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:	Edenderry Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Ofalia House, St. Mary's Road, Edenderry, Offaly
Type of inspection:	Unannounced
Date of inspection:	14 November 2023
Centre ID:	OSV-0000525
Fieldwork ID:	MON-0040392

About the designated centre

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

The designated centre is located within walking distance from Edenderry town centre. The centre is a single-story premises and provides accommodation for 28 male and female residents over 18 years of age in single and twin occupancy bedrooms, most with full en-suite facilities. The centre is arranged into two separate areas, on either side of the nicely decorated reception area. Communal sitting and dining rooms are located in both sides of the centre and residents have access to two enclosed gardens. The centre provides long-term residential care, respite, convalescence, dementia and palliative care services. Nursing care is provided for people with low, medium, high and maximum dependency needs. The provider employs a staff team in the centre to meet residents' needs consisting of registered nurses, care assistants, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	25

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
Tuesday 14 November 2023	09:15hrs to 17:00hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Overall, the feedback from residents living in Edenderry Community Hospital was that it was a good place to live. Residents told the inspector that they had established positive relationships with staff whom they had come to know well and this made them feel safe living in the centre. Residents were complimentary with regard to the care they received and gave examples of how staff ensured that they were supported to maintain their individual style and appearance. While residents expressed a high levels of satisfaction with the services, residents expressed some dissatisfaction with the quality of the activities programme.

The inspector was met by a clinical nurse manager on arrival at the centre. Following an introductory meeting, the inspector walked through the centre and met with residents and staff. The inspector observed that the environment was calm, relaxed and welcoming. Care was observed to be delivered in an unhurried manner. Staff were observed spending time engaging with residents and polite conversation was overheard throughout the morning while staff assisted residents with their care needs.

The inspector met with the majority of residents during the walk around the centre and spoke with five residents in more detail about their experience of living in the centre. Residents gave positive feedback with regard to the quality and quantity of food they received, and the availability of staff to assist them with their needs or simply spend time chatting with them. Residents confirmed that they had choice over their daily routine, including when to get up in the morning, the clothes to wear and whether or not they wished attend the communal areas or remain in their bedroom.

Residents were observed to enjoy a variety of communal and private areas located around the premises. Communal areas were observed to be spacious, and contained comfortable furnishings for residents. Residents were observed to spend most of their day in the day room, which was observed to be a hub of activity. Residents told the inspector that they enjoyed spending time in those areas as they could chat to staff near the nurse's station and also meet visitors. This space had natural lighting for residents and access to an enclosed courtyard through two single doors.

The centre was generally clean with the exception of some ancillary storage area, and sluicing facilities. Those areas were observed to be cluttered with items such as boxes of stock that impacted on effective cleaning of the area. A sluice facility was observed not to be appropriately maintained. Cleaning equipment was observed to be stored in one sluice room while the layout of a second sluice room did not support effective segregation of equipment used by residents to reduce the risk of cross infection.

Resident's personal clothing was laundered on-site. The laundry area was maintained in a satisfactory state of repair. The area was visibly clean and

appropriately laid out to support effective infection prevention and control. Residents reported their satisfaction with the laundry service.

Emergency escape exits were observed to be unobstructed. There were fire extinguishers located throughout the centre. While all fire doors were fitted with automatic closing devices, the inspector observed that some fire doors were not closing correctly. Additionally, combustible materials were being stored in an electrical room. This created a risk of fire in the area.

The dining experience was observed to be a pleasant and social experience for residents. Meals were observed to be freshly prepared and served to residents based on their choice and dietary needs. Residents spoke very positively with regard to the quality of food in the centre. Staff were observed to provide assistance to residents sensitively while supporting resident's independence. Residents were observed to be engaging with one another and appeared to be enjoying the company of staff and other residents.

Throughout the day of inspection, residents were observed to be engaged in a variety of activities that included exercise, games, and art and crafts. Residents spoke positively about a clay modelling class that was held the day prior to the inspection and detailed how they enjoyed it and admired the skill of the instructor who made Christmas decorations. However, residents told the inspector that although weekly activities were displayed on a board, scheduled activities could change at short notice. While residents confirmed that alternative activities were provided by health care staff, some residents reported that this arrangement affected their choice of how to spend their day.

The inspector observed that visiting was facilitated and was not restricted. Visitors were observed to meet with residents in the various communal rooms and in their bedrooms.

The following sections of this report detail the findings in relation to the capacity and management of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This was an unannounced inspection by an inspector of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspector followed up on the actions taken by the provider to address non-compliant issues found on the last inspection of the centre in January 2023 and found that while some improvement actions had been implemented with regard to fire safety, record management, and infection prevention and control, further action was required to achieve full regulatory compliance. This inspection found that while residents received a satisfactory standard of care, a poorly resourced organisational structure

impacted on effective governance and some of the management systems in place to monitor the service provided to residents.

The provider had completed a fire safety risk assessment of the centre in May 2022. A subsequent action plan developed from the findings of this assessment was forwarded to the Chief Inspector following the last inspection. This action plan was due to be completed by September 2023. The inspector found that the provider had taken some steps to improve the fire safety systems in the centre since the last inspection. For example;

- Some fire doors had been upgraded to ensure they provided adequate containment of fire and smoke.
- Areas that previously did not have emergency lighting had lighting installed.
- Locking mechanisms on some doors had been changed to thumb locks to ensure they facilitated timely evacuation of residents in the event of a fire.

However, there were further outstanding fire safety works required. For example, works had not yet commenced to address fire containment risks identified in the attic space of the centre. The inspector was informed that these works would commence in November 2023. A clear time-bound project plan to address the outstanding works had not been established, and a plan to manage any potential risk or disruption to residents during ongoing works was not available for review.

The Health Service Executive (HSE) is the registered provider of Edenderry Community Nursing Unit. A person in charge was supported clinically and administratively by two clinical nurse managers. A general manager of older people services provided oversight and support to the person in charge. The person in charge was not on duty on the day of inspection, however they attended the centre to meet the inspector and support the inspection process.

The clinical management in place to support the person in charge was not in line with the centre's statement of purpose, which outlined an organisational structure consisting of four clinical nurse managers (CNM). On the day of inspection, as a result of unplanned leave and two CNM vacancies, the person in charge was supported by only one clinical nurse manager. Clinical nurse managers had responsibility for monitoring the quality and safety of the service such as infection prevention and control, clinical documentation and providing supervision and support to the staff to ensure residents receive safe quality care. However, the inspector found that on a number of occasions, a CNM was required to cover vacant nursing shifts as a result of short-notice, unplanned leave. This meant that there was less time available for nursing oversight and governance. This organisational structure was found to impact on the consistent supervision and monitoring of the service.

The provider had management systems in place to monitor, evaluate and improve the quality and safety of the service provided to residents. This included a variety of clinical and environmental audits, analysis of complaints, weekly monitoring of quality of care indicators and trending of incidents involving residents. A sample of completed clinical and environmental audits were reviewed and found to be effective

in supporting the management team to identify deficits and risks in the quality and safety of the service. However, where quality improvement plans were developed following audit activity, the progress of the corresponding quality improvement action plans were not subject to frequent review of their progress. For example, an action plan developed in response to the findings of a clinical documentation and care plan audit contained over ten corrective actions. However, there was no evidence of the action taken to implement, or review the status, of those actions, and some clinical records remained incomplete.

The centres risk management policy detailed the management systems that should be in place for the oversight and monitoring of risk in the centre. As part of the risk management policy, a risk register to record all potential risks to resident's safety and welfare was required to be maintained. A review of the risk register found that some clinical and operational risks were identified and recorded. This included the risks associated with the reduced management resources in the centre, general fire safety, and infection control. However, some risks specific to fire safety had not been identified in the risk register. As a result, there were no risk controls in place to detail how the risks were being managed. This included the risks associated with outstanding fire containment works in the attic space.

The organisations and management of the staffing resources were not effective to ensure all aspects of the service needs were met. A review of the rosters for the previous three weeks evidenced challenges in maintaining planned nursing and health care staffing levels within the centre. The inspector found that, while the management team prioritised the staffing resource allocated to the care of residents, rosters evidenced that staffing resources were not adequate to respond to unplanned staff leave. Consequently, staff were redirected from their allocated duties such as housekeeping, and activities to support the delivery of care to the residents. This impacted on the quality of the service provided in these areas.

Record management comprised of a paper-based system. Staff personnel files contained a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021. The inspector found that some records required under Schedule 3 and 4 were not maintained in a manner that was safe. This included information pertaining to residents nutritional care and monitoring that were left unsecured in communal areas.

A training schedule was in place and staff were facilitated to attend training relevant to their role. A review of staff training records found that all staff had up-to-date training in fire safety, safeguarding of vulnerable adults and infection prevention and control. Staff referred to policies and associated procedures to underpin the delivery of safe and consistent care to the residents.

Regulation 16: Training and staff development

Staff were facilitated to attend training relevant to their role, and staff demonstrated an appropriate awareness of their training such safeguarding of vulnerable people,

fire safety, and infection prevention and control.

Judgment: Compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements. For example;

- Records were not kept in a manner that was safe. Records of residents dietary needs, associated health conditions, and weight records dated April 2023 were stored on a window sill in a communal dayroom.
- Records of staff worked rosters were not maintained in line with the requirements of Schedule 4(9). For example, rosters did not reflect the roster that was actually worked by staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had not ensured that there were sufficient staffing resources in place to consistently maintain planned staffing levels. The provider had failed to ensure the service had sufficient staffing resources to;

- ensure the management structure was maintained in line with the centre's statement of purpose. This impacted on effective governance and oversight of the service.
- maintain housekeeping and activities staffing resources to ensure a quality and consistent service was provided.

The management systems in place to monitor the quality of the service were not fully effective to ensure the service provided residents was safe, appropriate, consistent and effectively monitored. For example;

- Risk management systems were not effectively monitored or implemented. The centre's risk register did not contain known risks in the centre such as the risk associated with fire containment issues in the centre. In addition, the risk associated with staffing and management constraints had not been comprehensively assessed. This meant that actions to control and manage the risks had not been implemented.
- The systems of monitoring, evaluating and improving the quality and safety of the service were not effectively implemented. For example, improvement action plans in relation to clinical records, and infection prevention and control were not consistently subject to time frames, or progress review.

- There was poor oversight of the management of records.

The provider had failed to implement the compliance plan submitted following the previous inspection in respect of fire safety. This resulted in non-compliance with Regulation 28, Fire precautions.

Judgment: Not compliant

Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre

The registered provider had submitted notification of the procedures and arrangements in place for the management of the designated centre during the absence of the person in charge.

Judgment: Compliant

Quality and safety

Residents living in this centre received a good standard of care and support which ensured that they were safe and that they could enjoy a good quality of life. There was a person-centred approach to care, and residents' well-being was promoted. Nonetheless, the inspector found that outstanding non-compliance in relation to fire safety continued to pose a risk to residents' safety and well-being. Further action was also required to ensure full compliance with infection prevention and control, and assessments and care plans.

The fire safety action plan submitted following the previous inspection was in progress at the time of the inspection. The inspector found that while the provider had taken some action to ensure residents were protected from the risk of fire, further action was required to ensure fire containment works were completed in areas of the centre such as the attic.

A review of the care environment found that the provider had taken action to maintain an appropriate standard of environmental and equipment hygiene. Enhanced quality assurance processes to monitor the quality of equipment hygiene had been established. There was a cleaning schedule in place that ensure all areas of the centre were appropriately cleaned. However, the standard of cleanliness in the sluice facilities and in some storage areas was not consistent with the standard of cleanliness in other areas of the centre. This is discussed further under Regulation 27, Infection control.

The inspector acknowledged that the needs of residents were known to the staff. A sample of residents' individual assessments and care plans were reviewed. While all

residents had a care plan and there was evidence that residents' needs had been assessed using validated assessment tools, care plans were not always developed following a residents assessed need or risk being identified. Consequently, some care plans did not identify the current care needs of the residents or reflect the person-centred guidance on the current care needs of the residents.

A review of residents' care records found that residents had access to a general practitioner (GP) as requested or required. Arrangements were in place for residents to access the expertise of health and social care professionals for further assessment. These recommendations were observed to be implemented and reviewed frequently to ensure the care plan was effective.

The needs and preferences of residents who had difficulty communicating were identified by staff and effort was made to support residents to communicate their views and needs. Residents who required supportive equipment to communicate were provided with such equipment.

The centre was actively promoting a restraint-free environment and there were no bed rails in use in the centre. Restrictive practices were only initiated following an appropriate risk assessment, and in consultation with the multidisciplinary team and the resident concerned.

Residents had access to an independent advocacy service. Residents were provided with access to daily newspapers, radio and television. Religious services were held frequently in the centre.

Residents rights' were promoted in the centre. Residents were supported to engage in group and one-to-one activities based on their individual needs, preferences and capacities. However, the provision of consistent activities for residents was impact on by the instability in the staffing resources. For example, scheduled activities such as baking and exercise classes were postponed at short notice as a result of staff being redirected to laundry, housekeeping, or caring duties.

Resident meetings were held and records reviewed showed a high attendance from the residents.

There was evidence that residents were consulted about the quality of the service, the menu, and the quality of activities.

Regulation 10: Communication difficulties

The registered provider had arrangements in place to ensure residents who experienced communications difficulties were appropriately assessed, and supported to enable residents to make informed choices and decisions.

Staff demonstrated an appropriate knowledge of each residents communications needs, and the aids and appliances required by some residents to support their

needs, in line with the residents individual care plan.

Judgment: Compliant

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 27: Infection control

The provider did not fully ensure that infection prevention and control procedures were consistent with the National Standards for Infection Prevention and Control (IPC) in community settings published by HIQA.

The environment and equipment was not managed in a way that minimised the risk of transmitting a health care-associated infection. For example;

- Cleaning equipment and supplies were inappropriately stored in the sluice room and a vacant bedroom which presented a risk of cross contamination.
- Appropriate segregation of clean and dirty equipment in a sluice room were not in place. Equipment used by residents was observed to be stored on top of a bedpan washer. This created a risk of cross contamination.
- The management of storage areas in the centre did not ensure effective cleaning of those areas. Those areas were observed to be visibly unclean and the volumes of stock in stored in those rooms impacted on effective cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider was not taking adequate precautions against the risk of fire:

- Combustible items such as boxes and video cassettes were stored in an electrical communications room. The inappropriate storage of materials in the room had been identified by the provider as a fire risk but actions to mitigate the risk were not implemented.
- A number of fire fire doors were not functioning correctly. Some doors did not

close fully when released. This compromised the function of the doors to contain the spread of smoke and fire in the event of a fire emergency.

The systems in place for the adequate containment of fire were not robust. For example;

- There were areas where services such as pipes and electrics penetrated the walls and ceiling into the attic spaces. This included high risk areas such as an electrical store room and the communications room.
- Significant fire containment works had not commenced in the attic spaces where services such as pipes penetrated fire compartment walls in the attic space, and upgrading of compartment walls to prevent the spread of fire in the attic had not been completed. This compromised effective fire containment measures in those areas.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Care plans were not developed following a comprehensive assessment of the residents care needs. For example, resident's care plans did not accurately reflect the assessed needs of the residents and did not identify interventions in place to protect residents when identified as being at a high risk of falls or at risk of impaired skin integrity.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were provided with appropriate health and medical care, including evidenced based nursing care.

Residents had timely access to medical assessments and treatment by their General Practitioners (GP) and the person in charge confirmed that GPs were visiting the centre as required.

Residents also had access to a range of allied health care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of later life and palliative care.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

A restraint free environment was supported in the centre. Each residents had a full risk assessment completed prior to any use of restrictive practices. Assessments were completed in consultation with the residents and multidisciplinary team.

Residents who experienced responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were observed to receive care and support from staff that was person-centred, respectful and non-restrictive. Staff had up-to-date knowledge to support residents to manage their responsive behaviours.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were not provided with consistent opportunities to participate in activities in accordance with their interests and capacities. Residents reported that activities schedules were subject to change at short notice. Activity records reviewed by the inspector were not completed for a number of days and confirmed that planned activities were not always delivered to 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 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	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 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Edenderry Community Nursing Unit OSV-0000525

Inspection ID: MON-0040392

Date of inspection: 14/11/2023

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All Records from the communal space are removed and kept in the Nurses station immediately. Staff Nurse on duty ensures that there is no record left in Communal space. All staff have been advised that records are to be completed and maintained in a secure area CNM/ Nurse in charge will review rosters daily and ensure all staffing rosters are maintained and the planned roster and actual worked roster is maintained to reflect accurately the changes and staff who worked each shift when changes occur from the planned rota. Daily staff allocation kept in a separate folder and CNM/ Nurse in charge ensures that all changes are marked	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The staffing resources continue to be continually reviewed to ensure the safety and quality of care. On a daily basis staff levels and their deployment is reviewed by the PIC. A new CNM1 has commenced in post on the 27th November to strengthen the management team and support the PIC with oversight of the service. Regular agency staff are available to cover any contingency shortfall due to unplanned staff absences and the PIC maintains regular contact with a number of agencies to arrange additional cover if required for both planned and unplanned leave if necessary.	

Dedicated housekeeping staff will be assigned to each unit within the center and this will be identified on the daily staff allocation sheet rota.

Risk register will be reviewed and all risks will be assessed comprehensively.-Specific risk assessment now in place on the risk register in relation to the fire safety precautions.

A schedule of audits is being developed for 2024 and this includes audits of IPC practices, care plans, accident/incidents and near miss events and medication management practices to ensure oversight of the quality and safety of care in the center.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
CNMs/ ADON will do walk around daily and ensure all equipment is stored appropriately- 1st December
Upgrade work on Sluice room in HDU started on 27th November. Work will be completed by End of December. There will be an appropriate segregation of clean and dirty equipment in sluice room and more storage space in sluice room for residents' equipment such as urinals etc.
Removed all boxes from storage areas immediately and storage room checks will be added to Equipment audit- 30th December 2023
The IPC Policy will be discussed at the next staff meeting to ensure all staff are familiar with the policy and adherence to best practice

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Infrastructural fire safety upgrade works have started in the center to complete all matters outlined in the HSE fire risk assessment report. The works will include the remedial works to ensure all fire doors are functioning correctly and sealing of all areas to ensure fire containment compartments are fully secure.
An Audit will be completed on all Fire Doors and any deficits will be fixed to ensure all fire doors are functioning correctly
All combustible items ie. Boxes and Video cassettes were removed immediately from the electrical communications room.

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:
Each resident has an assigned key worker to develop an individualized care plan in agreement with the resident on admission. Care plans are reviewed at three monthly intervals or sooner in response to a changing need.

All residents clinical risk assessments and care plans will be audited and ensure that care plans are meeting the care needs of each resident and to guide staff intervention.

A schedule of planned audits will be developed with an action plan to ensure corrective actions to address any matters arising from audit findings

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A staff member will be allocated for Activities on daily basis.
Nurse in charge and CNM on duty will ensure that planned activities are delivered to residents. All staff involved in the delivery of activities have informed of the necessity to ensure activity records are maintained up to date and recorded on a daily basis.

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 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	15/12/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	15/12/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/12/2023
Regulation 23(c)	The registered provider shall ensure that	Not Compliant	Orange	31/12/2023

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	31/12/2023
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.	Substantially Compliant	Yellow	15/01/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	15/01/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and	Not Compliant	Orange	15/01/2024

	extinguishing fires.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	31/01/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	10/12/2023