough of the home to review & assess compliance with fire doors, firefighting equipment & escape routes lighting and	

obstructions.
• Staff nurses on duty for each shift are responsible for checking that the fire evacuation routes are clear. This will be enforced & supported by both the PIC,DPIC & Health and Safety officer.
• A refurbishment plan is underway throughout the home.
• Fire Works are underway throughout the home – these include – fire doors, compartments, replacing the current alarm system. We have submitted to the authority a plan for the completion of same.

Regulation 30: Volunteers	Substantially Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:
• Our volunteers onsite will be closely managed as per our policy.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The complaints procedure has been reviewed and updated on both our display throughout the home and within our Residents guide.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• As noted by the inspectors, we have a substantial refurbishment plan in progress and are working to improve the home for the benefit of our Residents and Staff. This does include replacing/repairing and repainting all of the high traffic areas within the home.
• The first floor bathroom will be repaired.
• The linen room on the first floor is part of the greater refurbishment plan so in the meantime, we will ensure that it is clean/safe and items are stored correctly within it.
• We will replace any stained ceiling tiles.
• The roof in the home has been replaced entirely within the last 2 years. There has in the past been some water damage, and these areas have been repaired and sealed.
• The two storage areas identified in the basement have been cleared entirely and will

not be in use again.
• As the refurbishment moves throughout the home, we will be replacing worn furniture. Furniture is on order since January to this purpose.
• The radiator in the bathroom near room 33 has been repaired and refinished.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• The introduction of a mealtime coordinator role for each dining room and area will improve the overall ambiance and experience for our Residents.

• We will hold toolbox sessions on mealtimes to ensure that our newer staff are fully cognizant of their responsibilities and how to enact these

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
As noted during the inspection, our PIC was able to address the majority of the environmental and cleaning issues to an appropriate standard by the second day of the inspection.
• Our DPIC has completed the HSELand Amric training and as soon as a ipc link course becomes available within our CHO we will ensure that our DPIC attends. We have the support of the group IPC lead for all and every ipc concern. All of our RGN have completed HSEland training in ipc. Through our involvements with the acute and community sectors, there are a number of members of the MDT who liaise regularly with the home and can offer guidance.
• Another topic for our toolbox sessions is IPC and the correct usage of PPE. These sessions will be held weekly and each department will attend same.
• We will replace the handwash sinks in both treatment rooms with clinical handwash sinks as per the guidance.
• All splashbacks around our handwash sinks will be either refinished or replaced as necessary.
• Review of storage areas both in the quiet room & lower ground floor has been undertaken. The quiet room has been restored, as noted on the second day of inspection, back to its original purpose. The lower ground floor storage areas have been cleared out of all materials. We have identified a further storage room in the lower ground floor which will be used instead & are in the process of re-appointing our storage

container outside for more suitable items.
• We will have staff training on waste management & segregation within the next 2 months. All clinical bins when in use during outbreak will be managed & part of the housekeeping schedule for same.
• The cleaning schedule for the staff area have been reviewed and strengthened to ensure that these areas are included daily in the cleaning rota.
• As per Regulation 16, we have reviewed all staff training in relation to IPC & PPE and as necessary, some staff have completed their refresher training in these topics. This is part of the daily oversight of the RGN on duty. Some staff have already refreshed their IPC, PPE and hand hygiene training and further training is booked for 20.03.2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Adequate precautions against the risk of fire & provide suitable firefighting equipment:
• Both of the areas on the lower ground floor have been cleared of all materials and in consultation with our fire advisor, will be sealed off, with access via a hatch to enable services etc. Both will have smoke & heat detectors in each.
• The maintenance plant room has been cleared to ensure the correct storage of combustible materials.
• The policy regarding this has been enforced.

Means of Escape including emergency lighting.
• The stairs and the exit near the ground floor dining room in the MH are scheduled for compartmental works to be completed by the end of April. This will enclose the stairwell from the first floor. A new fire door will be fitted to gain access to both this area and to exit the building.
• All emergency lighting checks are completed as planned and we will ensure that the directional signage is in place and the works will be signed off & certified by a competent person.
• The fire exits are part of the daily shift checks for the staff nurses to ensure that these are kept clear. The fire exits are on the maintenance daily checklist also. Oversight from the PIC & ROM will be implemented to ensure compliance.

Fire Safety Management.
• Fire drills will be run every month, alternating between compartments in the MH & SP. Fire drills are always run using nighttime staffing levels with Residents taking part as they wish.
• The fire evacuation plans will be reviewed and the firefighting equipment points and alternative means of escape will be highlighted.

Detecting & Containing fire.
• The fire (heat & smoke) detectors are part of the weekly checks that the MM will perform – The PIC & ROM will have oversight of these weekly also.

• All store rooms will be fitted with fire detectors as part of the fitting of the new fire alarm system. • The doors in the home are all to be replaced with new fire doors and we will review and replace any of the ironmongery that is not suitable. • All the riser doors to be replaced and fire stopping carried out in the voids. • The closing of doors is part of the fire evacuation procedure – with our regular fire drills and upcoming training, we will ensure that our staff are fully aware of the steps to be taken. • All doors will be fitted with the wired freeswinging door release that will automatically close when the alarm is sounded. • Doors on the service risers will be replaced as part of our works withing the coming months. • The electrical services cupboard on the first floor will be fitted with a fire rated door. • The store room adjacent to the lift on the ground floor will be fire sealed and the door corrected to ensure a full seal is maintained. • All access hatches to the attic void to be replaced with 60min rated hatches. • Compartment curtain wall in the attics to be assessed and repaired as required. • We are awaiting a review and report from EOBA regarding the Quiet room and its containment measures. • The lower ground floor storage areas will have fire detectors fitted and are fire sealed from the floor above.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • All staff nurses have completed their medication management training and are cognizant of their responsibilities in relation to the safe placement of the medication trolley, what should be stored and where. • All bottles containing liquids have been updated with date of opening & initials by staff member who opened same. • All medications to be returned will remain in locked treatment room until collection. • Both medication fridges have temperature records attached – this is part of the RGN on each shift duties to complete. We have temperature monitoring in the medicinal storage room.	
Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• As part of our annual review, we circulate surveys to both Residents and families regarding all aspects of our care delivery and life within our homes. The responses received will assist us in planning activities for our Residents. We also enquire to our Residents at every Resident meeting regarding their choice of activities/meals/menus etc and again use this information in planning our delivery of care.
• Our activities will be planned to ensure that both sitting rooms are included for various activities depending on the wishes of the Residents on each side of the home.
• With our regular staff meetings and policy reviews for staff across all departments we will ensure that all staff are aware that our Residents are central to all that we do.
• We will continue to conduct regular call bell audits to assess response times.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
• Our Resident guide has been updated.

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:
• All wound care plans are updated to ensure that they are relevant to the status of the wound and present treatment.
• We are in process of reviewing and updating our Residents "key to me" to ensure that we have captured the preferences and wishes of how our Residents prefer to spend their day.
• We have circulated and are compiling our annual quality report which is part made up from feedback from our Residents and Families in relation to all aspects of our service. This feedback will aid us in planning activities and outings for our Residents.

Regulation 10: Communication	Substantially Compliant

difficulties	
Outline how you are going to come into compliance with Regulation 10: Communication difficulties: • All Residents who have communication difficulties have had their careplans updated to ensure consistency of care.	

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 10(2)	The person in charge shall ensure that where a resident has specialist communication requirements, such requirements are recorded in the resident's care plan prepared under Regulation 5.	Substantially Compliant	Yellow	29/02/2024
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	01/05/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Not Compliant	Orange	01/07/2024

	training.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	01/04/2024
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.	Not Compliant	Orange	31/07/2024
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.	Not Compliant	Orange	31/07/2024
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	08/03/2024
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and	Substantially Compliant	Yellow	08/03/2024

	served.			
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure respecting complaints, including external complaints processes such as the Ombudsman.	Substantially Compliant	Yellow	29/02/2024
Regulation 20(2)(b)	A guide prepared under paragraph (a) shall include the terms and conditions relating to residence in the designated centre concerned.	Substantially Compliant	Yellow	29/02/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	15/03/2024
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	01/04/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service	Not Compliant	Orange	01/04/2024

	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.	Not Compliant	Orange	01/07/2024
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.	Not Compliant	Orange	31/07/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/07/2024
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	Not Compliant	Orange	31/07/2024

	designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/07/2024
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	08/03/2024
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	08/03/2024
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been	Substantially Compliant	Yellow	08/03/2024

	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.			
Regulation 30(b)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre receive supervision and support.	Substantially Compliant	Yellow	08/03/2024
Regulation 34(2)(a)	The registered provider shall ensure that the complaints procedure provides for the nomination of a complaints officer to investigate complaints.	Not Compliant	Orange	29/02/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared	Substantially Compliant	Yellow	01/04/2024

	under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
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	01/04/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	01/04/2024