Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Meath Community Unit</th>
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<tbody>
<tr>
<td>Name of provider:</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>1-9 Heytesbury Street, Dublin 8</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>11 April 2019</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0000477</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0024268</td>
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</tbody>
</table>
About the designated centre

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

The Meath Community Unit is a 51 bedded Unit which provides residential, convalescence and respite care. There is a Day Care Centre on site which provides services for older people from the area. At present, the service has capacity to provide long term and respite care to 51 people. Rooms are located over three floors, Camden (1st floor), John Glenn (2nd floor) and Maureen Potter (3rd floor). These were named by the residents committee. The day room where some activities are run is located on the ground floor. Access to residential care is following assessment by a Consultant in Medicine for the Elderly and completion of the Common Summary Assessment Report (CSAR). Respite services provide people with short breaks away from home, this service is offered to enable carers to take a holiday or a break to help them to continue caring. It is also provided to people who are living alone and require the support which is offered by occasional respite. Initial arrangements are made through Nursing Staff, Social Workers or General Practitioners, subsequent admissions are co-ordinated through the family and the Public Health Nurses and Nursing Administration in the unit. Respite is normally for a two week period.

The following information outlines some additional data on this centre.

<table>
<thead>
<tr>
<th>Current registration end date:</th>
<th>12/06/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>49</td>
</tr>
</tbody>
</table>

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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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 April 2019</td>
<td>08:50hrs to 16:45hrs</td>
<td>Michael Dunne</td>
<td>Lead</td>
</tr>
</tbody>
</table>
### Views of people who use the service

Residents spoken with expressed high levels of satisfaction with the service. The activity programme was one of the areas that residents liked, they were very happy with the variety of activities on offer and told the inspector that staff always supported them to attend whatever is on and also provided support should they wish to pursue individual activities. They also told the inspector that the centre had access to transport and that they often visited places of interest nearby.

Residents were very happy with the food provided. They said they liked the choice available and that the food provided was tasty. Residents stated that staff could not do enough for you, they were kind and courteous.

Residents said they felt safe in the centre, they said staff announced their arrival before entering your room. They mentioned that there was good communication with staff when carrying out care duties and that staff listened to what you they to say. Those residents spoken with also mentioned that they felt comfortable raising a concern with any staff member if they felt they needed to. Residents were happy that their family and friends were made feel welcome when visiting the centre.

### Capacity and capability

Overall this was a well managed centre with good systems and processes in place to monitor the quality of care provided in the centre. Improvements were required to ensure there were sufficient resources available, such as low low beds, and in complaints management.

There was a well defined management structure in place which allowed for effective communication and reporting. Regular meetings were held to monitor the effectiveness of care delivery which included the monitoring of both clinical and operational risks. There was evidence of an annual review of quality and safety. This review incorporated the views of the residents and family members gathered from ongoing communication and structured satisfaction surveys.

There was evidence of sufficient staff numbers on site to provide the required levels of care to residents. Staff were found to be responsive to resident need and communicated with residents in a person centred manner. Records seen indicated
that staff had attended regular training as part of their continuous personal
development. It was noted that there were high levels of agency staff in use at the
centre however the management team had made efforts to recruit permanent staff
with two permanent nursing staff due to commence employment in the near future.

The premises were well maintained and welcoming and there was evidence of
residents being supported to personalise their living space. Records seen indicated
that there were maintenance contracts in place to ensure that the home was well
maintained and suitable for its intended purpose.

The centre had made many improvements since the last inspection such as the
provision of an additional meeting space for residents and families. Evacuation
procedures for immobile clients had been upgraded and arrangements to reduce the
number of restrictive practices had reduced the numbers of restrictions in place.
However resources required review as some resident were still subject to restrictive
practices due to the lack of low low beds in the centre.

The complaints log was reviewed and although all complaints seen were dealt with
promptly and effectively the centres policy was not always been followed. In
addition the complaints policy was not advertised in an appropriate format.

Regulation 15: Staffing

Staffing levels in the centre were consistent with the levels as described in the
statement of purpose. Staffing rosters past and present were reviewed and showed
that all shifts had been covered by the centre. On the day of the inspection there
were sufficient numbers of staff with the required skill mix available to meet the
health and social care needs of the residents. There was an allocated nurse on each
of the three floors accommodating residents. There were sufficient numbers of
support staff available to ensure that residents health and social care needs were
met. Staff told the inspector that they had sufficient time available to them to be
able to provide support to residents. The inspector observed communication between nurse managers and care staff and saw that roles and
responsibilities were clear within the team.

The inspector noted that the centre was using high levels of agency staff due to
problems in recruiting permanent staff however it was recorded that a clinical nurse
manager and a staff nurse had recently been recruited and would be joining the
team in due course.

Judgment: Compliant
### Regulation 16: Training and staff development

Staff training records were well maintained and were available for review. They indicated that staff had attended a range of mandatory and additional training throughout 2018 and 2019. The suite of training attended included mandatory training such as fire, moving and handling and safeguarding training. In addition staff also attended training on elder abuse, CPR, Restrictive Practice, managing physical aggression and completing nursing records.

Discussions with staff confirmed that they were facilitated to attended regular training and felt it useful as they were able to use knowledge gained from these courses in their day to day work. Agency staff also confirmed that they had access to regular training provided by the centre.

Judgment: Compliant

### Regulation 21: Records

Record keeping with regard to schedule 2 of the regulations had significantly improved since the last inspection. Staff records reviewed contained required garda vetting disclosures, employment histories and evidence of relevant up to date qualifications. One staff record seen had only one references in place however there was evidence that management had requested the second reference to be remitted to the centre as it was currently been held by the provider. Records were stored securely in an office with restricted access but were easily retrievable for monitoring.

Judgment: Compliant

### Regulation 23: Governance and management

There was a stable management structure in place with clear lines of responsibility. The person in charge (PIC) was supported in their management role by two assistant directors of nursing (ADONS) and by a grade 3 clinical nurse manager. There was evidence of planning and review where regular monitoring meetings were in place to ensure a quality service was delivered to the residents. Residents care was monitored through a range of clinical audits such as falls, wound care, weight, restraint and medication review. Operational risks were monitored through the risk assessment process and a quarterly quality and safety committee meeting was in place to review all operational issues. The centre had recently commenced a quality improvement initiative to support existing structures to further
drive improvement in the centre.

Improvements were seen in the overall management of restrictive practices in the centre since the last inspection and the number of residents using bed rails had reduced significantly. The management team had also introduced training with regard to restrictive practice and this was available to all staff both permanent and agency. Although the numbers of residents using bed rails had been lowered significantly, there still remained a small number of residents using this type of restraint due to a lack of low low beds. The management team stated that they had requested more resources from the provider in order to reduce this number down to zero.

An annual review of quality and safety was completed for 2018 and incorporated learning gained from the analysis of both clinical and operational audits. This review also incorporated the views of residents that was collated from a residents satisfaction survey.

Judgment: Substantially compliant

**Regulation 3: Statement of purpose**

There was a written statement of purpose that described the services and facilities available in the centre. A review of the current statement of purpose confirmed that it accurately described the range of services on offer. There was evidence that the statement of purpose was reviewed regularly with the last review in November 2018.

Judgment: Compliant

**Regulation 34: Complaints procedure**

The centre had a complaints policy in place however the complete policy was only partially advertised at the entrance to the units. There was a notice board area in each unit where relevant information on key services was displayed and the centre agreed to advertise it in that location. The policy contained all the relevant information on how one would raise a complaint and on how it would processed, the right to appeal and feedback. There was evidence of external advocacy details advertised throughout the centre and details of your service your say and internal comments and suggestions initiative aimed at accessing residents views on the
quality of service provision.

Residents spoken with were clear about the process in raising a complaint and staff too were aware of their role in assisting residents raise a complaint if they wanted to. The centre had 3 complaints registered in the complaints log for 2018. All complaints were investigated and recorded in the complaints and there was evidence of feedback to the complainant. The centre however did not always follow its own policy and procedure as some records had not been fully completed.

Judgment: Substantially compliant

Quality and safety

Inspectors found that there were good health and social care outcomes for the residents using the service. There was evidence seen which indicated that residents played an active role in their care delivery and that their needs were assessed at regular intervals. The centre deployed a range of evidence based tools to ensure that resident needs were effectively assessed such as the use of clinical based risk assessment. There was an organised MDT (multi disciplinary team) meeting held each week to give clinical oversight for the residents health needs.

The centre had access to its own physiotherapy service and had recently recruited an occupational therapist to the team. Residents could keep their own GP if they wished and there were arrangements in place where three GP’s visited the centre throughout the week. Access to allied health professionals such as dieticians, tissue viability nurses and primary healthcare services such as dentists and chiropodists was well organised by the centre where timely referrals were seen to be made on behalf of the residents.

There was an activity programme in place which was popular with the residents. Residents who wished to pursue individual interests were supported by the staff team to do so. Residents commented that keeping active helped with their overall well being.

Residents felt that they were able to raise issues with the staff team on a day to day basis but also in resident committee meetings which were held every three months. There was evidence that residents could access independent advocacy as their details were widely advertised throughout the centre. Relatives spoken with during the inspection confirmed that residents were supported to maintain links with the community and that the home facilitated residents visits home. Visitors were made welcome to the home, the centre had developed a new facility where residents and family members could meet in private.

There were policies and procedures in place to ensure that residents were protected from abuse. Records seen indicated that staff both permanent and agency had received the mandatory training in this area. Staff records reviewed during the
inspection indicated that staff had the required garda vetting clearance in place.

**Regulation 17: Premises**

The premises were clean and welcoming. Accommodation was provided over three floors with each floor having its own dining room and two sitting rooms. There were additional facilities based on the ground floor where residents could gain access to a large activity room and a new meeting room where residents and families could meet. The ground floor also contained the offices of the centre’s physiotherapist, the recently recruited occupational therapist, the music therapist and the centre’s part-time social worker.

There was evidence that each unit was well maintained. The floors were clean, fixtures and fittings were of a good quality and the sitting rooms were decorated to a high standard. There were handrails along each side of the corridors and there was evidence of sufficient resources to maintain high levels of infection control. Minor defects pointed out during the centre walk round were addressed immediately by the centre’s maintenance team.

The centre has yet to overcome issues with regard to the storage of hoist equipment. Hoists are still being stored in the assisted bathrooms on each floor as was highlighted in a previous inspection.

**Judgment:** Substantially compliant

**Regulation 18: Food and nutrition**

The catering manager gave an outline as to how nursing staff communicate resident dietary needs to the kitchen. Where special or modified diets are required then this is communicated to the catering staff by the unit managers via an information sheet. Where residents did have a specific requirement around food then this was initially captured in their respective care plan. There was evidence that the centre was monitoring residents’ weight and when a concern was highlighted then it would be discussed at the multi-disciplinary team meeting (MDT) and a referral made to a dietician if required.

Residents were observed on the units having their lunch. There was evidence that residents were afforded a choice at meal times and that the dining experience was a relaxed one. There were sufficient numbers of staff on hand to provide support to the residents as and when they needed it. It was observed when residents had completed their meal they were asked if they would like to be taken from the dining room. Some residents preferred to have their meal in their bedroom and this request was facilitated by the care staff.
Outside of regular mealtimes residents could get access to additional food and drink.

Judgment: Compliant

**Regulation 26: Risk management**

There centre had arrangements in place in to monitor and manage the health, safety and risks within the centre. There was a risk policy and procedure and risk register in the centre which was well maintained and current. The centre had compiled a comprehensive list of both clinical and operational risks. Identified risks were controlled through the risk assessment process where risks were identified, control measures put in place to reduce risks and reviewed at regular intervals. One risk assessment reviewed concerned the storage of hoists and recommended that they be stored in an outside storage unit.

There were a number of contracts with service companies in place to manage and maintain facilities with the centre. There was evidence that equipment integral to the running of the centre was been serviced at regular intervals.

Judgment: Compliant

**Regulation 28: Fire precautions**

There was clear fire signage within each unit directing you to the nearest fire exit. All fire exits seen were clear allowing free egress in the case of fire. There was sufficient fire equipment located throughout the building and there was fire maps located in each unit. The fire management system was well maintained with contracts in place for the regular monitoring of the fire systems.

Records seen indicated that staff had received fire training and there was further fire training planned throughout the year. Staff confirmed that fire training consisted of fire drills and records seen indicated that different scenarios were used during the fire drills to make it more realistic for example an evacuation during the day and one at night. It was noted that each resident now had a personal emergency evacuation plan (PEEP) in place which gave details of how the person should be evacuated.

The centre had changed to a new system of daily and weekly monitoring of fire safety, not all documentation and paperwork had been updated to cater for the transition. Once highlighted the management team amended the required paperwork immediately to reflect its current practice.
The centre also replaced intrumesent strips in fire doors where they had become worn, this was done with immediate effect.

Judgment: Compliant

### Regulation 5: Individual assessment and care plan

A selection of care plans were reviewed and showed that residents had a pre admission assessment before been admitted to the centre. On admission a comprehensive assessment of the individuals health and social care needs was carried out. Where it was identified that residents had health or social care needs then care plans were created. Those care plans reviewed indicated that residents played a part in their construction. In circumstances where residents were unable to contribute to their care plan then relatives were consulted where appropriate.

Care plans were well constructed giving the reader a clear picture of the individuals need and the associated care intervention that were identified to meet those needs. There was evidence that care plans were being reviewed with four months or as and when required.

Judgment: Compliant

### Regulation 6: Health care

There was evidence that residents health care needs were dealt with in a proactive manner. Care plans were developed on the basis of assessment and where there was a health need identified the care plan was developed using evidence based nursing tools. The centre had access to a range of health care services including physiotherapy and occupational therapy which were based on site. The centre had access to three GP’s who attended the centre on a weekly basis. Referrals for primary healthcare services were processed through the Health Service Executive (HSE).

A dietician visited the centre on a weekly basis and access to speech and language therapy (SALT) was gained by referring to the local health centre. The centre also had access to both music therapy and social work support as these services were also based on site. Resident files contained correspondence from specialist teams and recommendations made by then were recorded and followed up in the individuals care plan.

Management of the centre used a range of clinical based audits to monitor risk of malnutrition, risk of pressure ulcers, risk of falls. Information from audits was discussed and analysed at the weekly MDT meetings.
Judgment: Compliant

**Regulation 8: Protection**

The centre had measures in place to ensure that residents were protected from abuse. There was a safeguarding policy in place and records examined confirmed that staff had attended safeguarding training on a regular basis. Agency workers spoken with at the time of the inspection confirmed that they too could access safeguarding training.

As mentioned earlier a small number of residents were still subject to bed rail restraint due to lack of low low beds. There was evidence available however that showed where residents were using bed rails, appropriate assessment and review was carried out. The review evidenced that least restrictive options were trialled and that open dialogue and discussion was held with family and residents around the use of bed rails.

Residents told the inspector that they felt safe in the centre and that if they had any concerns they felt comfortable raising these issues with any staff member. Discussions with both permanent and agency staff confirmed that they were aware of their roles and responsibilities in keep residents safe from harm.

Judgment: Compliant

**Regulation 9: Residents' rights**

Residents rights were promoted and respected by the staff team. Residents had access to a range of activities that they could pursue individually or in groups. The inspector observed staff supporting residents to attend various activity sessions throughout the day. Staff communication with residents was respectful and took into consideration the individual needs of the resident. Residents told the inspector that they were supported to maintain links with the community and some were supported to visit family at weekends. The centre had access to transport and residents often taken out to local places of interest.

Resident rooms were tastefully decorated with many containing residents artwork made during activity sessions. Resident rooms were sufficient in size in that residents had ample storage facilities, lockable cupboards and space to access seating. Rooms were well ventilated and all contained en suite facilities. All residents had access to their own TV and newspapers. Residents privacy and dignity was preserved in multiple occupancy rooms through the use of screen curtains although one had to be altered during the inspection to maintain residents
privacy and dignity.

Access to advocacy was widely advertised within each unit of the centre. There was a residents committee which met every three months. These meetings were facilitated by the activity co-ordinator and social worker and gave residents an additional opportunity to discuss the service they were receiving in the centre or indeed raise any concerns. Residents who attended these meetings said they found them useful.

Residents views were also canvassed through satisfaction surveys, results from these surveys were collated and formed part of the centres annual review of quality and safety.

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:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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</thead>
<tbody>
<tr>
<td><strong>Views of people who use the service</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 21: Records</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 18: Food and nutrition</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and care plan</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 9: Residents' rights</td>
<td>Compliant</td>
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Compliance Plan for Meath Community Unit OSV-0000477

Inspection ID: MON-0024268

Date of inspection: 11/04/2019

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. Specific 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:**

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
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<tbody>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Substantially Compliant</td>
</tr>
</tbody>
</table>

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The newly appointed Occupational Therapist (OT) will complete an individual assessment of the 3 residents identified during the HIQA inspection who are using bed rails in the centre. The OT will collaboratively work with the multidisciplinary team(MDT) to assess the residents need for a low low bed.

In the future, all new residents will receive an OT led assessment which will be discussed and signed off by the MDT. This assessment will be reviewed at each resident’s quarterly case conference and the resident's wishes will be considered in the decision making process regarding bed rails.

The 3 residents will be reviewed at the MDT on 29/5/19 after the OT assessments are completed in addition to, any new residents who require bed rail reviews.

The procedure in the centre in relation to, allocating bed rails for residents will also reviewed.

| Regulation 34: Complaints procedure         | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

At the entrance to each ward in the centre, Health Service Executive(HSE) ‘Your Service Your Say’ posters/ leaflets, and the complaints policy will be displayed. In addition, there will be a complaints, compliments and comments box available in the same area. In each ward on the notice board there will also be a copy of ‘Your Service Your Say’ posters/ leaflets, including the complaints policy for the centre.
The complaints log will be reviewed with special attention to the ‘follow up’ section to ensure that all complaints have been evaluated and followed up at a later date with concerned stakeholders. Once stakeholders feel their complaint has been addressed and they are happy with the outcome, the complaint will be signed off by nurse management. The Person In Charge (PIC) will ensure that person’s responsible shall oversee the complaints procedure to ensure all complaints have been dealt with in the appropriate manner in line with, the complaints policy and with HIQA Guidelines.

This process will be completed by the 29/5/19, and the complaints policy and procedures will be reviewed at the MDT meeting on that date.

<table>
<thead>
<tr>
<th>Regulation 17: Premises</th>
<th>Substantially Compliant</th>
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Outline how you are going to come into compliance with Regulation 17: Premises:

3 rooms (1 on each ward) in the centre will be decommissioned for the appropriate storage of hoists and other equipment.

The maintenance manager for the centre has been contacted on the 10/5/19 to begin this process.
**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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 17(2)</td>
<td>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.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>Regulation 23(a)</td>
<td>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.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>30/06/2019</td>
</tr>
<tr>
<td>Regulation 34(1)(b)</td>
<td>The registered provider shall provide an accessible and effective complaints procedure which includes an</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>07/06/2019</td>
</tr>
</tbody>
</table>
appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.

| Regulation 34(1)(f) | The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied. | Substantially Compliant | Yellow | 07/06/2019 |

| Regulation 34(3)(b) | The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that the person nominated under paragraph (1)(c) maintains the records specified under in paragraph (1)(f). | Substantially Compliant | Yellow | 07/06/2019 |