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:	Dunabbey House
Name of provider:	Health Service Executive
Address of centre:	Springmount, Dungarvan, Waterford
Type of inspection:	Unannounced
Date of inspection:	09 November 2022
Centre ID:	OSV-0000590
Fieldwork ID:	MON-0038098

About the designated centre

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

Dunabbey House is a single storey, purpose built centre and has operated as a designated centre for dependent persons since 1974. The centre is currently registered for 28 residents. Accommodation provided consists of 26 single bedrooms and one twin bedroom. A number of bedrooms have shared bathrooms and additional bathroom and toilets are located in close proximity to bedroom accommodation. The communal accommodation consists of one large sitting room as well as a number of smaller sitting rooms. There is a large dining room, an oratory, a small sunroom at the entrance which was very popular with residents. There are suitable paths for residents' use and an enclosed garden area with planted raised flower beds, pots and plenty of comfortable garden seating. There is one long bedroom corridor contained a number of large windows that caught the sun light. Each window had a cushioned seating area that facilitated residents to look out at the enclosed garden area, creating a pleasant place for sitting and reflection. The centre is located close to all amenities in Dungarvan town including shops, churches and restaurants. The

The centre provides residential care predominately to people over the age of 65 but also caters for younger people over the age of 18. The admission policy states that residents have to be within a low to high dependency level. Pre admission assessment is carried out by a member of the hospital management team to ensure the resident meets the admission criteria for Dunabbey House. It offers care to long-term residents and to short-term residents requiring 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:	21

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 9 November 2022	14:05hrs to 18:15hrs	Bairbre Moynihan	Lead
Thursday 10 November 2022	09:00hrs to 15:35hrs	Bairbre Moynihan	Lead

What residents told us and what inspectors observed

The inspector greeted and chatted to the majority of residents in the centre during the two days of inspection and spoke in more detail to five residents to elicit their experiences of living at Dunabbey House. Overall, residents were very positive about the centre, the food, staff and premises. Residents expressed satisfaction about how the centre was run and it was evident that staff had a good rapport with residents and were knowledgeable about their needs.

The inspector arrived in the morning for an unannounced inspection to monitor ongoing regulatory compliance with the regulations and standards. The person in charge was off-site at a CHO meeting on the afternoon of the first day of inspection and attended onsite later in the afternoon to speak with the inspector. The inspector was greeted by a staff nurse. An introductory meeting was held with the assistant director of nursing and staff nurse and was then guided on a tour of the premises.

Dunabbey House is registered for 28 residents with 21 residents on the day of inspection. The premises was a single storey building, built in the 1970s. The centre had 25 single rooms all containing a wash hand basin and three twin rooms. Twin rooms were single occupancy on the days of inspection. En-suite facilities and or jack and jill bathrooms containing a toilet and wash hand basin were available in the twin rooms. Shared showering and bath facilities were available. Residents had personalised their rooms with pictures, photographs and personal belongings from home. The centre had a number of shared communal spaces including a large sitting room and two smaller sitting rooms where residents could meet their visitors in private. In addition, there was a dining room, activation room and oratory. The centre had an enclosed garden with ample seating.

The provider had appointed an activities co-ordinator who worked Monday to Friday. Bingo was observed to be taking place on a number of occasions over the two days with residents engaging and enjoying it. In addition, residents were doing an exercise class. A number of residents preferred to spend their day mobilising around the centre or in the centre and reading books and newspapers. Mass was celebrated on Sunday in house and rosary was led daily by a resident. Residents described to the inspector a recent trip to the Comeragh mountains. Resident trips took place on Thursdays on alternate weeks. The mini bus could accommodate six residents and places were offered on a rotational basis. A film had been filmed in the centre prior to the onset of the COVID-19 pandemic. A special screening of the film in the local cinema took place for residents recently with newspaper cuttings of the occasion on display. An outing was planned in a local pub with live music and the Christmas party was due to take place on 2 December. Residents also had access to a trishaw bike if they wished to go on an excursion. At weekends residents had access to activities in Dungarvan Community Hospital which was across the road. Live broadcast of activities was available from there.

The lunch and teatime experience was observed. The majority of residents attended

the dining room with two to three residents sitting at each table. A small number of residents assisted catering staff at mealtimes. Residents were observed to be chatting to each other and with staff. Residents were offered a choice at mealtimes and food was observed to be nutritious.

It was evident that residents privacy was respected and staff did not enter residents rooms without permission or knocking first. Residents were consulted about the running of the centre through resident forum meetings and satisfaction surveys.

The next two sections of the report present the findings of this inspection in relation to 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

Effective governance and management arrangements were evident in the centre, ensuring good quality person centred care was delivered to residents. The inspector had identified improvements since the last inspection for example; curtain rails had been removed from the twin rooms. However, improvements were required in a number of regulations including outstanding items around the appointment of a person in charge and ensuring that the floor plans and statement of purpose matched the layout of the centre. Non compliances were identified in Regulation 28: Fire Precautions which will be discussed under the domain of Quality and Safety.

The registered provider was the Health Service Executive (HSE). The person in charge reported to the manager for older person services, who reported to the general manager for older person services and upwards to the Chief Officer. The manager for older person services attended the feedback meeting at the end of the inspection. The person in charge was also the person in charge of Dungarvan Community Hospital which was across the road. Following the last inspection the provider gave a commitment to HIQA that a person in charge would be appointed to Dunabbey House. A clinical nurse manager was appointed and in post since December 2021, however while the provider had evidence that the required documentation was submitted to HIQA for this appointment the notification was not submitted and therefore the person in charge remained unchanged since the previous inspection. Notwithstanding this, the clinical nurse manager reported to the person in charge in her role as director of nursing for both centres which provided oversight of the centre. The person in charge was supported in the role by two assistant directors of nursing, a clinical nurse manager, staff nurses, healthcare assistants, multi-task attendants, an activities co-ordinator and catering staff.

Staff had access to mandatory training and in addition staff attended other training including end of life care, fit for life and dementia training. A small number of gaps were identified which will be discussed under Regulation 16: Training and staff development. The statement of purpose and floor plans required review to ensure

they were in line with the footprint of the centre.

Management had completed a number of audits including sharps audit, sluice room audit and security safe. In addition, quality care metrics were completed on for example pressure ulcers and medicines with results inputted into an information technology system. Actions plans accompanied the audits. An infection prevention and control audit had taken place in May 2022 carried out by an infection prevention and control nurse from CHO5. A comprehensive timebound action plan accompanied the audit results. The risk register provided to the inspector on the day was out of date. The inspector was informed that the risk register was updated the previous day and was out of date due to staff vacancies at CHO level. The annual review of quality and safety of care was completed for 2021 containing an action plan.

Staff were pro-active in reporting incidents and this was encouraged by management. Incidents were discussed at the quality and safety meeting which was attended by management from both centres. Trending of incidents such as falls and medication incidents were evident. Incidents which met the criteria for reporting to the Office of the Chief Inspector were reported within the required timelines. The inspector did identify a small number of incidents such as resident absconsions which potentially could meet the criteria for reporting however, following discussion with management they stated that as it was a low support centre residents did go to the shops or the bank but on occasion they did not inform staff they were going and this was reported as an absconsion. Staff did a role call of residents at regular intervals during the day to check what residents were onsite at a given time.

Systems of communication were in place. Meetings took place between the person in charge and clinical nurse manager in August and July 2022. Clinical Nurse Manager (CNM) meetings with CNMs from both centres attending took place monthly and ward meetings with staff from Dunabbey Unit. All minutes contained an agenda, actions and the person responsible.

A small number of gaps were identified in staff records which will be discussed under the relevant regulation. Complaints viewed were appropriately managed in line with the regulations.

Regulation 15: Staffing

The centre had sufficient staffing taking into account the assessed needs of the residents and the size and layout of the designated centre. For example: two staff nurses and two healthcare assistants were rostered on a daily basis. One staff nurse and one healthcare assistant were rostered at night. In addition, the centre had an activities co-ordinator that worked Monday to Friday and catering and housekeeping staff rostered daily.

Judgment: Compliant

Regulation 16: Training and staff development

Gaps in training and staff development were identified including:

- Two staff had not completed training in managing behaviours that challenge within the last three years.
- Three staff had not completed hand hygiene training within the last two years. This is not in line with the centres' own infection prevention and control policy.

Safeguarding training and fire training will be discussed under the relevant regulation.

Judgment: Substantially compliant

Regulation 23: Governance and management

1) As part of the compliance plan from the inspection in 2021 the provider was to appoint a person in charge to Dunabbey House. A person in charge at clinical nurse manager level was appointed by the provider however, the provider had not submitted all documentation required to HIQA. This was completed following the inspection.

2) Improvements were required in the centres' oversight of risk. For example:

- An up-to-date risk register was not available onsite for the inspector to review with the action due dates on the risk register provided dated September 2021.
- No documentation was available to the inspector to indicate that the removal of the automatic door closures on residents' bedrooms had been risk assessed either prior to the removal or since the removal. In addition, this risk was not on the risk register provided to the inspector. It was unclear from speaking to management when the door closures were removed.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The floor plans and statement of purpose were not in line with what the inspector saw on the day. For example: the provider had converted a large sluice room into a sluice room and housekeeping room, however, it remained as a sluice room on the

floor plans and statement of purpose.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All incidents requiring notification were notified to the Office of the Chief Inspector in line with regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector reviewed the complaints log. Details of the complaint, the response and outcome of the complaint were logged. The complaints procedure was on display on the noticeboard in the waiting area at the entrance to the centre. The person in charge was the nominated person to deal with complaints. Residents spoken to were clear on how they would make a complaint.

Judgment: Compliant

Regulation 21: Records

While the majority of information required under schedule 2 was available in staff files, one record had a number of gaps in the employment history which were unaccounted for.

Judgment: Substantially compliant

Quality and safety

The inspector found the residents had a good quality of life in Dunabbey House and were encouraged to live their lives in an unrestricted manner. Overall, the inspector found that the care residents received was person centred with the views and wishes of residents respected.

Residents had good access to the general practitioner. The inspector was informed

that there was minimal waiting times for review by health and social care providers. Tissue viability advice and support was onsite in Dungarvan Community Hospital two days per week. In addition, the service had been approved for a advanced nurse practitioner in dementia care to be shared with two other centres.

While the inspector was informed that there was no restriction on visiting in relation to the number of visits per week and the length of time visitors could stay, the procedure that visitors had to undertake in order to gain access to the centre was overly restrictive. This will be discussed under Regulation 11: Visits.

Dunabbey House was built in 1974 and required ongoing upkeep and maintenance. Corridors in the centre were narrow but clutter free and assistive handrails were in place throughout. The centre was generally clean on the day of inspection and housekeeping staff were able to describe the cleaning processes in the centre. A link nurse practitioner was in place who had completed the relevant education programme and linked with four other link nurse practitioners from Dungarvan Community Hospital. The centre had a tagging system in place to identify equipment that was clean. Notwithstanding the good practices in place improvements were required Regulations 17 and 27: Premises and infection control which will be discussed under the relevant regulation.

Food was prepared in Dungarvan Community Hospital. Residents had a choice at all mealtimes and residents were complimentary in their feedback about the food. The provider had two up-to-date risk management policies in place that were in line with the requirements under the regulation.

Fire extinguishers, the fire alarm and emergency lighting had preventive maintenance conducted at recommended intervals. Each resident had a completed emergency evacuation plan in place to guide staff. The fire alarm system met the L1 standard which is in line with the current guidance for existing designated centres. Signage was in place to guide residents and staff to the nearest exit. However, improvements were required which are detailed under the regulation.

The provider had robust processes in place around the management of residents finances. These were managed centrally through the HSE with a member of staff identified who managed the finances onsite. A member of the accounts department attended onsite fortnightly to discuss any queries with residents about their finances. Additional good practices are discussed under Regulation 8: Protection.

Validated risk assessment tools were completed every four months or more frequently if required. Care plans were in place for residents and end of life care plans were identified as being resident specific with the residents' wishes at their time of death clearly outlined. However, some care plans had not been updated in line with the regulations which will be discussed under Regulation 5: Individual assessment and care planning.

An activities co-ordinator was onsite five days per week. Residents had access to the mini bus on alternate Thursdays if they wished to go on a day trip. On the second day of inspection the day trip was cancelled due to adverse weather conditions. The inspector spoke to a number of residents about the activities and a small number of

residents stated that they chose not to take part in activities as they preferred taking part in their own personal interests such as reading.

Regulation 11: Visits

The centres' visiting procedure was restrictive and not in line with national guidance. For example:

- Visitors were required to book a time to visit their relation/friend. However, management stated that visits were not restricted in terms of time limit and if a visitor turned up unannounced that they would be provided with access.
- Visitors were required to enter through a different entrance, complete a COVID-19 questionnaire and have a temperature check.
- Visitors were encouraged to take an antigen test but management stated that this was not mandatory.
- A risk assessment was completed in September 2022, was risk rated as a high risk and referenced interim public health guidance which has since been superseded by updated guidance.
- The visiting policy was dated as September 2022, however, it made no reference to national guidance, the requirement for a COVID-19 risk assessment or the encouragement of an antigen test.
- Visiting care plans referenced having two visits weekly by the resident's nominated visitor and an handwritten update stated to refer to visiting guidelines, however, the centre or the care plan were not in line with current visiting guidelines.

Judgment: Substantially compliant

Regulation 17: Premises

Improvements were required in order to ensure compliance with schedule 6 of the regulations. For example:

- General wear and tear was noted throughout the centre including chipped door frames and scuffed and chipped paint on walls and doors.
- The equipment storage room was a thoroughfare to the resident's bathroom.
- The housekeeping room contained washing machines where residents' clothing were washed. This posed a risk of cross contamination.
- The nurses' station was both a clinical and administrative room. Medication trolleys and monitoring equipment were stored in the room where residents files were kept and nurses updated their clinical notes.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with adequate quantities of nutritious food and drinks. Food was freshly prepared and cooked in Dungarvan Community Hospital. A choice was provided at all mealtimes and this was displayed in the dining room. Residents could avail of food, fluids and snacks at times outside of regular mealtimes. Support was available from a dietitian for residents who required specialist assessment with regard to their dietary needs. Modified diets were prepared in Dungarvan Community Hospital with a small number of residents requiring them. Staff were available in the dining room during mealtimes should a resident require assistance.

Judgment: Compliant

Regulation 26: Risk management

The centre had two up-to-date risk management policies in place. One policy outlined the risk management process and incident management. The second policy included the five specified risks and the measures and actions in place to control the risks.

Judgment: Compliant

Regulation 27: Infection control

The centre was generally clean on the day of inspection, however, areas for improvement were required in order to ensure the centre was compliant with procedures consistent with infection control. For example:

- The centre had a small number of hand hygiene sinks. None of these were compliant with the required specifications.
- The housekeeping room did not contain a janitorial sink.
- A small number of trays underneath the hand gel dispensers were dusty and stained.
- An outbreak summary form did not identify the learning or actions from the most recent COVID-19 outbreak.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Areas requiring action were identified including:

- Fire door closers had been removed from all residents rooms as residents were finding it difficult to open the doors with no date for re-installation of alternative door closers.
- A fire door outside the kitchen and the fire exit door on corridor 2 did not fully close. This would reduce their effectiveness in containing fire and smoke.
- A resident's toilet was within the same compartment as the kitchen.
- Agency staff had not been inducted in the centre's fire procedures other than how to check the fire panel.
- A number of gaps were identified in fire training. For example: the inspector was informed that fire training was required to be completed yearly. 11 staff had not completed fire training within the last year. In addition, 14 staff had not completed a fire drill in 2022.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Under regulation 5(4) care plans are required to be formally reviewed at intervals not exceeding four months. The inspector reviewed a sample of care plans. The evaluation notes which provided an update on the specific goals of the care plan were updated regularly however, management stated that the specific goals which guided the evaluation notes were required to be updated yearly. The inspector observed that this was not always completed either four monthly in line with the regulations or yearly. For example: a breathing and circulation and falls care plan had not been updated since 2018. Management stated that they were currently in the process of updating all records.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to medical care. The general practitioners (GPs) were available by phone Monday to Friday during working hours. In addition to this they attended onsite once weekly. Outside of these hours an out of hours service was available and attended if required. A dietitan attended onsite fortnightly. Management stated that there was approximately a one week wait for a physiotherapy review and speech and language therapy review from once the resident was referred. A longer waiting period was required for an occupational

therapy review which was escalated if required.

Judgment: Compliant

Regulation 8: Protection

The registered provider had assurances in place to safeguard residents and protect them from abuse.

- Staff had access to safeguarding training which was required to be completed three yearly. All staff had completed this training within the previous three years.
- Staff spoken with were knowledgeable of what constitutes abuse, the different types of abuse and how to report any allegation of abuse.
- Records reviewed had the required Garda (police) vetting disclosures in place for staff prior to commencing employment in the centre.
- The registered provider was a pension agent for eight residents. Systems were in place for the management of residents' finances through the HSE's central unit and managed locally through the patient accounts department with two staff signatures and the resident's signature required for any transaction.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had appointed an activities co-ordinator who worked five days per week. Activities were observed to be taking place during the two days of inspection.

Residents were consulted about the running of the centre through resident forum meetings and satisfaction surveys. Residents had a television in their rooms and access to a television in communal rooms. Residents were observed to be reading both local and national newspapers during the two day inspection. A computer was available for residents use in the waiting area.

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	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 21: Records	Substantially compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Dunabbey House OSV-0000590

Inspection ID: MON-0038098

Date of inspection: 10/11/2022

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Full review of staff training matrix to ensure compliance in all areas, in particular managing behaviours that challenge & updated hand hygiene.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Hospital Management are currently reviewing all options available in regards of appointing a PIC who will comply with the HIQA requirements. Robust plan to remedy the PIC governance - retain the current CNM as this enables her to gain the required management experience. Appointment of an ADON as PIC for the intervening period to provide governance & to ensure compliance until the suitable candidate takes up post.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of	

purpose: Full review / update of floor plans & SOP to reflect completed refurbishments to sluice, laundry room.

Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: HR department have given a commitment for closer scrutiny & auditing of applications in relation to gaps in employment. We invisage this will lead to changes in the policy.Full review completed into the one staff members employment history highlighted with service gaps, the gaps which was a result of compleyoion of Masters & change of employement.	
Regulation 11: Visits	Substantially Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: Review & update of: visiting policy, visiting access, local risk assessments. Review of Visiting Care plans, admission isolation periods.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Ongoing programme of painting & refurbishment to address day to day wear & tear. • Review of options of storage areas in the facility • Review of laundry area • Suitable area identified for nurse administration separate to clean utility, with refurbishment plan in place.	
Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control: Full review of facility completed by CHO5 IPC Lead 7/12/2022. Action plan in place to ensure compliance in regards to upgrade of sinks to compliance with specific IPC specifications. Review of outbreak summary report to include learning outcomes.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Ongoing fire safety training, drills, evacuations for all staff, including agency staff. Full review of facility by HSE Fire Officer with plan for programme of works to ensure compliance. Fire door closures replacement completed 19/1/23.	
Regulation 5: Individual assessment and care plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: Review & update of all residents care plans /care needs to ensure compliance with the regulations.	

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 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Substantially Compliant	Yellow	31/12/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/01/2023
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.	Substantially Compliant	Yellow	31/03/2023

Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	31/01/2023
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 details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	28/02/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/06/2023
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.	Not Compliant	Orange	10/02/2023

Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	31/01/2023
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/01/2023
Regulation 03(1)	The registered provider shall prepare in writing a statement of	Substantially Compliant	Yellow	31/01/2023

	purpose relating to the designated centre concerned and containing the information set out in Schedule 1.			
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	31/01/2023