Report of an inspection of a Designated Centre for Older People

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>The Tower Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>Clondalkin Nursing Home Limited</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>94/95 Cappaghmore, Clondalkin, Dublin 22</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>08 February 2018</td>
</tr>
<tr>
<td>Centre ID:</td>
<td>OSV-0000110</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0020742</td>
</tr>
</tbody>
</table>
The following information has been submitted by the registered provider and describes the service they provide.

The Tower Nursing Home can accommodate up to 21 residents. The centre can provide for a range of needs for both male and female residents over 18 years of age. The care provided is general nursing with specialist skills in palliative and end-of-life care. The person in charge and the nursing staff develop residents’ care plans after admission to the centre and this plan is reviewed at three-monthly intervals. A member of staff is responsible for activities and these include reflexology, aromatherapy, walks, trips out to the community, bingo and quizzes. There are seven single bedrooms and the remaining bedrooms are twin or triple rooms. Each room varies in size. There are no restrictions on visiting hours and residents have access to a portable phone to make calls in private if they wish. Residents are consulted on how the home is run and there is access to advocacy services where required.

The following information outlines some additional data on this centre.

<table>
<thead>
<tr>
<th>Current registration end date:</th>
<th>17/06/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>19</td>
</tr>
</tbody>
</table>
How we inspect

To prepare for this inspection the inspector or 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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>08 February 2018</td>
<td>09:30hrs to 17:30hrs</td>
<td>Sarah Carter</td>
<td>Lead</td>
</tr>
<tr>
<td>08 February 2018</td>
<td>09:30hrs to 17:30hrs</td>
<td>Angela Ring</td>
<td>Support</td>
</tr>
</tbody>
</table>
Views of people who use the service

During the course of the inspection, residents spoke with inspectors and expressed their satisfaction with living in the home.

They were particularly positive when giving feedback about their recent trips and activities in the community for example the residents had been on a recent day trip to a well known hotel for afternoon tea, and all reported really enjoying it.

Residents were facilitated to have flexible routines, and said that they could get up and return to bed whenever they wished.

Other residents spoken with highlighted their satisfaction with meals and commented on the fact that there was always a good choice of food available.

They also reported feeling safe and comfortable in the home, and that they had everything they needed. Residents also spoke kindly of staff, saying they were caring and available to them and knew them well.

Relatives did not wish to speak with inspectors on the day of inspection and no HIQA questionnaires had been completed.

Capacity and capability

The centre had good leadership and management systems in place. No actions required follow up in this area in the previous inspection in October 2017.

Overall inspectors found that the governance system in the centre had a positive impact on the lives of residents as it ensured that residents' needs were considered in the management of the centre.

The centre is family run, with a committed management team that consisted of the provider representative and two experienced nurses who share the person in charge role. As this is a small centre, residents knew the management team well and the team had a very hands on approach.

The provider has a restrictive condition on their registration indicating that a reconfiguration of the physical space must take place and be completed by December 2018. Inspectors found that while the provider was not yet in breach of this condition, there were no definitive plans in place to address the deficits in the premises. These deficits included the inadequate size and layout of the twin and
triple bedrooms which impacted negatively on residents. These rooms were small and had insufficient space for furniture and personal storage. Inspectors were informed by the provider representative that there were limited resources available in the centre due to its relatively small size. This issue had been identified in previous inspections and by the management team who were actively considering their options for reducing occupancy levels while maintaining sufficient income to run the service.

The management team communicated well with each other. There were regular governance meetings with set agenda items including audit reports and health and safety items. There were monthly clinical governance meetings.

There was evidence that information gathered from audits and meetings was used to improve the quality and safety of residents' lives, for example changes had been made to the decoration of the centre following a previous inspection and residents were consulted on that change. Another action identified by the management team was for regular de-cluttering of communal space to maximise the space available for residents.

There were sufficient staff on duty on the day of inspection. The staff resource was well utilised throughout the day, and activity staff were flexible in their working hours and available outside standard hours to facilitate residents to engage in particular activities. There was an additional member of staff recently employed to work in the evenings to meet residents' needs.

Staff were observed to respond actively to resident's needs, getting them what they wanted and assisting them throughout the centre. Staff were observed to respond warmly and positively to resident's concerns about their condition or their plans for their day. Staff files reviewed indicated that staff had mandatory training in fire safety and safeguarding. In a small sample of files reviewed, some staff had commenced work prior to securing Garda Síochána (Police) vetting disclosures. This had been resolved a short time after they commenced employment and the provider representative assured inspectors that all staff currently employed had vetting disclosures.

There was a good process of induction for new staff which included mandatory training and supervision by existing staff. Some staff had completed additional training on end of life care to ensure they had the skills to meet the needs of residents at all stages of their lives.

Regulation 14: Persons in charge

There were two staff members who shared the role of the person in charge. They were both suitably qualified and experienced, as required by the regulation.
Judgment: Compliant

### Regulation 15: Staffing

Sufficient staff were rostered to meet residents' needs. A qualified nurse was always available in the centre.

Judgment: Compliant

### Regulation 16: Training and staff development

In the sample of training files reviewed, staff had completed training in the following areas; manual handling, fire safety, behaviour that challenges and safeguarding.

Judgment: Compliant

### Regulation 23: Governance and management

There was a clear management structure in the centre with clear roles and responsibilities. An annual quality and safety review had been completed, in consultation with residents for 2017.

Judgment: Compliant

### Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose however some amendments were required to ensure it was in line with regulation.

Judgment: Substantially compliant

### Regulation 21: Records

Garda Síochána (Police) vetting disclosures were not in place for a small number of
employees recruited after April 2016, however it was received a short time later.

Judgment: Substantially compliant

**Quality and safety**

The service delivered in the centre was of good quality and focused on the day-to-day needs of the residents.

The centre has a strong culture of advocacy and there was an independent advocacy service available to residents which had been used a number of times in the previous year. The provider representative and person in charge were also involved in advocating for residents rights. They had facilitated a number of recent meetings and referrals to ensure a resident had an opportunity to move home. They had also successfully advocated for residents to gain access to additional state support services the previous year.

This culture of advocating for residents and their rights was also noted in the way that staff communicated about resident’s choices and the way in which they facilitated residents throughout the day. It also meant that residents could be safe and feel confident that their best interests were being considered.

There was a comprehensive activity programme in place. Activity care planning had been identified as an area for improvement in the last inspection. Residents told inspectors they had enough to do, and were enjoying all the activities. A "key to me" document had been completed with each resident and this informed staff of some of the resident’s interests. Resident and family surveys were completed in 2017, and the findings of these had contributed to the changes in the decor of the centre and in the choice of activities offered to residents.

The spiritual and cultural needs of the residents were met in a variety of ways, such as through visiting religious orders and facilitating trips to services in the community. Through staff knowledge of the residents and their close contact with them any resident’s interests or requests were considered and organised.

However, the small size of the centre and the limited space in bedrooms and communal areas was impacting negatively on residents in the following ways:

- Some adaptive equipment required by the residents had to remain in their bedrooms or in the bathrooms due to limitations in storage space.
- Residents’ access to their personal storage space was restricted due to the layout of the bedrooms and the position of furniture.
- Few bedrooms had room for seating. This meant that residents who shared bedrooms had limited access to private space and they had to rest and relax
in the communal area which comprised of an open plan sitting and dining area. This limited their choice and independence.

- Most residents were observed to spend the majority of the day in the communal area, where they dined and engaged in group activities. However, this area was also used by staff as a passageway to stairs and a bedroom area, which interrupted residents and their group activities.
- There was an inadequate number of sluice facilities with one sluice on the first floor. Several commodes were in use on the ground floor, and needed to be brought upstairs for appropriate cleaning. This had not been identified as an area of risk in the centre.

A wide range of evidence based nursing tools and assessments were in use. Residents were observed to be in good health and their conditions were well managed. Staff were responsive to changing needs and they referred residents as required to the local psychiatry of later life team, speech and language therapist and dietetics. There were care plans in place to support specific needs, for example for residents with responsive behaviours. Good daily nursing progress notes were maintained. Overall there was a strong culture of person centred care and support for the residents and they were included in the reviews of their care plans as much as possible.

End-of-life care was provided in the centre. When a resident in a shared room required their own room for end of life care the person in charge informed inspectors that she had consulted with residents in single rooms about a temporary switch. This had occurred a couple of times in the previous year.

Records maintained for behaviours that challenge had been identified in the previous inspection as an area for improvement and this had been addressed. There was a relatively high rate of bed rail use in the centre with half of residents using them. The assessment for and the monitoring of, the use of bed rails, did not mirror the centres policy or national guidelines. In addition, the consent forms were not accurate as no dates were recorded. The person in charge undertook to review all bed rails and trial alternatives if indicated.

Safeguarding measures were in place to protect residents. Staff had received safeguarding training and the policy was in date and in line with best practice. However the provider was a pension agent for a number of residents and their process of lodging the money to the centres business account was not in line with national guidelines. The provider representative submitted an update on this issue following the inspection, and they had started to organise the correct procedure with their bank.

The centre had an up-to-date risk management policy and the daily presence of the provider representative and person in charge ensured that incidents and adverse events were appropriately managed. Health and safety meetings took place with set agendas to address issues that were affecting the residents and the centre.

Residents who wished to smoke were facilitated to do so in a secure smoking area in the rear of the property and risk assessments were completed.
Ground floor bedrooms had patio doors that led out to the front driveway and parking area. These doors were included in the fire evacuation plan but were not designated fire doors. Inspectors also noted that cars were parked close to the these doors which could impede safe exiting in an emergency.

Some areas of risk were identified. Service records for the chair lift to the first floor were not available on the day of inspection. In addition, the provider had not assessed the risks associated with residents using this chair lift.

These findings highlight some unsafe practices in the area of risk management, finance, and bed rail use.

<table>
<thead>
<tr>
<th>Regulation 12: Personal possessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>In some bedrooms residents did not have sufficient storage space for their clothes and belongings due to limitations in space and furniture.</td>
</tr>
<tr>
<td>Judgment: Not compliant</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 13: End of life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some staff had completed extra training in end of life care and there was an up to date policy in place.</td>
</tr>
<tr>
<td>Judgment: Compliant</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 17: Premises</th>
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</thead>
<tbody>
<tr>
<td>The premises was small. Bedrooms on the ground and first floor were identified as having insufficient space for residents personal belongings and they had limited seating or no seating. There were inadequate sluice facilities. There was inadequate storage spaces for adaptive equipment, bins and commodes.</td>
</tr>
<tr>
<td>Judgment: Not compliant</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 26: Risk management</th>
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</thead>
<tbody>
<tr>
<td>The centre had a risk management policy. There was a register of risk in the centre</td>
</tr>
</tbody>
</table>
but some hazards had not been identified by the provider as per the centre policy, for example the use of the chair lift.

Judgment: Not compliant

Regulation 28: Fire precautions

Ground floor bedrooms had patio doors to the outside, which were included in the fire plan but were not designated fire doors. Vehicles were parked close to these exit doors.

Staff were up to date with their fire training, and fire equipment had been serviced as required by the regulations. There were personal evacuation plans in place for residents.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The inspectors viewed a sample of care plans and found that they reflected the residents needs and recommendations of visiting professionals. There was evidence of resident and family involvement in development of these care plans.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a choice of GPs and visiting professionals if required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Care plans reviewed indicated an appropriate record of responsive behaviour was kept. The centre kept a register of restraint and also documented when information was given to families. However the use of restraint was not in line with best practice.
### Regulation 9: Residents' rights

The provider actively promoted advocacy and residents were consulted with about the running of the centre. There was a comprehensive activity plan in place.

There was limited communal space and limited space in some shared bedrooms impacted on residents ability to conduct personal activities in private. Seating was absent or insufficient in some shared bedrooms.

### Regulation 8: Protection

Staff were trained in the prevention and detection of abuse.

The centre was a pension agent for some residents however a separate client account for residents pension was not in place.

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Judgment: Not compliant

Judgment: Not compliant

Judgment: Not compliant
Appendix 1 - Full list of regulations considered under each dimension

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 14: Persons in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 21: Records</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 12: Personal possessions</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 13: End of life</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and care plan</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 7: Managing behaviour that is challenging</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 9: Residents' rights</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Not compliant</td>
</tr>
</tbody>
</table>
Compliance Plan for The Tower Nursing Home
OSV-0000110

Inspection ID: MON-0020742

Date of inspection: 08/02/2018

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. Specific to that regulation, Measurable so that they can monitor progress, Achievable and Realistic, and Time 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:

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Substantially Compliant</td>
</tr>
</tbody>
</table>

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

The Registered Provider of the Tower Nursing Home, Patricia Robinson, will:

1. Prepare in writing a statement of purpose containing the information set out in Schedule 1.
2. This document will be sent to the Authority by 11 May 2018.
3. The registered provider and management team will review and revise the statement of purpose at intervals of not less than one year.
4. The review and revision of SOP will be reflected in the annual checklist plan for clinical management agenda, and will be reflected and recorded in monthly Clinical management meeting minutes.

| Regulation 21: Records             | Substantially Compliant         |

Outline how you are going to come into compliance with Regulation 21: Records:

The registered provider will:

1. Forward all Garda vetting forms will be returned to the Authority by close of business Friday 11 May 2018.
2. 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.
3. Record keeping as per regulation 21, will be included on monthly agenda checklist for clinical management meetings 4 May 2018.
<table>
<thead>
<tr>
<th>Regulation 12: Personal possessions</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 12: Personal possessions: The person in charge will, in so far as is reasonably practical: 1. ensure that all residents have access to and retains control over his or her personal property, possessions and finances and, in particular a resident uses and retains control over his or her clothes. 2. Rooms have been re-configurated in terms of bed reduction, to allow for more space and privacy for the resident. This change in bedroom space has allowed adequate space to store and maintain resident clothes and other personal possessions. 3. Continued reconfiguration of twin rooms to allow for more space for current residents. 31 August 2018. 4. As of 1 April 2018, Berendsen laundry services, have been employed by the Tower Nursing Home to label, launder and return individual bag of laundry to each resident. 5. (See appendix 1 for room configuration)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 17: Premises</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 17: Premises: 1. (see appendix 1 for bedroom reconfiguration) 2. Downstairs bedrooms will include seating for residents 3. Adaptive equipment, bins and commodes will be reconfigured into storage space. 30 August 2018. 4. Sluice facilities will be provided downstairs. DECEMBER 2018.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 26: Risk management</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 26: Risk management: The registered provider will: 1. set out the risk management policy (Sch 5) which will include (a) hazard identification and assessment of risks throughout the Tower Nursing Home (b) the measures and actions will be in place to control the risks identified; (c) the measures and actions in place to control the following specified risks: (i) abuse (ii) the unexplained absence of any resident (iii) accidental injury to residents, visitors or staff; (iv) aggression and violence; (v) self-harm; (d) arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents. 2. The use of chair lift and other electrical /non electrical equipment. 3. The registered provider shall ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to</td>
<td></td>
</tr>
</tbody>
</table>
Outline how you are going to come into compliance with **Regulation 28: Fire precautions**:

The registered provider has:

1. taken adequate precautions against the risk of fire, and currently provides suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings; as confirmed by the Chief Fire officer and approved documentation.

2. The current provision of adequate means of escape, including emergency lighting, will be enhanced with the provision of yellow box emergency warning on the ground at car park, which will alert all car drivers to the fact that they cannot park in designated emergency space outside fire escapes on the ground floor.

3. 4 Evacuation light up signs for 4 emergency doors have been ordered and will be fitted by 31st July 2018.

Outline how you are going to come into compliance with **Regulation 7: Managing behaviour that is challenging**:

The registered provider and PIC's will ensure:

1. that where restraint is used, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

2. The PIC's will review restraint individual risk assessment care plan procedures every 3 months

3. The PIC's will review restraint practices in accordance with national policy.

4. The PIC's will review restraint documentation 3 months

5. New care plans will include revised restraint documentation. 31 August 2018

6. The word ‘consent’ has been revised to family members have been ‘informed & made aware’ of restraint procedures for the resident in need of restraint. Completed.

7. Restraint is included as an agenda item on the monthly clinical management meetings. Completed.

Outline how you are going to come into compliance with **Regulation 9: Residents' rights**:

The registered provider will

1. provide more opportunity for residents to conduct personal activities in private. This will be achieved through the reduction of residents. Management will not admit any new resident after 19th June in 2018. The current resident status stands at 18. In process and to be completed by 31 Dec 2018.

2. The Statement of purpose will be revised to reflect the current number of residents. 31 Dec 2018
Outline how you are going to come into compliance with Regulation 8: Protection:

The registered provider shall take all reasonable measures to protect residents from abuse;

1. Staff training in relation to the detection and prevention of and responses to abuse is ongoing and included on the annual training matrix.
2. Resident personal finances policy document has been rolled out to all staff and a robust documentation of residents monies is audited 3 monthly.
3. A meeting was held with BOI, as a matter of accounting for residents monies being held by the pension agent on their behalf. The need to set up a savings account within the Provider account was discussed. The registered provider is awaiting confirmation from BOI as to the correct way to consider safeguarding clients monies in this way.
4. Registered provider will have detailed consideration on this by 30 June 2018.
5. The registered provider has also contacted the social welfare for further advice on this matter and to ensure transparency.
6. The company accountant has been informed of this matter of protection of resident monies and is acting accordingly.

**Appendix 1**

<table>
<thead>
<tr>
<th>Reconfiguration of bedrooms</th>
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</thead>
<tbody>
<tr>
<td><strong>Reduction of beds stages:</strong></td>
</tr>
<tr>
<td>Room 2 – twin room reduced to single room occupancy</td>
</tr>
<tr>
<td>Room 8- twin room will be reduced to single (with the onset of natural death of 1 resident occupier)</td>
</tr>
<tr>
<td>Room 7 – to be reconfigured to comfortably accommodate 2 residents</td>
</tr>
<tr>
<td>Room 12 to be reconfigured to comfortably accommodate 2 residents</td>
</tr>
<tr>
<td>Room 10- triple room to be reduced to twin bed occupancy (with the onset of natural cause of death for 1 resident)</td>
</tr>
<tr>
<td>Room 13 – Triple room to be reduced to twin bed occupancy (with the onset of natural cause of death for 1 resident)</td>
</tr>
</tbody>
</table>

*The reduction of residents will in turn, allow for more space and privacy in bedrooms. The reduction of residents will also impact on the communal space areas of dining and lounge.*

*Future appraisal of finance may allow for an increase in bedroom space through building refurbishment and the re-instatement of the 4/6 beds.*
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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 12(c)</td>
<td>The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30 August 2018</td>
</tr>
<tr>
<td>Regulation 21(1)</td>
<td>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.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>11 May 2018</td>
</tr>
<tr>
<td>Regulation 26(1)(a)</td>
<td>The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31 May 2018</td>
</tr>
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<tr>
<td>Regulation 28(1)(b)</td>
<td>The registered provider shall provide adequate means of escape, including emergency lighting.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31 August 2018</td>
</tr>
<tr>
<td>Regulation 28(2)(iv)</td>
<td>The registered provider shall make adequate arrangements for evacuating, where necessary, in the event of fire, of all persons in the designated centre and safe placement of residents.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31 August 2018</td>
</tr>
<tr>
<td>Regulation 7(3)</td>
<td>The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>8 May 2018</td>
</tr>
<tr>
<td>Regulation 8(1)</td>
<td>The registered provider shall take all reasonable measures to</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30 June 2018</td>
</tr>
<tr>
<td>Regulation 9(2)(a)</td>
<td>The registered provider shall provide for residents facilities for occupation and recreation.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31 Dec 2018</td>
</tr>
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<tr>
<td>Regulation 9(3)(a)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31 Dec 2018</td>
</tr>
<tr>
<td>Regulation 9(3)(b)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31 Dec 2018</td>
</tr>
</tbody>
</table>