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:	Fearna Manor Nursing Home
Name of provider:	Castlerea Nursing Home Limited
Address of centre:	Tarmon Road, Castlerea, Roscommon
Type of inspection:	Unannounced
Date of inspection:	03 August 2022
Centre ID:	OSV-0000339
Fieldwork ID:	MON-0037489

About the designated centre

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

The centre is a purpose-built facility single storey building that is registered to accommodate a maximum of 53 dependent persons aged 18 years and over. It is situated in a residential area a short drive from the town of Castlerea. Bedroom accommodation consists of 15 single and 19 double rooms all with en-suite facilities. There is a range of communal areas where residents can sit together and socialise. Other facilities include a dining area and spaces for visitors and people who smoke. There are toilets and bathrooms located near to communal areas. There are two outdoor areas that are easily accessible to residents. The centre caters for male and female residents who require long-term care and also provides care to people who have respite, convalescence, dementia or palliative care needs. In the statement of purpose, the provider states that they are committed to enhancing the quality of life of residents by providing a homely, safe and caring environment.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	38

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 August 2022	09:00hrs to 17:00hrs	Ann Wallace	Lead
Wednesday 3 August 2022	09:00hrs to 17:00hrs	Gordon Ellis	Lead

What residents told us and what inspectors observed

The inspectors found that residents were largely content with their lives in the designated centre however residents reported that there had been a turn over of staff in recent months which meant that some staff were not familiar with their needs and preferences for daily routines. In addition the inspectors found that where residents raised a concern about the behaviour of a member of staff this had not been followed up by the management team. Although the provider had implemented a programme of fire safety works following the last inspection this inspection found that significant works were still required to bring the designated centre into compliance with Regulation 28 and ensure that the residents were adequately protected from fire risks.

The designated centre is laid out over one floor. At the time of this inspection the provider had relocated the laundry to a vacant sheltered housing unit based on the same site. Bedroom accommodation was provided in a mix of twin and single bedrooms all with en-suite facilities. Bedrooms were of a good size and were well laid out for the residents. Residents brought in items of their own furniture and momentos from home. Residents told the inspectors that their bedrooms were comfortable and that they had enough space to move around safely and to store their belongings. However the layout of one twin room meant that the resident had to access the second resident's bed space to access their personal storage.

Communal areas were located to the rear of the building and consisted of a main lounge, with a sun lounge extension to the main room, an activities room and a dining room. Residents spent most of their day in the communal lounges either watching television or chatting with staff. Activities staff provided a mixture of one to one and small group activities ,however some residents who spoke with the inspectors said that the activities were not what they wanted to do and they preferred to spend time in their bedroom. All residents said that the daily routines in the centre were flexible and that they could chose how to spend their day including when to get up and what time they retired to bed. Those residents who were able to go out of the centre were facilitated to do so.

The activities room was a spacious bright room but was not being used on the day of the inspection. One resident was sitting alone in this room and staff informed the inspectors that the resident did not like the main lounge as it was busy and could get noisy at times. However the inspectors observed that the resident was sat spent significant periods of time without any interactions with staff or other residents and appeared to be quite isolated in the activities room.

Staff interactions with the residents were gentle and respectful. Staff worked well together to anticipate resident's needs and to respond to call bells when they sounded.

Overall residents reported that they felt safe in the centre however the inspectors noted that where a resident had raised an allegation about the behaviour of a member of staff that this had not been followed up in line with the designated centre's safeguarding procedures. This was addressed by the person in charge following the inspection.

Residents were seen enjoying their lunch time meal in the dining room or in the main lounge. Residents said that the food was very good and that meals were generous. Hot and cold drinks and snacks were served throughout the day. Staff provided discreet support for residents who were not able to eat independently. Meals were served hot and were nicely presented.

The next two sections of the report will discuss the findings of the inspection under the regulations as set out in the capacity and capability pillar and the quality and safety pillar.

Capacity and capability

Although some improvements had been implemented since the previous inspection inspectors were not assured that the provider had the governance and management structures in place to sustain these improvements and significant focus and resources were now required to ensure that the service provided to residents was safe, appropriate and effectively monitored.This was a particular concern in relation to repeated non-compliance's in Regulations 28 and 27 which had not been addressed by the provider following the previous inspection.

This was an unannounced risk inspection to monitor the designated centre's compliance with the Health Act 2007(Care and Welfare of Residents in designated Centres for Older People) Regulations 2013 (as amended) and to review the registered providers actions with regard to achieving compliance under regulation 23 governance and management, Regulation 27 infection control and Regulation 28 fire precautions which were found non compliant at a previous inspection undertaken in April 2022. Following the previous inspection in April 2022 the Chief Inspector had attached two restrictive conditions to the provider's registration. Condition 4 required that; The registered provider shall ensure that no new resident is admitted to the designated centre until the designated centre is judged to be compliant with Regulation 28 (Fire Precautions) by an inspector of social services. Condition 5 required that the provider; Notwithstanding the requirements placed on the registered provider to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 the registered provider shall take all necessary action to comply with Regulation 23; Governance and Management and Regulation 27; Infection Control to the satisfaction of the Chief Inspector no later than 31 July 2022. This inspector found that the centre was closed to new admissions however the provider was in breach of Condition 5 as they had not achieved compliance with Regulations 23 and 27 at the time of this inspection.

On the morning of the inspection neither the provider representative or the person in charge were available in the centre. The clinical nurse manager had also gone off duty which meant that a staff nurse was in charge of the designated centre. The person in charge arrived part way through the morning and facilitated the inspection for the rest of the day.

Castlerea Nursing Home Limited is the registered provider for this designated centre of which there are two company directors. One of the directors is directly involved in the management of the designated centre provided ongoing support to the person in charge and staff working in Fearna Manor. The person in charge had been appointed to their position in March 2022. The person in charge had previously worked in the centre for a number of years as a nurse and as a clinical nurse manager. They were supported in their role by a clinical nurse manager and a team of nurses, health care assistants, catering, housekeeping, administration and maintenance staff. A second clinical nurse manager had recently left the the staff team and had not been replaced.

The inspectors reviewed management records and spoke with staff working in the designated centre on the day of the inspection. Management records were not well maintained and a number of records were not available in the centre on the day. This included the records of management meetings for June and July and the records of audits that had been completed since the last inspection. As a result the inspectors were not able to verify what level of support was in place for the person in charge and for the staff team working in the designated centre. The inspectors were told that a senior manager was available to support the person in charge however there was no evidence that this person had been in the centre in the recent past. This was a concern as the person in charge was still relatively new in their role and there was a significant amount of focus and work required to improve the levels of non compliance found on this and in the previous inspection.

Regulation 14: Persons in charge

There was a person in charge who worked full time in the designated centre. The person in charge was an experienced registered nurse who met the requirements of the regulations.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents did not include all of the information that is required under Schedule 3 of the regulations. The following information was not available for two residents who were entered into the directory:

- Address.
- Date of birth.
- Gender.
- Marital status.
- Details of next of kin.
- Details of residents' general practitioner (GP).

Judgment: Substantially compliant

Regulation 21: Records

The following Schedule 2 information was not available for two members of staff:

- A photograph of the member of staff for identification purposes.
- Two written references including a reference from the person's most recent employer.

Judgment: Not compliant

Regulation 23: Governance and management

The management structure was not clearly defined and the input form the provider's senior management team for the person in charge was not sufficient to support them in their role. This was evidenced by:

- There was only one clinical nurse manager employed in the centre which was not in line with the management structure in the statement of purpose and against which the designated centre had recently renewed their registration which stated there were two.
- There was no record of management meetings and there was no evidence of the presence of the provider or members of the provider's management team in the designated centre.
- The newly appointed supervisor was not included on the roster for three weeks in August and there was no explanation given for the absence.

The management systems that were in place did not ensure the service was safe and appropriate and consistent.. This was evidenced by:

- There were no records of audits or quality checks that had been completed since the last inspection available on the day of the inspection.
- The oversight of key areas such as staff and resident records, infection prevention and control and maintenance of the premises was not robust and inspectors found a number of non compliances that had not been identified by the senior staff working in the designated centre. These are addressed under the relevant regulations.
- The management of risks in the designated centre was not effective which meant that risks such as the relocation of the laundry to a domestic style kitchen in a nearby sheltered housing facility had not been identified and appropriate steps had not been put into place to address those risks.
- There were no records of supervisory checks being done on the housekeeping services after May 2022 and the inspectors found a number of key housekeeping tasks had not been completed on the day of the inspection. These included no paper hand towels available at hand wash basins throughout the centre, a number of hand sanitizers were empty on the morning of the inspection and bins had not been emptied in a number of areas.

The provider had not implemented the actions required to bring them into compliance with Regulations 23 and 27 and as such were in breach of Condition 4 of their current registration.

Judgment: Not compliant

Regulation 3: Statement of purpose

There was a statement of purpose however the information needed to be updated to reflect recent changes to:

- Clinical managers on the management team.
- The Conditions of Registration of the designated centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had not submitted the following notifications as required under Regulation 31:

- The three monthly notification of all the restraints that were used in the designated centre in that three month period.

- The three day notifications required to inform the Chief Inspector of two incidents of alleged verbal abuse by a member of staff towards a resident that had occurred in May and June 2022.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The provider had prepared and updated the policies and procedures as required under Schedule 5 of the regulations.

The policies and procedures were made available to the staff

Judgment: Compliant

Quality and safety

The current management systems that were in place did not ensure that the service provided to the residents was safe and of a good quality.

Inspectors found there had been some progress of improvements in fire safety since the previous inspection. These included the fitting of a new compartment boundary, the completion of fire safety works to the laundry room, and compartmentation works in the attic space However inspectors found that the provider had failed to fully address the compliance plan response for Regulation 28 Fire Precautions from the previous inspections carried out in May 2021 and April 2022. As a result a number of fire safety non-compliance and risks still existed in relation to the fire safety precautions which meant that residents were not adequately protected from the risk of fire.

Following the previous inspection in April 2022 the provider had failed to submit the centre's fire safety risk assessment (FSRA) as requested by the Chief Inspector. The inspectors were furnished with the FSRA during the course of this inspection. However a review of the report showed that the majority of the recommended actions had not been completed, nor was there a clear plan in place to address the risks identified. This was of particular concern as the report identified a number of high risk areas particularly in means of escape and fire door compartmentation. In addition the FSRA report recommended that an urgent review of the fire strategy for the building be carried out. The overall judgement of the FSRA from the May 2022 was that there were substantial fire safety risks in the building and urgent action should be taken. However the provider had failed to implement these urgent recommendations and the fire safety risks had not been mitigated.

Following the inspection in April 2022 the provider had closed the laundry due to fire risks identified on that inspection. The laundry had been relocated to an adjacent sheltered housing unit on the same site but outside of the designated centre boundaries. The new laundry area was located in the domestic style kitchen and did not have suitable facilities. For example the washing machine did not have a disinfection or a sluice wash facility and there was not sufficient room to separate clean and dirty laundry in the small domestic kitchen where the washing machine was located. Furthermore this inspection found a number of repeated non compliances in relation to infection prevention and control practices and as such residents were not adequately protected from infections.

Residents told the inspectors that they felt safe in the centre however the inspectors found that where a safeguarding concern had been raised this had not been investigated and managed in line with the centre's own safeguarding procedures. This was followed up by the person in charge after the inspection however improvements were required to ensure that staff were consistently reporting any allegations or concerns and that these were followed up appropriately by senior staff.

Staff were familiar with the residents and with their needs and preferences for care and daily routines. Staff and resident interactions were marked by respect and empathy. However one resident who displayed responsive behaviours (How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment.) was isolated away from other residents at lunch time which was overly restrictive and did not promote the resident's dignity and enable them to socialise at meal times.

The seating arrangements in the main communal areas had been revised and residents were observed sitting in small groups chatting together or taking part in the activities that were on offer. This was an improvement from the previous inspection. Overall the premises met the needs of the residents however the layout of one twin room had not been reviewed since the last inspection to ensure that it met needs of the residents and that both residents were able to store their personal belongings in their personal space.

Regulation 17: Premises

The provider did not provide premises which conformed to the matters set out in Schedule 6 of the regulations. This was evidenced by:

- In one twin room a resident was required to enter another resident's bed space to access their personal belongings.
- The laundry facilities were not adequate as the laundry had been relocated to a nearby sheltered housing unit which was outside of the designated centre.

The laundry had a domestic washing machine which did not have a disinfection wash facility.
- A hoist had not been serviced in line with the manufacturers guidelines.

Judgment: Substantially compliant

Regulation 27: Infection control

The registered provider did not ensure that procedures, consistent with the National Standards for Infection Prevention and Control in Community Services (2018) published by HIQA, were implemented by staff. This was evidenced by:

- Cleaning records and schedules did not include the cleaning of communal areas. This was a repeated finding from the previous inspection.
- The sluice room , staff changing room and some store cupboards had visible dust and debris on the floors.
- Weekly cleaning checks were not available for June and July. This had not been identified by the management team and reflected the poor level of oversight of housekeeping services in the designated centre.
- There was no cleaning schedule for residents equipment. This was a repeated finding from the previous inspection.
- Cleaning items were being stored in the sluice room. This was a repeated finding from the previous inspection.
- A store room was used to store multiple items which included a foam mattress and some items of maintenance equipment.
- Clean mop heads and cleaning cloths were being stored in an open plastic box in the sluice room.
- A trolley with full black bin bags and folded cardboard were blocking access to the hand washbasin in the sluice room.
- The relocated laundry room was not fit for purpose and did not promote infection prevention and control standards.
- A number of hand wash sinks did not have soap and paper hand towels. Staff were using a roll of blue paper to dry their hands at hand wash sinks. This did not promote good hand hygiene practices and was addressed by the person in charge on the day of the inspection.
- Two hoist slings were being stored on wall hooks. Both slings were touching the floor. A third sling was left on top of the hoist. There was no system in place to inform staff that the slings had been laundered and were ready for re-use. This was a repeated finding from the previous inspection.
- There were not sufficient foot operated bins in the centre to facilitate the safe disposal of clinical waste.
- A number of swing bins located in in residents' bedrooms and in the communal rooms and bathrooms did not have lids in place.
- Personal protective equipment (PPE) storage units were not topped up with

aprons and gloves for staff to access.
- A number of hand sanitiser units were empty and had not been replaced.

Judgment: Not compliant

Regulation 28: Fire precautions

While some fire works had progressed, the provider had failed to take adequate precautions against the risk of fire and had failed to fully implement the safety recommendations of their own fire safety risk assessment (FSRA) which had been made available to them in May 2021 and an updated FSRA in May 2022. This was a particular concern in relation to repeated non-compliance's in regulations 28 which had not been addressed by the provider following the previous inspection in April 2022.

Improvements were required by the provider to ensure adequate precautions against the risk of fire. For example:

- Hoist batteries were left charging in an area which was a protected means of escape and where residents were accommodated. This was a repeated non-compliance.
- Oxygen cylinders were stored outside in a protected cage enclosure but were not chained to ensure they were secure and kept upright.
- A gas tank was stored within an external shed surrounded by flammable items.
- A vast quantity of oxygen cylinders were also stored in an external storage container. The cylinders were not chained or secured in an upright position and were stored with building materials and machinery. This required a review by the provider.
- A newly installed gas pipe required gas pipe identification paint to be applied, protected frames and signage to indicate valves were also required.
- Assurances are required in relation to the fire-rating of AstroTurf located in the courtyard beside a smoking area.

Means of escape in the centre required a review by the provider. For example

- The FRSA included recommendations regarding bedrooms where a single direction of travel was in excess of the maximum distance allowed, these had not been implemented. This was a repeated non-compliance.
- A rear fire exit to the assembly point was via an uneven gravel surface, which had the potential to impede residents during an evacuation. This was a repeated non-compliance.

Inspectors were not assured that the emergency escape lighting, provided throughout the centre was adequate. For example:

- While external emergency lighting had been provided above fire exits,

additional lighting along external escape routes to the assembly points were required, to provide illumination for residents in the event of a night time evacuation
- Works had been carried out in relation to internal directional signage and emergency lighting. However the inspectors noted, additional directional signage was required in some corridors and a fire exit sign above a door into a dining room was not functioning. This required a review by a competent person.

Adequate arrangements were not in place for maintaining means of escape and building fabric. For example:

- It was noted in the May 2022 FSRA, that a fire exit was not wide enough and needed to be widened to facilitate residents and their evacuation aids in the event of a fire emergency.
- The inspector identified some corridors were cluttered with laundry trolleys and a fire exit was blocked with serving tables. This could impede an evacuation.
- Cables were identified to have breached a fire rated ceiling in the boiler store room. This required sealing up.

Arrangements for reviewing fire precautions required improvement by the provider. For example:

- From a review of the providers' fire drill reports and from speaking with staff on duty, inspectors were not assured that all staff were aware of the procedures to follow in the case of fire. For examples:
- Staff spoken with were unsure where the fire compartments for horizontal phased evacuation were located in the centre. This was a repeated non-compliance.

Arrangements for containment of fire in the centre required improvement by the provider. For example:

- While new fire doors had been fitted to corridors and a laundry room, as previously identified in May 2021 and April 2022 inspections, inspectors were not assured by the fire doors throughout the centre would meet the required fire performance criteria. The findings of the second inspection in April 2022 were that work had not progressed in the replacement of fire doors. Furthermore the findings of the current third inspection was that the situation remained unchanged. For example, bedroom door openings had not been widened as recommended in the FSRA, doors still remained damaged, gaps were found around doors and fire doors constructed from 6 panel pine had not been replaced.
- The attic access hatches to ceilings through the centre had not been replaced to maintain the fire-rating performance. This was a repeated non-compliance.
- A cross corridor door had still not been fitted to the long corridor to reduce the risk of smoke logging protected corridors.
- Assurances were required in relation to protected corridor, compartments and

containment. For example, it was identified in the FSRA that protected corridor walls did not fully extend up to the underside of the roof finish and a open common attic existed. Also high risk room walls did not fully extend to the roof finish. Furthermore fire stopping works previously carried out to services that breached compartment walls had deficiencies.
- The inspector noted that a self-contained unit is in use as an off-site laundry facility for the centre. The self-contained units on site are extremely close to the centre and there is a possibility of a fire spread from one roof to the other through the eaves.

Arrangements for detection in the designated centre were not fully implemented. For example:

- The fire alarm detection system did not cover the toilets off the escape routes, the en-suites from resident's bedrooms or the attic spaces. This was a significant concern as fire/smoke could be present and remain undetected in these areas. This was a repeated non-compliance.

The person in charge did not ensure that procedures to be followed in the event of a fire were adequately displayed. For example:

- The evacuation floor plans required updating, they did not indicate the newly formed compartment that reduced the capacity of the largest compartment.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspectors observed a hand over sheet with resident.s names and personal care needs left unattended on a drinks trolley in the main lounge area. The document was removed by staff when prompted by the inspectors.

Judgment: Substantially compliant

Regulation 8: Protection

Two concerns that had been made by a resident and reported to staff had not been Investigated and followed up in line with the centre's safeguarding policies and procedures.

Judgment: Not 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 19: Directory of residents	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Fearna Manor Nursing Home OSV-0000339

Inspection ID: MON-0037489

Date of inspection: 03/08/2022

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Directory of Residents has been reviewed, updated and now contains all the required information.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All staff files have been reviewed and updated to contain the required information.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations. • The Statement of Purpose has been amended to reflect the current management structure.	

• All weekly management meetings are now documented with action plans, time frames, and completion dates where relevant. • All staff on duty are included in the roster. • All audits are up to date with action plans, time frames and completion dates. • A housekeeping supervisor has been appointed and robust housekeeping audits have been put in place and are overseen by the PIC. • In addition, there are numerous daily calls between PIC, area manager and registered provider representative and always have been. These are not documented. • Once the final works have been completed around fire prevention upgrade the risk register will be updated to reflect the actual conditions. The same applies to the relocation of the laundry from one of the independent living units back to the actual laundry, which ahs had all fire upgrade works completed for several weeks

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Statement of Purpose now reflects the current management team and conditions of registration.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The PIC is aware of their responsibility to complete relevant notifications and to submit same within the required time frame.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

An ongoing programme of works is almost completed, all bedroom entrances have been widened and doors replaced. The narrow fire exit is being widened in the next 3 weeks and minor touch up works to refresh paint where damaged by the ongoing will start next week. The new bedroom doors have also to be painted. Our fire engineer is checking on the requirement to have fire detection in the ensuites. It is not a requirement of building regulations apparently and it is poor practice due to the high number of false alerts caused by steam. An ensuite is not actually regarded as a high risk area under fire regulations.
The laundry will be moved back in to the main building once all works completed even though it is ready for use now but we have to wait for all works to be completed before fire officer will certify.
The double rooms with limited access are in use as single rooms. We may actually re purpose two other rooms as single bedrooms and thereby eliminate the issue but this decision has not yet been finalized.
Most of the equipment has now been serviced.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Housekeeping and cleaning schedules have been reviewed and now include all areas i.e. sluice room, staff room and communal areas.
• Weekly cleaning schedules are maintained.
• Maintenance and provision of appropriate storage is currently taking place.
• Schedules are in place for laundering and storage of slings.
• Appropriate bins will be provided for all areas.
• PPE storage units are now topped up at the start of each shift.
• Hand sanitizer dispensers are checked and topped up daily by housekeeping staff. A supervisor has been appointed in the housekeeping department and this role is overseen by the PIC.
• All schedules have ben revised to include the communal area, sluice room and staff area cleaning.
• Schedules now in place to record the cleaning of the cleaning equipment.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector

that the actions will result in compliance with the regulations.

The upgrade works are 90% complete with all bedroom doors having being replaced.
Excess oxygen cylinders (a lot of them empty) have been returned or are awaiting collection and all will now be stored upright and chained within the cage.
Gas pipe paint will be applied to the new pipe.
Astroturf is actually fire resistant and non flammable and designed to melt under extreme heat conditions. Fire-prone commercial areas such as airport landing strips have been using artificial grass for years because of its fire resistant properties. Artificial turf is non-flammable and will not catch ablaze. In situations of extreme heat or fire, the synthetic grass blades will melt, meaning it creates a barrier to prevent the flames from spreading on the ground. It is actually in widespread use in California as a precaution against wildfires.
The original supplier is no longer in business but it has never been a concern for the fire officer on their previous visits to the centre.
The exit routes to the front and side of the building are covered by public street lighting.
An additional sensor light will be installed at the rear of the building and that will cover the remaining area.
Hoist batteries will not be charged in this area.
The gravel area will be rolled and made smoother. A paved route may also be installed there at the same time as the door is widened.
When all works are done out fire engineer will review all signage and ensure it meets requirements.
All corridors will be clutter free.
Boiler store ceiling sealed.
Staff are aware that they move the resident beyond the nearest fire door. They may not equate this to fire compartments but this has been clarified for them. New exercises to be carried out late Sept / early October.
All compartment walls in the attic extend fully to the underside of the roof and fire stopping has no deficiencies.
Fire alarm will be extended to toilets off the escape routes and the ones in the attic will be extended further. This will be done within 3 weeks and has been delayed until all other works done. The issue of fire detectors in en suites has to be clarified.
Floor plans being updated to reflect current compartments now that all work has been completed around this part.
Gas valve location signage will be installed.
There are two possibilities for dealing with the excess single direction travel distance.
The first would be to install a fire door in the external wall of each of the two rooms involved. The alternative we will probably go for is to install a fire door in the long corridor near the laundry and create another small compartment.
Fire proof metal attic access panels are on order and will be installed as soon as delivered on site.
Whilst the inspector noted that the self contained units are extremely close to the centre they are built in accordance with planning given by the Local Authority and there is nothing that can be done about their location. Furthermore, it is quite common for care centres to be built as part of or adjoining apartment blocks and other commercial premises, such as restaurants and with a similar risk of fire spreading.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
All staff reminded of GDPR guidelines and all documents must be stored appropriately.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

All incidents now reported to Chief Inspector. For the avoidance of doubt, even though an incident may not have been reported to HIQA, it would always have been investigated.

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 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	04/08/2022
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Yellow	04/08/2022
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.	Not Compliant	Orange	30/08/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre	Not Compliant	Orange	16/09/2022

	has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
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.	Not Compliant	Orange	16/09/2022
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	16/09/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	14/10/2022

Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	31/10/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/10/2022
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	31/10/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/08/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are	Not Compliant	Orange	31/08/2022

	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	15/10/2022
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.	Not Compliant	Orange	31/08/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	16/09/2022
Regulation 31(1)	Where an incident 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.	Not Compliant	Orange	10/08/2022
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each	Substantially Compliant	Yellow	10/08/2022

	quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	04/08/2022
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	04/08/2022