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:	Lusk Community Unit
Name of provider:	Health Service Executive
Address of centre:	Station Road, Lusk, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	08 June 2022
Centre ID:	OSV-0000505
Fieldwork ID:	MON-0036541

About the designated centre

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

Lusk Community unit was purpose built on a green field site adjacent to Lusk village in North County Dublin. It was opened on 10th December 2001 as part on the Health Service Executive long term plan to provide care for older persons adjacent to or within their own community.

Lusk Community Unit is a 50 bedded unit providing 45 residential care beds and 5 respite care beds for the over sixty five age group. Residents are accommodated on two units with twenty five patients on each ward. Individuals who use respite services are accommodated in single and twin rooms. Due to their high dependency, residents are accommodated in shared facilities of two bedded rooms. All rooms have individual call bells, accessible light switches and television. A day care service is provided Monday to Friday each week.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	30

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 8 June 2022	09:35hrs to 17:05hrs	Arlene Ryan	Lead
Wednesday 8 June 2022	09:35hrs to 17:05hrs	Helena Budzicz	Support

What residents told us and what inspectors observed

On the day of inspection, the inspectors were met by the reception staff and the person in charge. Temperatures and signs and symptoms of COVID-19 were monitored before entering the nursing home.

The inspectors did a walk around the nursing home accompanied by the assistant director of nursing. During this tour of the nursing home, inspectors had the chance to speak with some residents and staff and were able to observe the residents' lived experiences in the nursing home. The nursing home was divided into two units, Rush and Lusk.

The inspectors observed that most of the residents' rooms contained personal items such as pictures, photographs and other personal items. The residents appeared content in their surroundings and pleased with their rooms. Each resident had a personal evacuation plan to assist staff with evacuation in the event of an emergency. Staff were seen to be available throughout the day to assist residents with any needs.

Some staff were observed interacting with residents in a kind and gentle way. The residents responded well to the staff and appeared relaxed in their company. A large proportion of residents were unable to inform the inspectors of their thoughts and feelings about living in the centre due to cognitive impairments; however, they appeared happy and content in their interactions. Residents were well-groomed, and clothing was clean. The staff were knowledgeable of the residents' likes and dislikes and were seen to be interacting well.

The majority of residents were in the Rush unit. The Rush Unit was quite spacious, and many residents were seen in one of the multiple communal areas in the centre. There was a large dining room, large sitting room, a lounge area, oratory and Snoezlen room (a multisensory, therapeutic environment that soothes, stimulates and helps reduce agitation and anxiety), which the residents could utilise. Access to two central courtyards was unrestricted in this unit, however, the courtyards were in need of maintenance and upkeep. Therefore, residents could not safely use and enjoy the outdoors and residents were not observed using these spaces on the day of inspection.

The Lusk unit had been separated by access-controlled doors, and those residents admitted for respite care were living in this unit which had been reconfigured to facilitate them. In order to reduce the risk of transmission of COVID-19 for both the long-term care residents and respite residents, this segregation had been implemented. Some bedrooms in the Lusk unit had been converted into a dining room, small sitting room and store rooms. Therefore the residents receiving respite care did not have access to the spacious living spaces in the Rush unit. The outside space on the Lusk unit was accessible through a fire door, but this was locked at the time of inspection. The garden area also required maintenance to allow residents to

enjoy this space.

The inspectors observed the dining experience during lunchtime in the respite unit, Lusk. The dining room was located in a converted store room. The inspectors saw that there was a window up high on the wall; therefore the residents did not have a view outside to enhance their dining experience. Furthermore, the choice of condiments and drinks were not available to the residents living in the Lusk unit during lunch mealtime.

There was a schedule of activities available to all the residents and included group activities and individual resident activities. During the morning, some residents were seen participating with an art therapist who provides this activity on a regular basis. Staff were engaging with residents on a one-to-one basis with a variety of activities.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

There was a clearly defined management structure in place that identified the roles and responsibilities of staff working in the centre. While there were management systems in place and some evidence of good nursing practices there were significant concerns in respect of the governance and management in the centre. The registered provider had failed to notify the Chief Inspector of changes to the designation of rooms and areas of the designated centre and as a result, was operating outside its condition of registration. An urgent compliance plan letter was issued to the provider after the inspection to address this issue immediately in order to come into compliance with regulation requirements.

An application to vary the condition of registration was received following the inspection. In addition the inspection found that further action was required under the following regulations; Regulation 4; Written Policies and procedures, Regulation 19; Directory of Residents, Regulation 23; Governance and Management, Regulation 9; Residents Rights, Regulation 17; Premises, and Regulation 27; Infection Control.

The purpose of this unannounced inspection was to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The Health Services Executive (HSE) is the registered provider. The centre is registered for 50 residents, and on the day of the inspection, there were 30 residents living in the centre, five of which were receiving respite care in the Lusk Unit.

Inspectors noted that the Lusk Unit had been completely separated from the Rush unit. The the decision to segregate the centre was to support infection prevention

and control in the centre, and the registered provider had consulted with public health prior to taking these decision. The registered provider had converted a number of registered bedrooms to be used for other purposes, and this was not in line with the centre's statement of purpose and floor plans submitted at the time of registration.

There was a clear management structure in place. There was an assistant director of nursing in charge on the day of the inspection who was supported by; the general manager, a clinical nurse manager, a team of nurses, healthcare assistants, catering staff, housekeeping staff, laundry staff, administration staff, a porter and complementary therapist. Staff vacancies were low, and the management team were actively recruiting for any vacant positions.

The staffing numbers and skill mix on this inspection were adequate to meet the needs of the residents, given their care needs and the layout of the building. Staff were visible on the floor, attending to residents' needs in a respectful manner throughout this inspection. In addition to the assistant director of nursing, there was a clinical nurse manager on duty on the day of inspection. The supervision of staff was good, which meant a high standard of care was delivered by staff.

Staff informed the inspector that training was available to them, and this was evidenced by a training record which was maintained to ensure that staff were up-to-date with any training requirements. A detailed education plan was available for review by the inspectors which included mandatory training and other training relevant to the staff's individual roles.

There was a list of residents living in the centre available to inspectors, including details of their next of kin and general practitioner (GP), but there was no comprehensive directory of residents in line with the Schedule 3 of the Health Act 2007.

All Schedule 5 policies were available for review. They were detailed enough to inform and guide staff practice when supporting residents and to ensure the safe operation of the service; however, a number of these policies had not been updated within the prescribed time frame.

There was a copy of the complaints procedure available on the notice board. The level of complaints was low, and each was recorded and investigated in line with the centre's policy. There was one open complaint on file. The complainant's satisfaction was recorded when closing the complaints.

Regulation 15: Staffing

The staffing and skill mix of staff on duty were appropriate to meet the needs of residents. There was a registered general nurse on duty at all times. All nurses on duty had a valid Nursing and Midwifery Board of Ireland (NMBI) registration.

Judgment: Compliant

Regulation 16: Training and staff development

A review of staff training records showed that staff had received training and staff informed inspectors that they were facilitated to attend mandatory training and other training appropriate to their roles. All staff had completed safeguarding training. There was a schedule of training in place to support staff.

Judgment: Compliant

Regulation 19: Directory of residents

There was no comprehensive directory of residents containing all the information specified in Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres For Older People) Regulations 2013.

Judgment: Not compliant

Regulation 21: Records

The sample of staff files reviewed showed that they were maintained in line with Schedule 2 of the regulations. Each staff file reviewed had a completed An Garda Síochána (police) vetting requests prior to commencing employment.

Judgment: Compliant

Regulation 22: Insurance

The centre had a state indemnity confirmation statement for the nursing home.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider was found not operating within the confines of their registration conditions and statement of purpose and had failed to notify the Chief inspector of changes to the designated purpose of a number of areas in the designated centre. The registered provider had failed to complete an application to vary conditions 1 and 3, with an up-to-date statement of purpose and floor plan, for the designated centre's registration following the reconfiguration of Lusk Unit.

Some of the management systems in place to oversee the effective running of the service were not sufficiently robust to provide effective oversight of service provision; This included oversight of audit for premises and infection control practices to ensure that they effectively identified areas for improvement. Many audits in place were in the form of checklists and there was no clear record of how these informed the quality improvement plan of the centre.

Many of the risk identified during the inspection had not been identified in the designated centre's risk register, for example maintenance, premises and infection control risks.

The annual quality and safety report did not include details of resident and family involvement in the running of the centre.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of contracts for the provision of services were examined. These included details of the service provided and the fees to be charged for such services. The resident's room number was also included in the contract.

Judgment: Compliant

Regulation 34: Complaints procedure

A copy of the complaints procedure was on display in the reception area. The policy was up to date and identified the designated person to deal with complaints. It also outlined the complaints process.

Judgment: Compliant

Regulation 4: Written policies and procedures

A number of Schedule 5 policies had not been updated within the prescribed time frame.

Judgment: Substantially compliant

Quality and safety

Overall, residents received a good standard of service and care in the designated centre. There was a high standard of care intervention which ensured that residents had timely access to both health and social care supports. However, some urgent works which posed immediate risks to residents' health and safety and to support residents' rights to enjoy the outside space in the garden were required within the centre as detailed under Regulation 17: Premises.

A sample of residents' records showed that a pre-admission assessment had been completed prior to the residents' admission, followed by a comprehensive nursing assessment on the day of admission. A range of validated assessment tools was used to inform the care plans developed within 48 hours of admission. A selection of wound care plans were reviewed and were found to be very well organised, reviewed regularly and updated. There was clear documentation of wound progress and healing.

There was evidence of residents receiving medical and allied health care professional services. There were good arrangements in place for general practitioner (GP) cover with a GP attending the centre most weekdays. The GP met the inspectors on the day of the inspection. The nursing staff had good knowledge and experience in pressure ulcer and wound care.

The provider had systems in place to monitor restrictive practices to ensure that they were appropriate, and there was good evidence to show that the centre was working towards a restraint-free environment in line with local and national policy. Safeguarding practices and care plans were in place, and staff had completed their safeguarding training. Staff were knowledgeable about the measures to protect residents from abuse.

Overall the premises were clean, however there were significant concerns in respect of the segregation and layout of the centre. Laundry facilities were provided on-site for the residents' clothing. Bed linens and towels were sent off-site for washing. The laundry assistant explained the process for this service to the inspectors. Clothing was labelled with the resident's names to prevent it from getting lost. Residents' clothing was returned to the residents' rooms once cleaned. The laundry rooms was clean and organised.

Residents were facilitated to exercise their civil, political and religious rights. Residents had access to radio, television, and newspapers, both local and national, together with access to the Internet. There was an activities schedule in place.

Residents were seen to participate in activities, some actively and some passively, depending on their individual preferences and capabilities. The centre had purchased a number of smart speakers allowing residents and staff to select different genres of music depending on the residents' preferences. Nevertheless, inspectors observed practices which significantly impacted on resident's rights and dignity.

Visiting arrangements were in line with the national guidance. Although the inspectors did not meet any visitors on the day of inspection, they were aware that there were no restrictions in place in the entrance hall. A log of visitors to the centre was in place.

Regulation 11: Visits

Visits were facilitated in line with the current guidance. Inspectors observed that the visitors were risk assessed prior to entering the centre.

Judgment: Compliant

Regulation 17: Premises

As a result of segregating the two units, the registered provider did not ensure that the premises were appropriate to the number and needs of residents and in accordance with the Statement of purpose prepared under Regulation 3. Residents in the Lusk unit did not have access to appropriate communal spaces (dining and sitting room facilities) and independent access to outdoor space.

The registered provider did not provide premises which conformed to the matters set out in Schedule 6. The following issues were identified:

- The flooring was heavily marked or damaged in multiple rooms and throughout the centre, posing a trip hazard and not supporting effective cleaning processes.
- The lids were not placed on containers containing chemicals in the cleaner's room, posing an exposure risk.
- The courtyards and gardens were not maintained to an acceptable standard. The grass had not been cut, there were weeds in between the paving, and some paving was uneven, preventing residents from using these spaces safely.
- There were ongoing maintenance requirements in the centre. All jobs were logged centrally, and maintenance was attended to when requested; however, maintenance staff were not on-site frequently enough to address all issues.
- There were holes in multiple ceilings, posing a risk of smoke or flames

travelling in the event of a fire.
- Visible signs of water damage/ leaks on ceilings and floors pose a risk to infection control practices.
- Some bathroom vents were not in working order.

Judgment: Not compliant

Regulation 27: Infection control

While, overall the centre was clean and staff were knowledgeable in infection prevention and control, a number of issues were identified that could potentially have a negative impact on infection control processes and procedures :

- The desk at the nurses' station was not clean. There was dust and debris visible behind some filing trays. The surfaces at some of the nurses' stations were worn and did not support effective cleaning.
- Multiple pieces of furniture and equipment had damaged surfaces which prevented effective cleaning. Rust was noted on several pieces of equipment; on the chemical dispenser, or on multiple shower chairs and handrails in bathrooms, kitchen trolleys and trays were worn and rusty preventing effective cleaning.
- Seals around toilet bases and at the back of sinks were damaged and did not allow for effective cleaning.
- The chlorine-based cleaning solution was in use despite no positive cases of COVID-19 in the centre.- this was not in line with best practice and current guidance
- Refrigerator temperatures in the medication room were not checked routinely, and some were dirty, posing a risk of contamination to contents.
- Storage practices, including locations of stored items and appropriate shelving, required review to allow for effective cleaning of the store rooms. There was evidence of inappropriate storage of clean and dirty items in the same room, creating the risk of cross-contamination.
- There was no clear process for the identification of clean items, including equipment, linens, and hoist slings, in order to prevent cross-contamination of these clean items.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of eight residents' files and found evidence that validated assessment tools were used to assess residents' dependency needs, risk of falls, risk of impaired skin integrity and nutritional risk screening. Mobility

management, wound care plans, and personal care plans were in place to direct the staff to assist residents to meet those needs. Wounds were managed well, and appropriate equipment to meet their assessed needs, such as pressure-relieving equipment or manual handling equipment.

Judgment: Compliant

Regulation 6: Health care

There were good standards of evidence-based health care provided in this centre. General practitioners (GPs) and medical consultants such as psychiatrists of older age and geriatricians attended the centre to support the residents' needs.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a low incidence of restraint usage in the centre. Restraint was being effectively monitored by the management team. Enabler care plans reflected the use of restraint in the centre and supported residents with their preferences and choices. There was evidence that residents who presented with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were responded to in a very dignified and person-centred way by the staff using effective de-escalation methods.

Judgment: Compliant

Regulation 8: Protection

The inspectors found that measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures or suspicions of abuse.

The centre was a pension agent for three residents, and adequate banking arrangements were in place for these residents.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors found that while overall there were good practices in respect of access to activities, opportunities for stimulation and engagement in the Rush unit, the decision to segregate the residents into two units significantly impacted the rights of the residents in the Lusk unit. These residents did not have access to outdoor space and dignified facilities such as comfortable communal areas and dining facilities. Furthermore their dining experience was suboptimal, with limited access to condiments and drinks.

Residents rights to dignity was also not consistently upheld as inspectors observed institutionalised practices in the management of personal laundry. For example, inspectors observed shared items of clothing such as hip protectors, which did not have individual residents' name on them. This resulted in the use and reuse of laundered hip protectors between residents. This practice is not upholding residents' dignity rights.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Not compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Lusk Community Unit OSV-0000505

Inspection ID: MON-0036541

Date of inspection: 08/06/2022

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 19: Directory of residents</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 19: Directory of residents:
1) The Designated Centre's directory of residents was updated to include all the information specified in Schedule 3 of Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Completed on 13 July 2022.

2) When there is a new admission to the Designated Centre, the directory of residents will be dynamically updated by the assigned administration staff.

3) Every quarter the directory of residents will be reviewed by the Person in charge (PIC) to ensure compliance with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
1) In line with the Designated Center's Statement of Purpose and Function respite services will be fully reintegrated within the centre. Completed on 18 July 2022.

2) This is in line with public health advice and will be supported and guided by the infection prevention and control specialist nurse.

3) Education sessions on the Health Act and Regulatory handbook (July 2022) will be delivered to the Person in charge, PPIM and to Registered Provider Representative. To be</td></tr>
</table>

completed by 31 October 2022.

4) Risk register for the Designated Centre was updated to include all identified risks and actions. These risks and actions will be reviewed and monitored monthly.

5) All unit governance committees will report to the quality and patient safety committee for the community nursing units.

6) All audit activity will be tracked and monitored by the quality, patient safety committee.

7) The Designated Centre will implement a monthly quality and patient safety walk around. Every quarter this will include senior management and Quality Patient Safety representative.

8) The quality and safety report template will be revised and will include a section on the involvement of residents and their families in the running of the center. This information will be collected through resident council meetings, feedback surveys, complaints and compliments.

9) A quality improvement plan will be drafted for the Designated Centre and include the compliance plan for the recent inspection. Initially the compliance plan will be monitored and evaluated through a monthly compliance meeting. To commence by 31 August 2022.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
1) All policies were reviewed and updated in line with the prescribed timeframe. Completed on 08 July 2022.

2) Monitoring, review and updating of policies will be coordinated through the Designated Centre's quarterly policy committee meeting.

3) The policy committee will report to overarching Quality and Patient Safety Committee for Dublin North City and County Community Nursing Units.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: 1) On 11 July 2022 the PIC and Registered Provider Representative (RPR) completed a walk around of the Designated Centre's premises with maintenance and estate manager. A list of immediate actions was collated and requests submitted to the maintenance department - Flooring project tendered…………completion 30 November 2022 - Bathroom rails & seals………………completion 31 October 2022 - Bathroom vents cleaned……………completion 31 July 2022 - Nurses station desks re-varnish…completion 31 August 2022 - Ceiling tile replacement……………completion 31 September 2022 2) It has been agreed with the maintenance department and estates to implement a planned preventative maintenance programme. 3) The incumbent landscaping company have reviewed the scope of service which has been added to the maintenance contract. 4) The PIC will meet the maintenance department on a monthly basis and any issues not resolved will be escalated to Director of Nursing and RPR. The first meeting occurred on 11 July 2022. 5) All staff have been reminded of their responsibility to identify and report any risk and maintenance issues that become apparent on a daily basis. 6) Building facilities maintenance audit in line with SFG-20 will be developed, monitored and signed off by the PIC and maintenance manager. First audit to be completed in August 2022. 7) Lids replaced on the chemical containers on the day of inspection. PIC has ensured that the cleaning supervisor and staff were made aware of the risks. Action completed on 9 June 2022.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: 1) Cleaning schedules have been reviewed and additional accountability controls have been included. To be completed on 22 July 2022. 2) Equipment maintenance issues to be highlighted at handover. New equipment was ordered on 14/07/22, which include kitchen trolley, trays, shower trolley. 3) Training in relation to cleaning products and solutions and methods commenced on 20	

July 2022.

4) Toilets and washing facilities have been inspected by the maintenance manager and included on the centre's programme of works.

5) Refrigerator temperatures are checked daily and cleaned weekly and cross checked weekly by CNM2. Completed on 8 July 2022.

6) Each resident will have their own personal hoist sling with an individual cleaning schedule and stored appropriately. To be completed by 30 September 2022.

7) The environment will be reviewed and decluttered by 30 August 2022. This will be monitored by the CNMs on a daily basis.

8) With reintegration of the centre, storage facilities have been reinstated and a stock management system introduced. To be completed by 30 August 2022.

9) The Infection Prevention and Control nurse will attend the handover safety pause once a week.

10) IPC nurse will participate in the centre's monthly quality and safety walk around

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1) The Designated Centre will be reintegrated, with respite and long term residents' care and support needs provided across the full premises. This will ensure access to outdoor space, comfortable communal areas and opportunity for an optimal dining experience for all residents. This will incorporate access to drinks and provision of all condiments at mealtimes. Completed on 18 July 2022.

2) All Hip protectors are now labelled and designated for individual use only. Once laundered hip protectors are returned to and appropriately stored in each resident's personal possessions. Completed on 12 July 2022.

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(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	18/07/2022
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	30/11/2022
Regulation 19(1)	The registered provider shall establish and maintain a Directory of Residents in a	Not Compliant	Orange	13/07/2022

	designated centre.			
Regulation 19(2)	The directory established under paragraph (1) shall be available, when requested, to the Chief Inspector.	Not Compliant	Orange	13/07/2022
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Orange	13/07/2022
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	31/10/2022
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.	Substantially Compliant	Yellow	31/10/2022
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	Substantially Compliant	Yellow	30/09/2022

	Authority are implemented by staff.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	08/07/2022
Regulation 9(3)(a)	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.	Not Compliant	Orange	18/07/2022