



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

Issued by the Chief Inspector

Name of designated centre:	Corbally House Nursing Home
Name of provider:	Corbally House Nursing Home Ltd
Address of centre:	Mill Road, Corbally, Limerick
Type of inspection:	Unannounced
Date of inspection:	08 June 2022
Centre ID:	OSV-0005560
Fieldwork ID:	MON-0036946

About the designated centre

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

Corbally House Nursing Home is registered to provide care to 41 residents. It is located on the outskirts of Limerick city in a residential area on the banks of the river Shannon. Private accommodation comprises of 35 single bedrooms and three twin bedrooms, 20 of which have en suite shower, toilet and wash-hand basin facilities provided. Resident accommodation is over two floors with the majority of the residents residing on the ground floor. Stairs and a chair lift provide access between floors.

There is plenty of outdoor space with landscaped gardens located to the front and side of the centre and a secure outdoor courtyard by the front entrance with garden furniture, bird tables and potted plants. There is an internal enclosed winter garden with glass walls and glass ceiling for light and sunshine which was a focal point in the centre and enjoyed by residents and relatives throughout the year.

The centre provides residential care predominately to people over the age of 65 but also caters for younger people over the age of 18. It offers care to residents with varying dependency levels ranging from low dependency to maximum dependency needs. It offers care to long-term residents and to short-term residents requiring rehabilitation, post-operative, convalescent and respite care.

The centre provides 24-hour nursing care with a minimum of two nurses on duty during the day and one nurse at night. The nurses are supported by care, catering, household and managerial staff. Medical and allied healthcare professionals provide ongoing healthcare for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	39
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 8 June 2022	10:15hrs to 17:15hrs	Sean Ryan	Lead
Wednesday 8 June 2022	10:15hrs to 17:15hrs	Niall Whelton	Support

What residents told us and what inspectors observed

Overall, inspectors found that the residents living in this centre were supported by caring staff who knew them well. Residents reported that they enjoyed their life in the centre and that the staff were kind to them. Inspectors found that the atmosphere in the centre was quiet, calm and orderly. Residents told inspectors that the provision of activities had improved in the centre and there was always something enjoyable to do throughout the day.

Inspectors were guided through the centre's infection prevention and control measures on arrival to the centre. Following an introductory meeting, inspectors walked through the centre.

On the morning of inspection, residents were observed walking around the centre and engaging with staff. There were musical activities taking place in both dayrooms and staff were present to support residents with their needs. Some residents were receiving visitors in the enclosed garden while others were enjoying the sun and appeared relaxed in their environment. Staff were observed responding to residents requests for assistance without delay. Residents confirmed their satisfaction with the length of time it took to have their call bell answered when seeking assistance from staff.

Some residents told the inspectors that they felt safe living in the centre and stated that they could voice any concerns they may have to a member of staff. Records reviewed by inspectors confirmed that all concerns were appropriately recorded and responded to.

A number of residents were observed to use the selection of communal day rooms available. Other residents chose to spend the day in their bedrooms. Staff were observed supervising residents in the communal areas while other staff were allocated to spend time with residents who chose to remain in their bedrooms. Residents were seen to be socially engaged and facilitated to engage in activities of their choice.

Inspectors noted that the provider had made some improvements since the previous inspection. The dining room had recently been repainted and the oratory was in the process of being redecorated. Residents complimented the colour chosen in both areas. The provider confirmed that plans were in place to replace worn and damaged floor coverings and repaint areas of the centre where walls were damaged and chipped. Inspectors observed that, internally, access to some communal bathrooms and shower rooms was impeded by clutter, with items such as wheelchairs, hoists and linen trollies. This posed a risk to residents who mobilised independently. Some assistive equipment was observed to be in a poor state of repair and did not facilitate effective cleaning, increasing the infection control risk to residents. Inspectors observed that there were numerous areas in the centre that

were not clean.

Efforts had been made to remove combustible materials, identified during the previous inspection, from the basement to minimise the fire risk to residents. Oxygen cylinders had been moved from the basement to an external storage space while the provider was awaiting the delivery of a storage cage. Inspectors observed several fire doors that were held open with wooden wedges. This meant that the effectiveness of the fire doors were compromised in their function to contain smoke and fire.

An activities board displayed the activities scheduled for the week and this included group physiotherapy and exercise, live music and singing, health and wellness groups and Mass. Staff informed the inspectors that the activities plan had been revised following the last inspection, and in consultation with the residents.

The following section of this report details the findings with regard to the capacity and management of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended). Inspectors followed up on the action taken by the provider to address significant issues of non-compliance found on the last inspection in March 2022 and found that while the provider had taken some action to address issues found with fire safety, the premises, record management and the provision of activities for residents, the findings of this inspection were that significant action continued to be required in the governance and management of the service provided to residents. Inspectors found that ineffective systems of monitoring and oversight resulted in repeated non-compliance under;

- Regulation 23, Governance and management,
- Regulation 5, Individual resident assessment and care plan,
- Regulation 16, Staff training and development,
- Regulation 27, Infection control, and
- Regulation 28, Fire precautions.

Significant non-compliance with Regulation 28, Fire precautions, were identified during the last inspection of the centre on 2 March 2022 and 7 March 2022 where the provider had failed to identify serious deficits with the systems of detection, containment and management of fire. Following that inspection, and subsequent engagement with the office of the Chief Inspector, the provider gave assurances that the necessary action would be taken to comply with the regulations.

Following the last inspection, the provider had completed a fire safety risk assessment of the centre. A subsequent action plan developed from the findings of this assessment was forwarded to the Chief Inspector. This action plan is due to be completed by September 2022. Inspectors found that the provider had taken some steps to improve the fire safety systems in the centre since the last inspection. For example;

- The emergency lighting and fire detection and alarm systems had been upgraded,
- Areas that previously had no fire detection coverage had detectors installed.
- Large volumes of combustible materials and loose oxygen cylinders had been removed from the basement area.
- Keys to locked emergency exits were placed in break glass units adjacent to exit doors.

However, the provider did not present a clear time-bound project plan of works completed to date, and the outstanding works required. As a result, there was no clear timeline for the works to be completed or no effective risk management systems in place to manage any potential risk or disruption to residents during on-going works. Similarly, there was no clear time-bound project plan of works to address maintenance and decoration of the premises.

The organisational structure of the centre remained unchanged since the last inspection. The person in charge reported directly to the registered provider, who also provided administrative support. An assistant director of nursing and clinical nurse managers supported the person in charge and deputised for them in their absence. The person in charge was not on duty on the day of inspection however they attended the centre for a short period to meet inspectors. The assistant director of nursing was not in the centre on the day of inspection. A clinical nurse manager facilitated the inspection in the absence of the nurse management team. The clinical nurse manager was responsible for both the administration of the service and delivery of direct care to residents. Inspectors found that this arrangement impacted on the supervision of the quality and safety of the service.

There were management systems to monitor the quality and safety of the service provided that included a schedule of audits. Inspectors reviewed a sample of completed clinical audits and found that some audit tools were not effective in supporting the management team to identify risks. For example, audits of residents' falls had not identified that falls were not consistently managed in line with the centres own procedure or that corrective actions arising from analysis of falls incidents were not implemented such as reviewing falls risk assessments and care plans. Therefore, an effective or appropriate quality improvement plan could not be developed.

The centre risk management policy detailed the management systems that should be in place for the oversight and monitoring of risk in the centre. As part of the risk management policy, a risk register to record all potential risks to resident's safety and welfare was required to be maintained. However, inspectors found that there was no risk register to record or monitor environmental risks in the centre and

therefore, the effectiveness of controls in place to mitigate risks could not be measured or evaluated.

Governance and management meetings had been enhanced to discuss areas of risk such as the premises, fire safety and infection prevention and control. There was evidence that deficits in the service were discussed between the management team. However, records did not evidence quality improvement plans where deficits in the service were identified.

The staffing levels were appropriate for the size and layout of the building and to meet the assessed needs of the current residents. A review of the rosters evidenced that there was adequate staffing in place to support housekeeping, catering and social care activities.

A review of staff training records found that all staff had up-to-date mandatory training in fire safety, safeguarding of vulnerable adults and infection prevention and control. However, staff spoken with, and observed by inspectors did not demonstrate appropriate levels of knowledge, commensurate to their role. In addition, the system in place to supervise staff was not effective. Inspectors observed repeated poor practice in relation to fire safety, and infection prevention and control.

Record-keeping and file management systems had improved since the last inspection. Residents clinical care records were maintained on the electronic record systems and staff were observed to be proficient in navigating the system. Staff personnel files were subject to ongoing audit and review to ensure they contained the information required by Schedule 2 of the regulations.

Regulation 15: Staffing

There was sufficient staff with an appropriate skill mix on duty to meet the needs of residents and having regard to the size and layout of the centre. There was a registered nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

The inspectors were not assured that there were adequate staff supervision arrangements in place to ensure that staff had the required competencies and knowledge to deliver effective and safe services to the residents. This was evidenced by:

- Staff demonstrated a poor awareness of fire safety and inspectors were not

assured that the fire safety training that was provided to staff contained content as required under Regulation 28(1)(d).

- A number of staff demonstrated poor practice in relation to the use of personal protective equipment (PPE), the appropriate storage of cleaning equipment, and the management of toilet aids to reduce the risk of cross contamination.
- Staff did not demonstrate an appropriate knowledge of the centre's cleaning procedure. For example, staff had poor knowledge of the cleaning agents used.

This is a repeated non-compliance from the last inspection.

Judgment: Not compliant

Regulation 21: Records

The provider had taken action to ensure record-keeping and file management systems met the requirements of the regulations. Records were securely stored and readily accessible.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that the registered provider had failed to take action to ensure governance and management systems were robust to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced by;

- The provider had failed to implement their own compliance plan submitted by the provider following the last inspection. For example, the provider had failed to;
 - ensure appropriate and effective oversight of fire safety and infection prevention and control.
 - ensure that risk was effectively identified, recorded and managed in line with the centre's own policy. Environmental risks, such as those associated with fire safety, infection control and the premises were not recorded or managed effectively.
 - effectively implement the audit schedule to monitor the quality and safety of the service provided to residents. Audits were not used effectively to identify risks or develop quality improvement plans. For example, an infection prevention and control audit completed in May 2022 identified high levels of compliance in areas such as

environmental hygiene, quality of cleaning and maintenance and consequently no quality improvement plan was required.

While the frequency of governance and management meetings had increased, there was no time-bound, quality improvement plans arising from those meetings to address premises, infection prevention and control or fire safety deficits.

The provider did not ensure that the service had sufficient staffing resources to ensure the management structure, and deputising arrangements for the person in charge, was maintained in line with the centre's statement of purpose. Furthermore, the person identified to oversee infection prevention and control was engaged in nursing duties and unable to review or supervise infection prevention and control practices.

Judgment: Not compliant

Quality and safety

The inspectors found that the interactions between residents and staff was kind and respectful throughout the inspection. Residents were satisfied with the quality of care they received and staff were observed to respond to residents requests for assistance without delay. Nonetheless, inspectors found that non-compliance in relation to fire safety and infection prevention and control impacted on residents' safety and well-being. Further action was also required to ensure compliance with the premises, and assessments and care plans.

The fire safety action plan submitted following the previous inspection was in progress at the time of the inspection. Inspectors found that while the provider had taken some action to ensure all areas of the centre had fire detection in place, the provider had failed to take appropriate actions to mitigate the risks to residents until the fire works were completed. This was evidenced by the lack of awareness demonstrated by staff of the fire risks in the centre and the observed poor practice of wedging fire door open. Further findings are discussed under Regulation 28, Fire precautions.

The centre's risk management policy contained all the information required under Regulation 26, however, the content of the policy had not been implemented as discussed under Regulation 23. Inspectors found that environmental risks were not identified or recorded in line with the centre's own policy.

Inspectors found that the daily, face to face care delivered to residents was of a satisfactory standard. Inspectors acknowledged that staff were knowledgeable with regard to resident's individual care needs and preferences. However, a review of the electronic document system identified gaps in residents assessments and care plan records where information pertinent to guiding person-centred care was not evident. Care plan reviews had not been consistently completed in line with the requirements

of the regulations. This is described further under Regulation 5: Individual assessment and care plans.

A review of residents' records found that there was regular communication with residents' general practitioners (GP) regarding their healthcare needs. Arrangements were in place for residents to access the services of allied health and social care professionals.

Following the previous inspection, the provider submitted a compliance plan to address deficits with the premises with regard to storage and maintenance. The plan to address maintenance and redecoration of the centre is due for completion by September 2022. Inspectors acknowledged that redecoration and maintenance works had commenced in the centre and two rooms had been repainted. However, inspectors found that the actions taken by the provider to reduce the inappropriate storage of equipment and items in the centre was not adequate. Resident's communal shower rooms and toilets were used to store equipment which posed a falls risk to the residents.

There was adequate supplies of personal protective equipment available to staff and wall mounted hand sanitisers were placed throughout the centre and at the point of care. Areas occupied by residents, such as communal dayrooms and bedrooms, were clean on inspection. However, communal bathrooms, en-suite showers and storage areas were not cleaned to an acceptable standard. Inspectors observed poor examples of adherence to standard precautions. While the provider had sought the advice of a competent person with regard to the layout of the laundry to reduce the risk of cross infection, there had been inadequate action following this review. The findings identified repeated non-compliance with regard to the oversight of infection prevention and control practices and the cleaning procedure and were indicative of a lack of a robust infection prevention and control monitoring and auditing system. Further oversight of infection prevention and control was required and is further discussed under Regulation 27; Infection control.

There were opportunities for residents to consult with management and staff on how the centre was run. Minutes of residents meetings evidenced that following the previous inspection, residents were consulted about the quality of activities and the activities scheduled was revised.

There was an activity schedule in place and residents were observed to be facilitated with social engagement and appropriate activity throughout the day. Residents had access to television, radio, newspapers and books. Internet and telephones for private usage were also readily available.

Regulation 17: Premises

The registered provider had not taken appropriate action to ensure compliance with Regulation 17. This was evidenced by;

- There was inappropriate storage of equipment in multiple areas of the premises. For example, storage areas contained cleaning equipment, toilet aids, chemicals and residents equipment with no segregation of these items.
- Resident's equipment such as shower chairs and commodes were visibly rusted.
- Floor coverings in the kitchen were damaged and there were areas of damp observed on the ceiling under the sky light.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Each resident's needs in relation to hydration and nutrition were met and meals and mealtimes were observed to be an enjoyable experience for residents.

Residents were provided with a choice at each meal and staff were available to provide discrete assistance and support as required. Arrangements were in place to support residents identified as nutritionally at risk such as monitoring of residents weights and referral for nutritional management advice.

Judgment: Compliant

Regulation 27: Infection control

The provider had failed to implement adequate infection prevention and control procedures consistent with the national standards for infection prevention and control in community services published by the Authority. This was evidenced by;

- There was poor oversight of the cleaning procedure and the quality of environmental hygiene. For example, staff did not demonstrate an appropriate awareness of the cleaning agents used for cleaning. Store rooms, dirty utility, laundry and showers in residents en-suites were visibly unclean.
- The bedpan washer was not operational and the cleaning and decontamination of toilet aids was not in line with recommended safe practice to reduce the risk of cross contamination.
- There were poor practices observed with regard to hand hygiene. Staff were observed wearing gloves inappropriately and wearing jewellery that impacted on effective hand hygiene.
- Cleaning equipment continued to be stored inappropriately in the dirty utility and there was no dedicated room for the storage or preparation of cleaning agents and equipment.
- The laundry area did not have a clean to dirty flow to reduce the risk of cross

contamination.

This is a repeated non-compliance from the last inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

Notwithstanding the action taken to date by the provider, the registered provider had failed to ensure that the actions taken to ensure residents were protected from the risk of fire were adequately monitored and reviewed. This was evidenced by;

- Poor practices were observed where fire doors were being kept open by means other than appropriate hold open devices connected to the fire alarm system. The daily check, recorded on the day of inspection logged that no doors were held open.
- There was no documented plan in place to ensure a safe system of managing the risk of fire during fire safety upgrade works.
- The centre's own fire safety policy was not being implemented
- The management of keys to exit doors was not robust. For example, while there was a back up key in a break glass unit beside each exit, inspectors found that the primary key to an exit opposite the nurses' treatment room were not located in their designated area, creating a high risk the exit door may not be opened in a timely manner in the event of a fire emergency.
- Oxygen cylinders were stored under an external stairs and were not secured.

Fire doors to a significant number of bedrooms were not fitted with automatic door closers and while plans were in place to address deficits with the fire doors, there was no risk assessment or oversight of the safe management systems to ensure the safety of residents living in the centre. Staff spoken with were not aware of the requirement to manually close doors in the absence of the automatic door closers.

Although the fire safety upgrade works were not yet due to be completed, there was no progress made with addressing fire containment measures. For example, the fire door in the kitchen was still unable to be closed fully; this was due to have been repaired by 11 May 2022.

While staff were documented as having up to date fire safety training, the practices observed during inspection and the lack of fire safety risk awareness, inspectors were not assured that the fire safety training provided, captured the full extent of the requirements of the regulations. This is actioned under Regulation 16, training and staff development.

The assessed evacuation requirements for some residents were documented as being last reviewed since 2019, therefore inspectors were not assured that robust systems were in place to ensure the safe evacuation of all residents.

Fire drill reports did not contain sufficient information to demonstrate the effectiveness of the evacuation procedure.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of the residents assessments and care plans found that care plans had not been reviewed following a change in a residents health status or assessed need as required under Regulation 5. This was evidenced by;

- Residents described as being a high risk of falls were not identified as such within their individual care plan as evidenced in two care plans reviewed. Care plans and falls risk assessments had not been reviewed to reflect a change in assessed needs following a falls incident involving residents.
- Resident's assessed as a high risk of malnutrition were not identified as such within their nutritional care plan. The interventions in place to support the residents were not detailed in the residents care plan.
- Four care plans had not been reviewed at four monthly intervals and where necessary, revised, in consultation with the residents and, where appropriate, their representative as required by the regulations.

Judgment: Not compliant

Regulation 6: Health care

Residents were observed to have access to a range of medical supports including access to GP's, psychiatry, and allied health and social care professionals such as dietitians and speech and language therapy.

Judgment: Compliant

Regulation 9: Residents' rights

Overall, the inspectors found that the staff ensured that the residents' rights were upheld in the designated centre. Staff were observed to engage in positive, person-centred interactions with residents.

There was an activity schedule in place. Residents were observed to be socially engaged throughout the day of the inspection.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Corbally House Nursing Home OSV-0005560

Inspection ID: MON-0036946

Date of inspection: 08/06/2022

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 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>*Intensified fire safety awareness carried out for all staff, headed by our Fire Marshall. These includes weekly, Friday, fire drills made up of different scenarios, compartment and horizontal evacuation appropriate to the facility to ensure staff are confident in the evacuation procedure.</p> <p>*Good practice of the use of PPE will be strictly observed and immediate correction whenever needed. Creation of some additional storage in CHNH was completed on 1st week July 2022 and some are still ongoing and is expected to be finished by 30/09/2022. This is for the purpose of ensuring that there will be appropriate storage of cleaning equipment in the facility to reduce the risk of cross contamination.</p> <p>*All staff have completed their training in March 2022. Staff will then be supervised by each head Dept. to ensure staff are knowledgeable, supported and guided in achieving competency in the safe delivery of care. IPC lead will then support and supervise staff, particularly the housekeeping Dept. to acquire appropriate knowledge in the facility's cleaning procedure. This includes the use of cleaning agents.</p>	
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>*Management have put system in place to monitor risk associate for Fire and IPC. A copy</p>	

of Fire evacuation procedures is placed strategically around the premises for reference. Fire Marshall will oversee Fire Safety. PIC and IPC lead will oversee IPC. Environmental Risk register is now in place and all identified risks were documented in the Risk Register. PIC will ensure risk were identified and controlled measures were in place and reviewed for effectiveness.

*Audit schedule will be implemented to identify risk and develop Quality Improvement Plan. PIC and IPC Lead have reviewed the audits to ensure that it is specific to center's needs and identified risk.

*Governance and Management meeting is increased and Quality Improvement Plan will ensure action plan are measurable and developed following the management meeting.

* Additional nursing staff are being recruited and thus will free up the management so they can focus on supervision of staff and quality of service.

Regulation 17: Premises	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:
 *Storage has been increased and tidied up, segregation of different areas i.e. cleaning, toilet aids, and residents equipment are separated.

*Floor covering as has been explained is due to be completed if all goes to plan 30/09/2022.

*Equipment is replaced when wear and tear is noticed.

Regulation 27: Infection control	Not Compliant
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Outline how you are going to come into compliance with Regulation 27: Infection control:

*New audit tools implemented that are designed for the nursing home to monitor the quality of the environmental, hygiene and staff refresher training re: cleaning procedures and cleaning agents.

*Bedpan washer is fully operational and will be checked regularly to ensure safe practice and to reduce the risk of cross contamination.

*Staff are all updated with hand hygiene training. Good hand hygiene practices are also

highlighted during safety pause.

*Designated store rooms for cleaning equipment are now being renovated.

*Advised has been sought for advise and has been risk assessed. Controls has been in place to minimize the risk of infection until the laundry can be reconfigured.

Regulation 28: Fire precautions

Not Compliant

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

*Risk Register assessment updated. Risk assessments for fire safety works at CHNH are documented to assess the risks involved at the time of those works and to cause minimum disruption to residents.

*Door closers are missing in some rooms. Staff reminded daily during the handover to ensure all doors are closed and ensure not to use wedges. PIC will do spot check. Staff training has been updated to ensure awareness of this risk. Management will do daily check and will be rectified. Fire risk identified has been updated in the risk register.

*Fire safety policy is in the nurse's station and will be circulated to all staff.

*Keys are stored in a designated area. All staff knows they are there and stored nowhere else.

*Oxygen cylinders is now stored outside in a secured cage.

*As of the end of July 2022, 90% of fire doors have been upgraded to meet the standards required. All doors remain closed until automatic door closures are put in place once upgrade of doors is completed. 30 September 2022.

*Kitchen fire door now fixed.

*We have reviewed fire testing to ensure staff are confident in the evacuation procedure. Fire safety training has been amended to reflect CHNH premises, layout and fire risks.

*Weekly, Friday, fire drills made up of different scenarios, compartment and horizontal evacuation appropriate to the facility to ensure staff are confident in the evacuation procedure.

* PEEP have all been updated. Going forward PEEPS will be reviewed in a quarterly basis.

Regulation 5: Individual assessment and care plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</p> <p>*Risk assessments are carried out to all residents. Residents identified as high risk of fall will be reflected in their care plan. This plan will be reviewed * 3 months or sooner when necessary.</p> <p>*Nutritional care plan created for resident who were identified as high risk for malnutrition. Management will support, supervise and follow up with the resident's risk assessment as practicable as possible.</p> <p>* Care plans has been reviewed and will be reviewed quarterly or sooner when necessary. Residents and their representative will also be consulted. MDT will remain in the development of the care plan.</p>	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/09/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2022
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and	Not Compliant	Orange	30/09/2022

	details responsibilities for all areas of care provision.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/09/2022
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	30/09/2022
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	30/09/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including	Not Compliant	Orange	30/09/2022

	emergency lighting.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/09/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/09/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	30/09/2022
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2022
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all	Not Compliant	Orange	30/09/2022

	persons in the designated centre and safe placement of residents.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	30/09/2022
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/09/2022