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:	Droimnin Nursing Home
Name of provider:	Droimnin Nursing Home Limited
Address of centre:	Brockley Park, Stradbally, Laois
Type of inspection:	Unannounced
Date of inspection:	03 May 2023
Centre ID:	OSV-0000702
Fieldwork ID:	MON-0039688

About the designated centre

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

Droimnin Nursing Home is a designated centre for older people. The centre has two buildings that are purpose built. The centre provides accommodation for a maximum of 70 male and female residents, over 18 years of age. Residents are admitted on a long-term residential, respite and convalescence basis. The centre is located at the end of a short avenue in from the road and within walking distance to Stradbally, Co Laois. A variety of communal rooms are provided for residents' use including sitting, dining and recreational facilities. Each resident's dependency needs is assessed to ensure their care needs are met.The provider employs a staff team in the centre to meet residents' needs consisting of registered nurses, care assistants, activity, administration, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	59

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 May 2023	10:00hrs to 18:30hrs	John Greaney	Lead
Thursday 4 May 2023	09:00hrs to 16:00hrs	John Greaney	Lead
Wednesday 3 May 2023	10:00hrs to 18:30hrs	Niall Whelton	Support
Thursday 4 May 2023	09:00hrs to 12:00hrs	Niall Whelton	Support

What residents told us and what inspectors observed

The overall feedback from residents were that staff were kind and caring and that they were happy living in the centre. Findings of this inspection were that significant action is required in the areas of governance and management, assessment and care planning and fire precautions to support the provision of a safe and quality service to residents.

The inspectors arrived to the centre unannounced in the morning of the first day of the inspection. The inspection was conducted over the course of two days. The person in charge was away from the centre, conducting a pre-admission assessment but arrived in the centre later in the morning. Inspectors were met by the recently appointed regional manager. New governance structures had recently been put in place to provide oversight of all of the centres with links to the board of directors of this centre. The new governance structure included a regional manager with responsibility for a number of centres, to whom the persons in charge of each centre would report. An assistant director of nursing had been due to take up post prior to this inspection, but this had not happened and a recruitment capaign was recommenced in order to fill this post. A clinical nurse manager had commenced employment in the centre in the months prior to this inspection.

Following an opening meeting with the regional manager, inspectors were accompanied on a tour of the premises, where the inspectors met and spoke with residents in their bedrooms and in the various day rooms.

Droimnin Nursing Home is located close to the town of Stradbally, Co. Laois and is registered to accommodate 70 residents. It is a two storey building situated on spacious grounds that contain a number of other private dwellings that were originally designed for independent living purposes. The provider has no involvement in these dwellings. All of the bedrooms are single occupancy and are en- suite with shower, toilet and wash hand basin.

The ground floor of the centre is called Dunamaise and accommodates 29 residents. Communal space on this floor comprises a large reception area with a variety of comfortable seating and also contains a table and chairs. Adjacent to the reception area is a secure outdoor space that is landscaped to a good standard with plant beds and also has suitable garden furniture. It is readily accessible to residents from different parts of the centre. This area is used by residents that smoke. The inspectors observed that there was a fire extinguisher, fire blanket and smoking apron located immediately inside the door leading to this area. The area, however, was not equipped with a call bell, should residents wish to call staff while smoking here.

One of the bedrooms viewed by inspectors on the tour of the premises contained cardboard boxes. Inspectors were informed that these were to be used to return the belongings of a deceased resident to family members. Management were irequested

to source alternative means of returning possessions to family members. Inspectors also found an ointment in the en suite bathroom of a recently vacated room, but the label on the ointment indicated that it had been intended for a different resident. There was also a dining type chair stored in this bathroom.

Records were seen to be archived in a room adjacent to the kitchen and across from a staff room at the end of a corridor. This room was also used to store equipment and was generally untidy. While the area was not accessible by residents or visitors, all members of staff had access to this area and there were no restrictions on any member of staff accessing these records. The door to the room was open. This does not comply with general data protection regulations (GDPR). Additionally, inspectors were informed that archiving system did not support records to be readily identifiable and retrievable should they be required.

The first floor is called Tursalla and accommodates 41 residents. This area is accessible by stairs and a lift. Communal space here comprises a reception area, where most residents spend their day. There are also two day rooms, two dining rooms and an activity room. There is an outdoor area that is currently closed to residents. It was found on the last inspection that the decking had an algae like coating that made it slippery and unsafe for residents. The area also poses other risks, such as exposed nails on a wooden surround of a roof light. This area is listed as communal space on the centre's Statement of Purpose. Discussions with management indicate that the reopening of this area is not on the priority list and therefore any resident that wishes to avail of outdoor space will have to go to the ground floor.

The inspectors observed maintenance issues throughout the centre. There were a number of cracks within the structure of the building. There were areas of the premises internally that had cracked plasterboard and there was some damaged flooring. On the walk through, it was observed that the room used by the physiotherapist was locked with a pad lock and management were unable to provide a satisfactory explanation for using a pad lock to secure the room. Management were requested to remove this lock and if the room needed to be secured, then an alternative lock should be installed that would allow residents or staff to exit the room should it be locked from the outside. It was also noted that the thumb lock on the inner side of a number of bedroom doors were missing the thumb lock, which has fire safety as well as privacy implications for residents in these rooms. It was noted that the majority of the ancillary rooms, such as housekeeping rooms and sluice rooms, and also communal bathrooms, did not have signage on the doors to identify their function. It was evident from marks on the doors that the signage had been removed. Management were unable to provide an explanation as to why the signage was removed.

Inspectors observed some fire safety risks on the walk through of the premises. Mass was underway in the centre's oratory when inspectors were touring the premises on the first morning of the inspection. When inspectors returned to the oratory, there were three residents with restricted mobility awaiting assistance to return to sitting rooms or their bedrooms, depending on their preference. There were two candles lighting on the alter and there were no staff present, as they were

in the process of assisting other residents from the oratory. Management were requested to risk assess the use of candles and to sure that adequate mitigation measures were in place should they wish to continue to use live candles.

Inspectors also observed some infection prevention and control issues on the walk through of the centre. A housekeeping room on the ground floor did not have a wash hand basin. The wash hand basin in a sluice room on the ground floor did not have hands free taps, which does not comply with good hand hygiene practices.

While significant improvements were required, residents spoken with were complimentary of staff and their responsiveness to their needs. There was generally a calm atmosphere in the centre and staff appeared to know residents well and residents were relaxed in the company of staff. residents were observed to be enthusiastically participating in activities over the course of the two days of the inspection. There were two activity coordinators providing activities over seven days of the week. Care staff were also seen to facilitate activities, particularly in the upstairs area, while activity staff were facilitating activities on the ground floor.

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

Capacity and capability

This inspection was conducted over two days by inspectors of social services. It was a risk-based inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and follow up on the actions taken by the provider to address significant issues of non-compliance identified during inspections of the centre in January 2023 and August 2022. Inspectors also used information received by the office of the Chief Inspector, both solicited and unsolicited, to inform lines of enquiry for the inspection. Following receipt of the information, the Office of the Chief Inspector wrote to the provider and requested a provider assurance report on the care and welfare of residents in the centre. This information was also used to support the development of lines of enquiry for this inspection. The findings of the inspection are detailed in this report and validate the concerns expressed in the unsolicited information received by the office of the Chief Inspector.

Droimnin Nursing Home Limited, a company comprising three directors, is the registered provider of Droimnin Nursing Home. While the provider is not involved in the operation of any other nursing homes, the company directors are involved in the operation of four other nursing homes throughout the country. None of the directors attended the centre in person on the days of inspection or for the feedback meeting at the end of the inspection. The Operations Director did participate in the feedback session via conference call.

The centre's registration was renewed on 22 December 2022. The provider had applied to register 101 beds, however, the findings of an inspection conducted on 23 August 2022 identified that a second building, also known as Oughaval, was not equipped or fit for occupation. It was also found that the staffing profile available was not commensurate with the required staffing for 101 beds. Following that inspection, a cautionary meeting was held with the provider in October 2022 advising them that the centre was in an escalation process. Assurances were sought that governance and management arrangements would be put in place reflecting those identified in the centre's Statement of Purpose. Assurances were also sought from the provider that adequate staffing resources would be put in place to meet the health and social care needs of residents. A decision was made to partially grant the application to renew the registration, allowing a maximum of 70 residents to be accommodated in the centre.

Overall, findings of this inspection were that, similar to the two most recent inspections conducted in August 2022 and January 2023, current governance and oversight of the centre was not effective and did not ensure that services were provided in line with the centre's statement of purpose. Inspectors found that, while the provider commenced a programme of oversight to monitor the service through an overarching programme of audits, the system was not sufficiently robust to identify or address deficits in quality and safety, as evidenced by the findings of this inspection. This resulted in repeated regulatory non-compliance in the following regulations:

- Regulation 5: Individual assessments and care plan
- Regulation 16; Training and staff development,
- Regulation 23: Governance and management,
- Regulation 28 Fire precautions
- Regulation 31: Notification of incidents.

In addition, the provider was found to be non-compliant with Regulation 6: Health care, Regulation 17: Premises, Regulation 25: Temporary absence and discharge of residents, and Regulation 28: Fire precautions, on this inspection.

New governance and management arrangements were in the process of being established for the oversight of this and the four other designated centres in which the directors of Droimnin Nursing Home Limited are involved. A new regional manager had commenced in mid-April 2023 and was responsible for the oversight of this and two other designated centres. A compliance and quality manager had also been recruited but was temporarily acting as director of nursing in another centre in the weeks prior to this inspection. Other management personnel recruited included an operations director and human resources manager. The enhanced management structure, however, had not yet embedded in practice and on the days of this inspection it was evident that inadequate oversight contributed to deficiencies in the quality and safety of care provided to residents.

A commitment given in the Statement of Purpose of 0.25 whole time equivalent (WTE) for the post of Clinical Director was found not be in place at the last inspection, however, the clinical director was providing support remotely. Since

then, the clinical director was acting as director of nursing on a full time basis in another centre and was therefore not available to support the PIC in this centre, even on a remote basis. It was also found on the last inspection that there were frequent changes to the person in charge resulting in three different persons in charge of this centre during the calendar year 2022. Subsequent to that inspection, a further change in the person in charge (PIC) took place on 01 February 2023. Following the relocation of the then PIC to another role, the assistant director of nursing (ADON) was promoted to PIC. This resulted in a vacant ADON post, in addition to the already vacant clinical nurse manager (CNM) post, both of which are key roles in the clinical governance of the centre. The CNM post was filled in March 2023 but the ADON post remains vacant.

On arrival at the centre, both the regional manager and CNM were present in the centre. The PIC arrived to the centre later in the morning, having been off-site conducting a pre-admission assessment of a potential new resident. There was also a team of nurses, health care assistants, activity, administration, maintenance, domestic and catering staff. A review of the roster identified that there was adequate staff on duty on the days of the inspection. However, there continued to be a reliance on agency staff. While the inspector was informed that efforts were made to have regular agency staff, a review of records indicated that frequently some agency staff only worked in the centre for one or two shifts. As a result, residents would not be familiar with staff and agency staff would not have the same knowledge of the individual needs of each resident as the centre's own staff.

Staff were supported and facilitated to attend training. There was a high level of attendance at mandatory training and training records indicated that all staff had attended up-to-date training in mandatory areas. However, while a new system for the induction of new staff was being developed, it was not yet operational and gaps were identified in the induction record of one senior member of staff.

Regulation 14: Persons in charge

The person in charge was appointed to the role on 01 February 2023. The person in charge has the required experience and qualifications set out in the regulations.

Judgment: Compliant

Regulation 15: Staffing

There were adequate numbers and skill mix of staff to meet the needs of residents on the days of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

While a new induction checklist had been introduced since the last inspection, further action was required to ensure that on completion of the induction period, there was a sign-off to indicate that the new employee had demonstrated competence in all areas of work relevant to their role.

The induction checklist for one member of the nursing staff did not have their competency to administer medications assessed even though this was part of the induction checklist.

Adequate clinical supervision arrangements were not in place to ensure that care was delivered in accordance with each resident's care plan and the recommendations of allied healthcare professionals.

Judgment: Not compliant

Regulation 21: Records

A review was required of the storage of archived residents' records. These were seen to be stored in a room that was also used to store equipment. The door to this room was unlocked and all staff had access to this area.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. The inspectors found repeated failings in the governance arrangements and ineffective management systems to ensure a safe, monitored and consistent service was provided. For example:

- the governance and management structures in the centre were not in line with the governance structure as outlined in the statement of purpose and were not implemented in practice. For example, there was a commitment to a 0.25 WTE clinical director post to this centre but the clinical director was working full time in another centre. Additionally, the post of ADON was vacant

- commitments outlined in compliance plans submitted following previous inspections have not been fully implemented
- poor oversight of the submission of statutory notifications to the Chief Inspector, particularly in relation to pressure ulcers
- inadequate oversight of clinical care. For example, there was not adequate oversight of wound care to ensure that dressing changes were completed in accordance with recommendations from wound care specialists
- while there were action plans associated with many of the audits, they did not identify who was responsible for implementing the actions and there was no follow-up to confirm that the actions were completed
- while there were fortnightly management meetings, minutes of those meetings did not identify that there was adequate oversight of the quality and safety of care at a senior management level. For example, discussions with staff and a review of records indicated that results of audits were not routinely discussed
- there was inadequate oversight of fire safety resulting in the need to issue immediate and urgent compliance plans in relation to fire safety during and following this inspection
- the induction record for a recently recruited member of the nursing team indicated that competency in medication administration had not been assessed despite this being identified as part of the induction process
- adequate arrangements were not in place for the return of personal possessions of deceased residents in a manner that respected their dignity
- there were inadequate systems of oversight in place to monitor and respond to issues of concern found by the inspectors, particularly in relation to assessment and care planning, residents healthcare, admission and discharge procedures, fire safety, and maintenance of the premises
- there was a continued reliance on agency staff in order to meet the staffing needs of the centre. For example, in the week prior to this inspection there were twelve healthcare assistant shifts and one nursing shift covered by agency staff. As a result, residents would not be familiar with staff and agency staff would not have the same knowledge of the individual needs of each resident as the centre's own staff.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications were not submitted in accordance with Schedule 4 of the regulations. For example, quarterly notifications for quarter 1 of 2023 did not include all of the pressure ulcers sustained by residents. This is a repeat finding as notifications required to be submitted on a quarterly basis for issues such as expected deaths and pressure ulcers were not submitted for the latter half of 2022. Additionally, a notification of the unexpected death of a resident was not submitted within the required time frame.

Judgment: Not compliant

Quality and safety

Overall, the feedback from residents was positive and inspectors were satisfied that residents were happy living in the centre. However, action was required in the areas of fire safety, assessment and care planning, and the premises. These issues and other areas of required improvements are discussed in more detail under the relevant regulations of this report.

The provider was in the process of transitioning from paper-based care records to an electronic care records management system. On the days of the inspection the CNM was in the process of entering residents' details on the electronic system, however, this had not been completed and paper-based assessment and care plans were still being used by nursing staff.

Residents had pre-admission assessments conducted prior to admission in order to ascertain if the centre could meet the assessed needs of each prospective resident. Following admission, residents' social and health care needs were assessed using validated tools, to inform care planning. Residents were assessed using validated assessment tools for issues such as nutrition, skin integrity, falls and dependency levels. While improvements in the degree of personalisation of care plans had been found at the last inspection, there continued to be significant deficits in assessments and care planning. Action was required in relation to ensuring that all assessments were reviewed at a minimum of every four months or when there were changes in the resident's condition. There was also a need to ensure that adequate assessments were conducted and recorded in relation to the skin condition of residents, particularly those that were incontinent or had been identified as at risk for skin breakdown. Even though there was an enhanced focus on skin care and wound management as a result of concerns communicated to the provider by an external party in relation to the high number of residents that developed wounds, gaps in care records were identified on this inspection. These and other assessment and care planning issues are described in more detail under Regulation 5 and Regulation 6 of this report.

Residents' health and well-being was promoted by regular reviews by general practitioner (GP) services that visited the centre regularly. Inspectors were informed that the GP routinely visited late on a Friday evening. This was a busy time with reduced staffing. This is when night nurses commence their night shift and would be carrying out their initial assessments of residents. The provider was requested to ensure that adequate clinical oversight arrangements were in place to ensure that GPs had access to all the required clinical information and that any changes to residents' treatment plans were implemented.

There was a policy in place for the prevention, detection and response to allegations or suspicions of abuse. Staff spoken with were knowledgeable of what constitutes

abuse, the different types of abuse and how to report any allegation of abuse.
A review of a sample of personnel files indicated that all staff had Garda (police) vetting disclosures in place prior to commencing employment in the centre.

Residents were consulted about the running of the centre through meetings and a satisfaction survey as a means of providing feedback on the quality of the service. Minutes of resident meetings reviewed by the inspector showed that relevant topics were discussed including mealtimes, staffing, and activities. There was not always an action plan associated with the meetings to ensure that issues raised were addressed. Residents could exercise choice over many aspects of their day, such as when to get up, where to have their meals and in what activities they would like to participate. Inspectors observed residents enthusiastically participating in group activities on both floor over the course of the two days of the inspection. On the afternoon of the second day of the inspection and traditional Irish music group visited the centre and a large number of residents were observed to be enjoying the performance.

The inspectors reviewed the fire safety register and maintenance records. These were found to be organised and up-to-date. There were comprehensive records of checks being completed.

During the inspection, from a review of documentation and drawings, it was apparent that the actual fire compartment boundaries did not accord with those identified to inspectors by staff. There was a need for clarity around compartment boundaries. There was also a need to review the vertical evacuation strategy of residents from the first floor. There were significant deficits noted to fire doors throughout the centre. The registered provider confirmed that a fire door inspection, by an external contractor was due to be carried out on 16 May. Due to concerns found on inspection in relation to fire safety, immediate and urgent compliance plans were issued to the provider during the inspection and on the day following the inspection. The provider submitted a response confirming that the issues would be addressed. These and other issues relating to fire precautions are outlined in more detail under Regulation 28.

Actions relating to the premises from the previous inspection had not not been addressed. Further actions were identified on this inspection and these are set out in regulation 17.

Regulation 11: Visits

The registered provider had arrangements in place to facilitate visiting in the centre. Residents could meet their relatives and friends in the privacy of their bedrooms or in designated visiting areas in the centre.

Judgment: Compliant

Regulation 17: Premises

Action was required to ensure compliance with Regulation 17 and Schedule 6:

- there were a number of cracks within the structure of the building. Some had been filled but not painted. Assurance was required that the cracks did not impact the structural integrity of the building
- the flooring in the treatment room was damaged under the clinical handwash sink
- the plasterboard at the base of a service shaft in a sluice room was damaged from a former leak and not repaired
- the skirting board was missing in a cleaners store
- the plasterwork of the wall in the laundry room was marked and damaged
- signage had been removed from most doors other than bedroom doors with no rationale for their removal
- ceiling tiles in a number of areas were either stained, damaged or missing
- the physiotherapy room was locked with a padlock on the corridor side which looked unsightly and also had implications for the means of escape from this room
- lighting units had been replaced in a number of areas; the ceiling had not been painted where the old ones were removed
- the alarm pull cord in a shared bathroom was broken
- externally, there was no call bell available for residents to summon help, including the outdoor smoking area
- the first floor outdoor area was not suitable for use and as a result the area was locked and not available for use by residents; the timber deck had an algae surface creating a slip hazard and there were sharp edges to the area surrounding a light shaft from the floor below

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

Documentation in relation to each resident's care and condition was not always fully and accurately completed. For example:

- each resident had a "Hospital Passport" designed to relay relevant information to hospital staff on transfer to an acute care facility. Some sections of these were pre-printed and did not provide adequate detail of the care to be delivered to each resident
- the hospital transfer record for one resident did not accurately reflect their skin condition based on a review of records in the days leading up to the transfer

Judgment: Not compliant

Regulation 27: Infection control

A review was required of hand washing facilities in the centre. For example:

- while preparatory plumbing had been completed in the treatment room for the installation of a wash hand basin, this had not yet been installed. Works had not progressed since the last inspection.
- there was no wash hand basin in the housekeeping room on the ground floor
- the wash hand basin in the sluice room on the ground floor did not have hands free taps

Inspectors observed a tube of ointment in a resident's bathroom that was labelled for use by another resident.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had failed to meet the regulatory requirements in relation to fire precautions and had not ensured that residents were adequately protected from the risk of fire.

Following the issue of an urgent compliance plan to the provider following the inspection, immediate assurance was sought and received, to address the following risks:

- from a review of the Personal Emergency Evacuation Plans (PEEPs) and speaking to staff, the assessed evacuation needs of residents were not up-to-date and it was unknown when they were last reviewed
- drill records did not reflect that vertical escape routes were tested during simulated drills
- the evacuation aids (ski sheet and mattress) did not freely fit through the door and landing configuration of Stairs 2, 3, 4 and 5 at first floor level and required either bending the mattress or tilting it to reach the flight of stairs. This may lead to injury of the resident or obstruction of the escape route. The space to manoeuvre the mattress at the ground level of the stairs was also tight.
- the fire compartments on floor plans shown to the inspectors indicated larger fire compartments than those being practiced during fire drills. This may result in residents being moved into areas not safe from the fire
- fire doors to risk rooms (other than bedroom doors) were routinely left open.

Assurance was required how this will be managed until the fire door audit scheduled for 16 May 2023 is complete
- there was no risk assessment for the absence of automatic door closers to bedroom doors. Assurance was required that robust management procedures are in place to ensure that bedroom fire doors are closed in the event of fire
- high risk rooms were being used to house combustible storage

In addition to the above, the provider was not taking adequate precautions against the risk of fire, nor adequately reviewing fire precautions, for example:

- the use of candles was not being adequately risk assessed or supervised. Two candles were found to be lit following mass in the oratory; the candles were next to paper and immobile residents were left unattended while waiting to be assisted from the oratory
- the information contained on the evacuation section of the dependency schedule was incorrect
- drill records dating back to June 2022 had identified issues with doors not releasing when the fire alarm is activated
- oxygen was not being stored in line the centres own policy. For example, there were four unsecured oxygen cylinders in the ground floor treatment room behind the door. They were at risk of being damaged or falling over
- fire doors were being held open by means other than appropriate hold open devices connected to the fire detection and alarm system
- there was an exposed wire within a lighting unit in the equipment/records store

The means of escape, including emergency lighting was not adequate:

- emergency lighting was not available along some external routes leading to the assembly points
- the second assembly point identified to inspectors was not provided with signage
- the width of the path outside the dining room exit was too narrow when the exit door was open
- there was a padlock and shooting bolt on the corridor side of the physiotherapy room. This created a risk of someone being locked within the room
- the thumb turn device on some bedroom doors had been removed; if the door was locked from the corridor side there would be no means to open these doors from the bedroom side
- there was no means to ventilate smoke from one of the escape stairs
- there were locks between the top of the door and the frame on the doors to the first floor Kitchenette/dining area; these locks were activated by a generic key presenting a risk to occupants being locked in the room

Arrangements for the containment of fire were not adequate, for example:

- deficiencies were noted to fire doors throughout the centre; there were excessive gaps to the bottom of a number of doors, some doors were not

fitted with automatic closing devices, some were getting caught on the floor covering, there were holes in fire doors where locks were removed and there were missing heat and smoke seals
- there was a gap observed between the frame of the fire door of an electrical room and the wall in which it was fixed to; the only protection from a fire spreading was the architrave on the bedroom corridor side of the wall
- assurance was required that ceilings provided adequate containment of fire where required; for example, there were attic hatches which did not appear to be fire rated
- service penetrations were observed in fire rated construction which were not adequately sealed to ensure containment of fire
- the glazing to the first floor courtyard was not fire rated in line with documentation shown to inspectors which detailed the fire safety design strategy

In addition to the actions identified in the urgent compliance plan detailed above, the measures in place to safely evacuate residents and the drill practices in the centre required action:

- the simulated drills did not reflect that full compartment evacuations took place and did not reflect the dependencies of residents. Furthermore, this risk was increased as the fire compartment boundaries shown to staff, were not correct and fire compartments were significantly larger than those identified to inspectors.

The arrangements for calling the fire service was not adequate. The fire safety action plan displayed at the fire alarm panel included an incorrect phone number for calling the fire service

While the emergency lighting system was being serviced at the appropriate intervals, the annual certificate to verify that the emergency lighting system was free from fault was not available.

The procedures to follow in the event of a fire were displayed at the fire alarm panel only and were not promintley displayed in other areas of the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure that full and comprehensive assessments were completed and reviewed at regular intervals or when indicated by a change in the resident's condition and following a review by healthcare professionals. In particular, there is a need to ensure that all opportunities are availed of to assess each resident's skin condition and that the frequency of assessment is based on an assessment of risk for each individual resident. There was also a need to ensure that

adequate records were maintained of care delivered to residents. For example:

- adequate records were not maintained of the frequency at which residents' incontinence wear was changed or the condition of residents' skin during the provision of personal care to support the development of a toileting programme or a skin care schedule
- while residents were assessed on admission and reviewed on an ongoing basis, not all assessments were reviewed at a minimum of every four months, such as oral assessment or mental status
- evidence-based assessment tools, such as those to assess the risk of developing pressure sores, were not always accurately completed

Judgment: Not compliant

Regulation 6: Health care

There were a large number of residents with wounds in the centre. Despite previous engagement with the provider about the monitoring of residents' skin status, it was found on this inspection that a high standard of evidence-based nursing care was not provided to residents in relation to the management of wounds. This is supported by the findings that;

- a review of a sample of wound care records identified that dressing changes were not always done at the recommended frequency
- there was a delay in referring a resident for dietetic review despite significant weight loss

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Staff spoken with by inspectors knew how to positively react to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). Records indicated that ten residents had bed rails in place while in bed. Where restraints were used, records indicated alternatives to restraint were trialled prior to use.

Judgment: Compliant

Regulation 8: Protection

All residents spoken with stated that they felt safe and were complimentary of the care provided by staff. Adequate arrangements were in place for the reporting and investigation of suspicions or allegations of abuse.

The provider is pension agent for two current residents and adequate banking arrangements were in place for the management of this money. Since the last inspection the provider had successfully refunded money to the next of kin of two deceased residents for whom they were pension agent. Efforts were underway to return the money for a third resident.

Judgment: Compliant

Regulation 9: Residents' rights

While there were regular meetings held with residents to ascertain their feedback on the operation of the centre, records of residents' meetings did not identify if issues raised at those meetings were addressed to the satisfaction of the residents.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence or discharge of residents	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Droimnin Nursing Home OSV-0000702

Inspection ID: MON-0039688

Date of inspection: 04/05/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The induction checklists for new staff that commenced in January 2023 have been reviewed to ensure that there is a sign off to indicate that they have demonstrated competence in all areas of their role. • The identified staff member has now completed 3 supervised medication rounds to ensure competency. • Both the PIC and CNM attend daily handovers and staff huddles throughout the day. A New ADON has been appointed who will commence full time in September. A day and night report has been implemented for nurses, which they submit to the PIC and CNM and provides updates on resident's status. This provides additional opportunities for the PIC to oversee, supervise, guide and direct care. Monthly nursing and HCA meetings have commenced. A clinical facilitator has been engaged and in place since 16th May who is providing direct "on the ground" teaching, training, support and guidance to all clinical and care staff. The PIC/CNM review the details of GP/ MDT visits to ensure that all directions have been actioned and communicated to the relevant departments.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • The storage area has been reviewed and has become a dedicated archive room that is kept locked. • All equipment has been removed and stored appropriately.	

Regulation 23: Governance and management	Not Compliant

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

• The statement of purpose will be reviewed and updated to reflect the current management structure. An ADON Has been recruited who will commence full time at the beginning of September.
• Oversight of the information required for statutory notifications has improved with regular audits and weekly monitoring.
• Moving forward, all notifications will be submitted within the statutory time frame.
• The PIC/CNM will review all wounds weekly to ensure that recommendations from wound care specialists are being followed.
• The audit action plans will identify the person responsible for implementing the actions and the completion date. These will be reviewed monthly to ensure the actions have been completed and documented.
• The agenda for the senior management team meetings has been amended to include audit results and analysis. This is discussed monthly at the meeting.
• The CNM is checking the fire book weekly to ensure that the means of escape and all other checks are completed as per schedule.
• The PEEPs are updated at a minimum of 4 monthly intervals or sooner if required. The PIC oversees the PEEPs and allocation of resident bedrooms to ensure they accurately reflect the residents needs and support safe evacuation. Fire safety is included in the monthly health and safety walk through. Newly identified risks have been assessed.
• The staff member identified at inspection has now completed the competencies as per the induction process.
• Arrangements for the return of personal belongings have been reviewed and a more appropriate means of packing residents' belongings has been ordered.
• All systems have been reviewed in relation to care planning, healthcare, fire safety, admissions, discharges, and maintenance to ensure improved oversight. These include regular IPC/ Health and safety walk through, heads or department meetings, weekly checks, and audits.
• The nursing home, like many others in the sector, is experiencing some recruitment difficulties. There is a robust recruitment drive in progress.
• As far as is reasonably practicable vacant shifts will be covered by permanent staff and where an agency is required, there is an ongoing request for staff that are familiar with the residents and the service. This is reliant on the availability of these agency staff.
• 6 nurses have been recruited and are due to complete RSCI exams on the 15th & 16th July, 4 HCAs have been recruited and will commence employment once requirements for schedule 2 staff files re complete.
• A further 3 HCAs have been interviewed and offered posts (awaiting acceptance notices). Once these staff are in the post, the requirement for agency staff should be significantly reduced.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• There has been a full review of the requirements for notifications and moving forward all notifications will be submitted in line with the statutory requirements.
• All new pressure ulcers sustained between April and June 2023 will be included in the next quarterly notifications.
• Since the inspection all incidents that require a notification have been submitted within the specified timeframe.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A structural engineering firm have been requested to carry out an onsite visit to review cracks in the structure of the building, awaiting confirmation of date from engineer.
• the flooring in the treatment room was damaged under the clinical handwash sink. The work has been assessed & currently waiting a quote and commencement date from the appointed company. This work will then be completed as part of the nursing homes capital expenditure program.
The plasterboard at the base of a service shaft will be completed by 7.07.23.
• The skirting board repair will be complete by 7.07.23.
• The plasterwork in the laundry room will be repaired by 31.07.23.
• Signage has been replaced 6.06.23.
• Ceiling tiles will be repaired by 7.07.23.
• Padlock on the physiotherapy room was removed & replaced with a combination lock 4.06 23.
• Ceilings where lighting units had been replaced have been painted 6.06.23.
• The call bell in the shared bathroom was replaced 4.06.23.
• The external smoking area has been assessed by an external contractor, who has identified an appropriate waterproof call bell system for outdoors, same ordered and to be delivered and fitted by 31.07.23.
• the first-floor outdoor area was not suitable for use and as a result the area was locked and not available for use by residents; the timber deck had an algae surface creating a slip hazard and there were sharp edges to the area surrounding a light shaft from the floor below. – This area has been closed for residents' safety and a review is currently ongoing for upgrading the space. This will be completed as part of the nursing homes capital expenditure program and scheduled based on the availability of contractors.
• The exposed wire within a lighting unit in the equipment/ records store has been

repaired 10.06.23.
• Replacement of thumb locks is in progress, 14 have replaced, order placed, and pending delivery dates will be refitted by 31.07.23.

Regulation 25: Temporary absence or discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
• Following the introduction of a new CRM system for resident records, a comprehensive transfer document is available (which can be saved on the CRM system) This is based on the national transfer document and will provide details on all resident's relevant details. This document will be used, with additional information, when a resident is transferred to hospital.
• Guidelines have been issued to staff on how to complete this document.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A quote is waited for completion of the following works (assessment completed 29.06.23)
• Installation of a hand wash basin in the treatment room
• Installation of a wash hand basin in the housekeeping room on the ground floor
• Installation of hands-free taps ion the wash hand basin in the sluice room on the ground floor. – a quote has been received for these upgrades work, they will be completed as part of the nursing homes capital expenditure program and scheduled based on the availability of contractors

• Following the inspection, all bedrooms were checked to ensure that the creams were appropriately labelled.
• This practice is now included in the monthly health and safety walkthrough.
• Nurses and care staff have all been advised regarding the labelling of creams and lotions appropriately and to ensure that all cream in bedrooms belongs to the resident occupying the room.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
An external Fire consultant completed a full fire risk assessment on 15.05.23 which included a separate fire door audit. The findings of this report noted that the risk level of the centre was "Tolerable" and that "no major additional controls [were] required".

Fire related action items completed to date:
• The PEEP document was reviewed, and a clear concise document has been created. PEEPs now reflect day and nighttime evacuation requirements. All residents have been reassessed and the PEEPs will be updated four months or sooner if required. (5.05.23 & ongoing)
• Evacuation training and fire drills will now include vertical escape routes. (commenced & ongoing)
• 5 new fire evacuation chairs have been purchased and are in place on the first floor. All staff will have training on how to use this equipment (31.07.23)
• Fire compartments and zones have been discussed with the fire safety trainer and evacuation training and drills will now include the full compartments (commenced & ongoing)
• Evacuation plans also include full compartments with compartment number, fire zones within the compartment, resident bedroom number, dependency, evacuation equipment needs and nearest most appropriate exit route. (8.05.23 & ongoing reviews & updates)
• All staff have been advised that the fire doors should not be left open. Notices have been placed on the doors to remind staff. The daily means of escape route checks have been updated to include the same (5.05.23)
• Fire safety and fire doors is discussed daily at handover (5.05.23 & ongoing)
• The PIC and CNM as part of their daily walks through the units will check that fire doors are closed (5.05.23 & ongoing)
• Risk assessment completed for the absence of automatic door closures to bedroom doors. Closing of bedroom doors will be included in simulated fire drills and fire safety training. All staff have been made aware of the control measures required as identified in the risk assessment (8.05.23)
• High risk rooms were cleaned out and all inappropriate items removed. These high risks are now included on the Health and Safety Walk and checked that they remain free from combustible storage (1.06.23 & ongoing monthly)
• Candles are no longer in use in the Centre. Battery candles have replaced these candles. (5.05.23)
• The dependency schedule has been revised and the information regarding evacuation is now documented in the evacuation folder. (5.05.23)
• No oxygen is currently stored in the building. (5.05.23)
• Staff have been advised not to hold doors open by any means other than appropriate hold open devices. This is included in the daily means of escape checks. (5.05.23)
• The exposed wire has been addressed and is now resolved. (8.05.23)
• 2nd assembly point signage is now in place. Padlock has been removed from the physiotherapy room and replaced with a combination lock.
• Thumb turn device replacement program is in place, 14 have been replaced, replacement locks ordered and to be fitted by 31.07.23 (depending on delivery dates)

• The locks between the top of the door and the frame on the doors to the first floor Kitchenette/dining area have been removed.
• The simulated drills will include full compartment evacuations and take into consideration the dependencies of residents. All compartments have been reviewed & documentation updated, which includes full compartment, including fire zones, residents' evacuation needs.
• The fire safety action plan displayed at the fire alarm panel has been updated, the procedures to follow in the event of a fire are prominently displayed in other areas of the centre.

Fire related action items to be completed:
• Emergency lighting within the centre is currently under review by an external contractor, this upgrade work and will be scheduled based on the availability of contractors.
• Width of path outside the dining room exit under review by an external contractor, upgrade work of required will be scheduled based on the availability of contractors.

• The fire risk assessment noted issues with doors. Currently awaiting external contractors to visit the nursing home to quote for these works, these works will then be scheduled based on the availability of contractors.
• The fire risk assessment also noted issues relating to penetrations in fire rated ceilings relating to hatches, utility pipes, vents / ducts, and light installations. Currently awaiting external contractors to visit the nursing home to quote for these works, these works will then be scheduled based on the availability of contractors.
• Currently awaiting external contractors to visit the nursing home to quote for other fireworks including the fire stopping in the electrical room, smoke ventilation from one of the fire escapes, and glazing of first floor window, these works will then be scheduled based on the availability of contractors.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• A new computerized care plan system is being introduced as a staged project to ensure that staff have the required training and understanding to implement this effectively.
• A review of all available assessment tools has been completed and now a comprehensive list of those more suited to the service has been agreed.
• Every resident is currently undergoing a full review using the assessment tools.
• All reassessments will be completed by 31st July.
• All care plans will be complete by 31st August.
• All nurses are currently undergoing one to one training on the nursing process (assessment, planning, implementation, and evaluation)

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Care staff are now using the computerized system to record residents' daily care which includes repositioning, changes in condition of resident's skin, continence management, diet etc.
• This computerized system allows for review dates to be set and reminders to alert nurses to review assessments and care plans. Guidelines are being created to support staff on when assessments should be assessed and the appropriate time frames.
• The clinical facilitator commenced onsite on 13th May with a primary focus on skin care which includes best practice in skin care, use of barrier creams, repositioning, mattress/ equipment selection, assessing skin, documenting, and reporting.
• All nurses have had one to one training on wound assessment, identification of wound types, selection of dressings, reassessment, and recording.
• The clinical facilitator has worked directly on the ground with staff to teach, guide and support best practice.
• Current audit and data analysis (prevalence and incidence rates) shows that there is a significant level of improvement in care, care provision, staff skills and understanding of skin care.
• Monthly analysis of all weights is undertaken by a senior staff member with review and follow-up to ensure all referrals are made in a timely fashion.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The person in charge will review all minutes from residents' meetings and ensure all issues raised are actioned as appropriate. This will be documented by PIC.

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.	Not Compliant	Orange	04/09/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	04/09/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	04/04/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	11/05/2023
Regulation 23(a)	The registered provider shall	Not Compliant	Orange	04/09/2023

	ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
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	04/09/2023
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.	Not Compliant	Orange	21/07/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the	Substantially Compliant	Yellow	04/04/2024

	prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
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	Red	04/04/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	04/10/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	04/04/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	04/04/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and	Not Compliant	Orange	31/07/2023

	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.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	04/04/2024
Regulation 28(2)(iii)	The registered provider shall make adequate arrangements for calling the fire service.	Substantially Compliant	Yellow	05/05/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Red	30/06/2023
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	30/06/2023
Regulation 31(1)	Where an incident	Not Compliant	Orange	31/07/2023

	set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.			
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Not Compliant	Orange	31/07/2023
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	31/08/2023
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	Not Compliant	Orange	31/08/2023

	that resident's family.			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	31/07/2023
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	31/07/2023
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	07/07/2023