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:	Dalkey Community Unit for Older Persons
Name of provider:	Health Service Executive
Address of centre:	Kilbegnet Close, Dalkey, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	28 August 2024
Centre ID:	OSV-0000510
Fieldwork ID:	MON-0044650

About the designated centre

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

The centre is based in South Dublin and is run by the Health Service Executive. The centre is close to bus routes no 29 and no 8 and to the dart service. It was purpose built in 2000 and provides 34 registered beds. There is also a day care service run on the same premises. The staff team includes nurses and healthcare assistants at all times, and access to a range of allied professionals such as physiotherapy and occupational therapy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	33

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 28 August 2024	09:05hrs to 16:55hrs	Lisa Walsh	Lead
Thursday 29 August 2024	08:15hrs to 14:10hrs	Lisa Walsh	Lead

What residents told us and what inspectors observed

The inspector greeted and chatted to a number of residents in the centre to gain an insight into their experiences of living in Dalkey Community Unit for Older Persons. The inspector also spent time in the communal rooms observing resident and staff engagement. Overall, feedback from residents was that they liked living in the centre. Residents said the staff were "very nice and very good". Even with the praise for staff members individually, all residents spoken with expressed their view that there needed to be more staff on duty and gave examples of waiting extended times for care and attention. In addition, they said that there was a lot of agency staff in use in the centre and they did not know them or their care needs as well.

The inspector arrived at the centre in the morning and was met by the clinical nurse manager (CNM) in the absence of the person in charge. Following an introductory meeting, the inspector was guided on a tour of the centre. The person in charge later attended the centre and met with the inspector.

The centre is set out over two levels, with resident accommodation on the first floor. The centre was located in the heart of Dalkey and some of the residents bedrooms had pleasant views of the nearby historic castle. The centre has 36 registered beds, which are separated into two units, hill view and castle view units. Following completion of renovations, the hill view unit, had 12 single occupancy bedrooms, six of which have en-suite facilities and six which have access to shared communal bathrooms, three double rooms, which all have en-suites facilities and two triple bedrooms, with access to shared communal bathrooms. The castle view unit, was configured to accommodate 12 residents, with two rooms currently occupied as twin bedrooms at residents requests and eight single occupied rooms. The two twin rooms will be converted to single bedrooms, to complete the providers extensive renovations to ensure the rooms achieve compliance with Regulation 17; Premises. During the inspection, the inspector was informed that a resident in one of the twin rooms is due to move to another room. Following this, the castle view unit will have one twin room and 9 single occupancy bedrooms. The total registered beds available will also reduce to 35. Once the last twin room in castle view is converted to to a single room, the registered beds available will then reduce to 34.

Residents' bedrooms were personalised and homely. Residents in single bedrooms had a pleasant space to relax in. In general, the size and layout of the bedroom accommodation were appropriate for resident needs. However, the configuration of one of the bays in the two triple room bedrooms did not afford residents enough space to have a chair so they could conduct task such as dressing in private. On the days of inspection these bays in were unoccupied. On the previous inspection, it was observed that the triple bedrooms in the hill view unit had limited wardrobe storage. In the compliance plan, the registered provider had committed to adding additional storage for residents personal belongings. However, no additional storage was available in the triple rooms. Three small glass panels were present on all bedroom doors and some of the panels were missing an opaque film to provide privacy. The

inspector was informed that an opaque film had been applied to all glass panels since the last inspection. The inspector could see into residents' bedrooms while they were receiving personal care.

In general, the premises was found to be maintained to a good standard internally and externally. However, some hoists were seen to be stored in communal toilets, which is a repeat finding. It was also observed that the laundry room required attention, this will be discussed later in the report. The ground floor accommodated a day service, laundry, administrative offices, storage and staff facilities. As well as resident accommodation on the first floor, there was also a large dining room, smoking room and a sitting room next to an oratory. There was a partition between the oratory and sitting room which could be opened to create a bigger communal space. There were two outdoor patio areas available to residents. These areas were well maintained and contained safe paving and seating areas with chairs for residents to use when spending time outside. The inspector was informed that a smoking shelter will be placed in large patio area.

Residents and their loved ones reported to the inspector that staff were kind, patient and "work very hard" to support residents, however, "there was not enough of them". For example, residents told the inspector that staff levels were insufficient resulting at times in waits for assistance of up to 30 minutes to attend to the bathroom. Some residents reported that there was insufficient staff to assist with showering on certain days, with the inspector observing a resident waiting until 11.20am for a shower since 8am on the first day of inspection. Residents reported there were often delays in night time staff answering call bells and one resident spoke about having to shout for assistance in order for staff to answer their call bell. Residents spoken with also told the inspector that there was different staff everyday and that there was a lot of agency staff used in the centre. Some residents said that the agency staff do not know them and their care needs, which impacts in how the care they received is delivered. Visitors who spoke to the inspector also reflected that the staff treated the residents with respect, with one visitor saying "staff treat my mother like their own". They also expressed concerns regarding staffing levels and the use of too many agency staff saying that the agency staff "don't know the little things" about the residents. Another visitor said "staff are outstanding in their kindness but they seem to be short staffed".

The inspector observed the lunchtime experience in the large bright dining room on the first floor. Residents meals were prepared in the kitchen on the ground floor and then transported in a bain marie to the dining room and served. Menus were on display and there was a choice of meals being offered to residents. Residents were complementary of the food with some spoken with saying the food was "very good" and "great". Residents who required assistance at mealtimes were observed to receive this support in a respectful and dignified manner. There was positive interaction noted at mealtimes and throughout the day between staff and residents.

Residents were neatly dressed and observed to be up and about in the various areas of the centre throughout the two days of inspection. On the morning of the first day of inspection, some residents were gathered together in the sitting room for a facilitated reminiscence session about their past professions. Residents were making

a collage while chatting and having tea and biscuits, which they seemed to really enjoy and engage with. Other residents were having a massage with aromatherapy. In the afternoon on the second day of inspection, residents and their visitors were in the sitting room chatting while doing a quiz. During this an ice-cream trolley was brought around to all the residents in the centre which brought an element of good fun to the day. Other residents were also in the oratory listening to music and making a tapestry. Residents reported enjoying the activities available to them with one resident saying " there was plenty to do".

The following two sections of the report present the findings of this inspection concerning governance and management arrangements in place in the centre and how these arrangements impacted 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

Overall, the inspector found that improvements were required in a number of areas of the service to ensure the service was safe, consistent and of a good quality. In particular, the systems in place with regard to oversight of staffing, temporary absence or discharge of residents, individual assessment and care planning, fire precautions, protection, managing behaviour that is challenging, infection control, records and directory of residents.

This unannounced inspection was carried out over two days by one inspector in Dalkey Community Unit for Older Persons to assess compliance with the regulations. Following an introductory meeting with the clinical nurse manager in the absence of the person in charge, the inspector was guided on a tour of the premises. During the inspection, the inspector spoke with several residents and their visitors to gain insight into their experience of living in the centre. The inspector also spent time observing interactions between staff and residents and reviewing a range of documentation.

The Health Service Executive (HSE) is the registered provider for Dalkey Community Unit for Older Persons. There was a clearly defined management structure with identified lines of accountability and responsibility. The person in charge worked four days a week in the centre and reported to general manager for older persons. The clinical management team consisted of a person in charge and clinical nurse managers (CNM). The person in charge also had oversight of a team of nurses and healthcare staff, activity staff, catering, household and portering staff.

While there were a range of management systems in place they did not consistently ensure improvement actions were completed. While there was an audit schedule in place, some key areas of oversight were not included and it was not sufficiently robust to identify improvements required so the registered provider could implement plans that would affect change. For example, no call bell audits were being

completed, however, it was fed back as an issue by residents. A full detailed call bell report was available on the system used, however, the management team was not reviewing these. Therefore, there was no system to identify call bell time responses and trends in the centre.

While some actions had been completed following the last inspection, there were also repeated non-compliance's and there were actions detailed in the compliance plan following the last inspection, which had not yet been taken to address areas of non-compliance. The person in charge had identified that the audit system in place for assessment and care plans required improvement, as they had noted issues that were not being identified. The inspector was informed that assessment and care plan audits were completed every four months to ensure oversight. However, no audits had been completed since December 2023.

The provider had completed the annual review of the quality and safety of care delivered to residents for 2023. The inspector saw evidence of the consultation with residents and families reflected in the review.

Since June 2024 the registered provider had reduced the total number of staff nurses and healthcare assistants available each day. This was reduced from 12 staff nurses and healthcare assistants in total to 10 staff nurses and healthcare assistants in total each day. The inspector was informed that the number of registered beds had reduced in recent years, however, the registered provider had not reduced the number of staff in line with this reduction at the time. There were a number of vacancies in the centre and the inspector was informed that it is unclear if these positions will be replaced due to the reduction of registered beds. Vacancies consisted of a CNM, senior nurse, staff nurse, three healthcare assistants, two chefs and three catering assistants. Of the sample of rosters reviewed, agency staff was used daily to cover absences. The inspector was also informed that there had been a recent change in the service used to provide agency staff cover. Although the reduction of staff was in line with the reduction of registered beds, the inspector found that the allocation of staffing was insufficient to meet the assessed needs of the residents and had impacted the quality of care provided to residents. For example, the call bell reports reviewed by the inspector showed that some residents had to wait 12 minutes or more for staff to respond to the call bell to attend to their care needs.

Since the last inspection the person in charge had worked to ensure that records were available in the centre, such as Garda Vetting Disclosures and the details required under Schedule 2 of the regulations. They were implementing a new system of maintaining these records within the centre so they are accessible. The majority of staff files and Garda Vetting Disclosures were available for review by the inspector, however, further action was required to ensure full compliance. This is detail under Regulation 21: Records.

Regulation 15: Staffing

A review was required of the number and skill mix of staff having regard to the needs of the residents and the size and layout of the designated centre to ensure effective delivery of care. The findings of this inspection were that:

- Residents told the inspector that sometimes they had to wait for a prolonged period of time before they received the care requested. For example, on review of call bell records, some residents were having to wait over 12 minutes for staff to attend to them after using the call bell to seek assistance. One resident had to wait 43 minutes for staff to attend to them after using the call bell for assistance.
- Residents satisfaction surveys completed highlighted residents concerns of the over reliance on agency staff and the number of staff available to have daily showers. Residents reported that there was too many agency staff which impacted care provided.
- On the day of inspection a resident was waiting from 8am to 11:20 am to be supported to shower and get up out of bed for the day.
- An increase in falls was reported in management meetings. In addition, it was noted that due to a shortage of staff in one unit neurological observations were not being taken for some residents who had an unwitnessed fall in line with policy.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents did not include all of the information specified in paragraph (3) of Schedule 3. For example, the directory given to the inspector did not record:

- The name, address and telephone number of the resident's general practitioner.
- If residents were transferred to another designated centre or to a hospital.
- The name and address of any authority, organisation or other body which arranged admission.
- Where a resident had died at the designated centre, the date, time and cause of death (when established).

Judgment: Substantially compliant

Regulation 21: Records

The person in charge had introduced a new filing system to maintain information set out in Schedule 2 to be available in the centre. However, the person in charge was

the only person who had access to these records and the inspector was unable to access these until the person in charge attended the centre. In addition, a sample of staff files were reviewed and did not contain all the information as outlined in Schedule 2 of the regulations, for example:

- There was no staff file or record of a Garda Vetting Disclosure form available for a new staff who had started in the centre three months previous to the inspection.
- Two staff files had no copies of written references.
- A staff file had a recent photograph, however, there was no evidence of their identity.
- Documentary evidence of relevant qualifications was no available in one staff file.

This regulation has had a not complaint finding on the previous three inspections.

Judgment: Not compliant

Regulation 23: Governance and management

Management systems in place did not ensure that the service was safe, effective and consistent at all times, for example:

- The registered provider had not taken adequate precautions by means of fire safety management and fire drills to ensure that staff working in the centre were aware of the procedure to be followed in the case of a fire. This is detailed in Regulation 28: Fire precautions.
- Audits completed did not consistently identify key areas of improvement required so the registered provider could implement plans that would affect change. For example, there was no system in place to monitor the staff response times to call bells that could facilitate them to identify issues relating to response times. Therefore, the provider was not able to identify the long waits reported by residents, and no quality improvement plan had been developed. A review was required to ensure that the registered provider had allocated sufficient resources for effective delivery of care.
- The management oversight of residents' individual care needs, assessments and care plans was not fully effective and no care plan audits have been completed since December 2024.
- The oversight of the documentation of restrictive practice was not robust. A restrictive practice register was in place, however, the register did not accurately reflect the use of restrictive practice used in the centre on the days of inspection.
- The oversight of residents finances within the centre was not effective. This is detailed under Regulation 8: Protection.
- The inspector found that some of the actions identified from the previous inspections' compliance plan had not been addressed.

- There was repeated non-compliance's with Regulation 9: Residents rights, Regulation 21: Records and Regulation 25: Temporary absence or discharge of residents.

Judgment: Not compliant

Regulation 31: Notification of incidents

All incidents that were required to be notified to the Chief Inspector were notified.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training and all had completed fire safety training. The majority of staff had completed safeguarding training, with five staff due to complete a refresher in safeguarding training. Additional safeguarding training was scheduled and staff who required a refreshed were scheduled to attend.

Judgment: Compliant

Quality and safety

While the inspector observed kind and compassionate staff treating the residents with dignity and respect, the systems overseeing the service's quality and safety needed to be more robust and required improvement. In particular concerning, fire safety, managing behaviour that is challenging, temporary absence or discharge of residents, assessment and care planning, infection control, protection, residents' rights and information for residents.

A paper-based system of care planning and documentation was used by nursing staff. The inspector reviewed a sample of assessment and care plans and found that some care plans were not reviewed at four monthly intervals in line with the regulations.

It was evident that the person in charge had been working to reduce the usage of physical restraints such as, bedrails, used within the centre. Multi-disciplinary reviews were occurring monthly where physical restraint usage in the centre was discuss to review the restrictive practice in place to ensure it’s ongoing necessity and benefit to the resident. While there had been an improvement in the use of physical

restraints, the use of chemical restraint required review as they were not always managed in accordance with the national restraint policy and guidelines.

Staff were knowledgeable about what constitutes abuse, the different types of abuse and how to report suspected abuse in the centre. The registered provider had a local policy aligned with the HSE's national safeguarding policy. The person in charge investigated allegations of abuse in the designated centre. The provider was a pension agent for 17 residents. Records shown to the inspector confirmed residents' money was managed through a separate client account. However, further improvement in managing residents finances held in the centre was required.

There was a programme of activities provided in the centre to meet residents' occupational and recreational needs. A dedicated activity co-ordinator, who worked part time was observed engaging with residents throughout the day. On the day of inspection, there was other external staff providing activities also. Residents told the inspector that they enjoyed the activities available in the centre and that there was plenty to do. In general residents rights were respected, however, residents rights to privacy was not being fully supported.

Overall the centre was generally clean and tidy with one resident being high complementary saying "the place is spotless". However, the laundry systems did not fully comply with the National Standards for Infection Prevention and Control in Community Services (2018).

The inspector reviewed the arrangements at the centre to protect residents from the risk of fire. There was a fire safety policy in place, which was last review in July 2024. All staff had up-to-date fire safety training completed and each resident had a personal emergency evacuation plan (PEEP). Some areas of improvements were required in relation to fire safety to ensure adequate precautions were in place, which included fire drills and evacuation signage.

Regulation 20: Information for residents

The registered provider had prepared and made available a guide regarding the centre which was available to residents. It contained information on the services and facilities, terms and conditions relating to residence in the centre, arrangements for visits and information in relation to independent advocacy arrangements. It also contained information on the complaints procedure, however, it did not include external complaints process such as the ombudsman.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

On review of a sample of residents' records where the resident was temporarily absent from a designated centre, the inspector found that these did not contain copies of relevant transfer letters with relevant information about the resident to the receiving hospital. This is a repeat finding.

Judgment: Not compliant

Regulation 27: Infection control

While there were good infection control practices seen in the centre in relation to cleaning of the premises. The laundry arrangements in place were not in line with best practice. For example:

- There was no markings in the laundry room to clearly segregate the clean and dirty area.
- Multiple baskets with clean clothes were broken which impacts the ability to effectively clean them and were stored on the floor of the laundry room. Clean cloths were also stored next to dirty equipment.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had not consistently ensured adequate means of fire safety management and fire drills at suitable intervals to ensure that persons working at the centre and, residents were aware of the procedure to be followed in the case of fire. For example, there was no records of regular fire drills taking place. Records of fire drills provided to the inspector were for fire safety training and these did not simulate full compartment evacuation with the appropriate staffing levels. The inspector was informed that no fire drill had taken place outside of fire safety training in 18 months. Therefore it was not possible to ascertain if residents could be evacuated in a timely manner to a place of relative safety.

Examples were seen that did not provide assurances that the arrangements for containing fires would be adequate. For example, the door of the laundry room was held open by a bin. This would mean that in the event of a fire, containment of fire and smoke could not be assured. While maps on the walls were showing the layout of the centre, they did not correctly identify the compartments in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Comprehensive assessments were completed for residents on or before admission to the centre. Care plans based on assessments were completed no later than 48 hours after the resident's admission to the centre. However, some residents care plans were not reviewed at intervals not exceeding 4 months. In addition, some residents care plans were not updated following assessment. For example, a resident had been assessed for the use of a bedrail. However, the care plan had not been updated to include the change to supports required for the resident.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The inspector was not assured that chemical restraints were used in accordance with national policy. For residents who had responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment), care plans were in place. However, some care plans did not detail the use of PRN (medicines only taken when the need arises) medication to manage responsive behaviours. Therefore, the care plans did not detail a stepped approach to ensure that the least restrictive response was used when supporting the resident. On review of ABC (antecedent, behaviour and consequence) charts which noted an incident that had occurred and the management of the incident was documented. It was recorded that the resident was given PRN medication with no least restrictive alternative responses trialled first.

Judgment: Substantially compliant

Regulation 8: Protection

The provider was a pension agent for 17 residents. Records shown to the inspector confirmed residents' money was managed through a separate client account. In addition to the client account, a sum of money was held in the centre for residents daily use. This was not accessible to residents at the weekends, however, they could request money in advance. A separate excel sheet recorded the balance of money available to residents within the centre. However, this balance did not correlate with the money held for residents in the centre. The inspector was not assured that all reasonable measures were in place to protect residents finances.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The activity programme available to residents on the day of inspection provided opportunities for residents to participate in meaningful activities in accordance with their interests and capacities. Residents could also exercise choice about how they spent their day. However, the inspector identified that residents' privacy in some bedrooms was not being fully supported in the centre. This is a repeat finding. Three small glass panels were present on all bedroom doors. Some of the panels had an opaque film applied to the glass panels to provide privacy, however, not all glass panels had this measure in place and so the inspector could see into residents' bedrooms.

In addition, the configuration of a bay in the two triple room bedrooms did not afford residents enough space to have a chair so they could conduct tasks such as dressing in private. On the day of inspection this bay in both triple rooms was unoccupied.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 16: Training and staff development	Compliant
Quality and safety	
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Dalkey Community Unit for Older Persons OSV-0000510

Inspection ID: MON-0044650

Date of inspection: 29/08/2024

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The provider is planning to recruit 3 HCAs as soon as recruitment is permitted to ensure that as many permanent staff are on duty as possible and reduce agency usage. A business case is being prepared to support this process. It should be noted that the Centre operates a daily ratio of 1:3.5 (staff : resident), this does not include the CNM2s on duty on the day, whom are supernumerary. • Ward managers (CNM's) will ensure that call bells are responded to as soon as possible. This will be audited going forward and performance managed if necessary with the PIC. • Some staff have attended falls management training and remaining staff are booked to attend over the next eight weeks. • Ward managers to ensure that Neuro-observation policy is strictly adhered to. This will be a focus on Care Plan Audits to be conducted by PIC and/or nominee. • There is adequate staffing levels within the Unit to ensure all residents personal care requirements are met together with resident daily bathing requirements. The PIC and PPIM will ensure to the greatest extent possible that consistent agency staff are secured until the recruitment strategy as set out at point 1 above is implemented.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: • A directory of all Residents has been established to include information as specified in Schedule 3 and according to Regulation 19, it is being maintained daily.	

Regulation 21: Records	Not Compliant

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

• A full review is ongoing to enhance the current storage practice of staff records retained in the Unit for the required period of time as stipulated by the Regulations. Records of Staff are electronically accessible and some are available locally in accordance with Regulation 21 and as set out in Schedule 2. It is projected that all information will be accessible/available locally once the current review id concluded

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• To ensure compliance with Regulation 28 and 23, floor plans have been amended with all compartments clearly marked. Monthly fire drills are carried out by staff in the Centre under the guidance of a fire protection company. All staff are up to date with appropriate Fire training and weekly fire registers are being introduced/maintained.
• Weekly call bell Audit in place to ensure effective operation of the system with immediate escalation to maintenance/contractor where necessary.
• Monthly Metrics Audit of Nursing Care Plans with action plans are in place and a CNM1 is allocated to monitor that all action plans are carried out within the stipulated period.
• All Nursing Care Plans have been audited and CNM1 is monitoring and following up with all action plans to improve Residents experience.
• The use of Restraint is a key focus of the monthly MDT and QPS meeting to ensure that action plans are consistently developed. The care plans of all Residents where appropriate validated restraints are in place are reviewed to ensure alternatives to restraints are used and recorded.
• Chemical restraints audit are now included in the Restraint register to monitor effectiveness and review for alternatives.
• The Unit evaluates its compliance with relevant standards and regulations and implements a structured quality improvement programme to address any deficiencies. There is appropriate management strictures (clinical and non-clinical) in place to ensure that services are provided in a safe appropriate, consistent manner, which is monitored regularly and audited.
• Quality improvement plans at monthly QPS are taken account of necessary improvements arising through Inspections from both internal and external service audits/reviews.
• In Accordance with Regulation 25, the Unit has recently adopted the National Transfer Letter for every transfer to acute hospitals and re-admission process back to the Unit, the copy of this form will be kept in the Resident's chart every time there is a transfer

and/or temporary discharge.
• The Centre operates a Patient Private Property (PPP) system where a specific amount of cash is held securely for residents on site. A separate record reflective of deposits in the Central Investment fund is maintained for each resident and called upon when a Residents property request is in excess of the resources maintained locally. The PPP cash is then periodically topped up to ensure adequate supply of cash available for residents.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:

• Quality information and effective information are important to improve the quality of services for our Residents, in compliance with Regulation 20, the Centre's Residents guide has been updated to include external complaints process e.g. Ombudsman and this will be published before the end of 2024.

Regulation 25: Temporary absence or discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:

• Clinical Nurse Managers will ensure that a copy of the National transfer letter is kept in the Residents chart every time there is a transfer or temporary discharge

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• In compliance with Infection Prevention Control and Regulation 27 to achieve the best outcome for Residents, the laundry clean and dirty areas have been clearly redefined to assure appropriate separation of compartments.
• Broken laundry baskets have being replaced.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• To ensure compliance with Regulation 28 and 23, floor plans have been amended with all compartments clearly marked. Monthly fire drills are carried out by staff in the center under the guidance of a fire protection company. All staff are up to date with Fire training.
• All Staff to ensure that Fire Policies, both national and local are followed strictly.
• Fire registers will be maintained weekly on each Ward area.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

• Each Resident has a care plan based on the comprehensive assessment of their needs; these are implemented, evaluated and reviewed as their needs change and overseen by the CNMs.
• A CNM1 has been allocated to audit, review and monitor all Nursing Care Plans, the Audit was completed on 25/09/2024.
• Action Plans on all Nursing Care plans are been monitored by the CNM1 and staff are been supported to ensure all Nursing Care Plans up to date.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

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

• The Centre will ensure that Residents experience care that support their physical behaviour and psychological wellbeing, least restrictive alternatives will be explored and documented prior to the consideration of any form of chemical restraint.
• Staff will document and monitor the effectiveness of all prescribed chemical restraint.
• Staff will be trained to ensure up to date knowledge and skills in the management of behavior that is challenging.
• Chemical restraints audit are now included in the Monthly Restraint register to monitor effectiveness and review for alternatives.
• All prescribed Psychotropic medications are to be reviewed by the Medical Officer regularly for effectiveness and alternatives explored.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• The Centre operates a Patient Private Property (PPP) system where a specific amount of cash can only be held in a secure manner for residents on site. A separate record is held for each resident and when a resident requests money from their account is it taken from the PPP cash and the amount is deducted from each individual residents PPP account. The Centre operates a PP policy in line with the Providers National Financial Regulations. The PPIM/Manager locally will ensure that all reasonable efforts are made to ensure Residents requirements over weekends in particular are planned to ensure that the required needs of residents are made. Any Resident can request/expect that the full amount of their PP secured can be made available with reasonable notice albeit the Provider does not advocate retaining large volumes of case unsecured in Residents personal possession.

Regulation 9: Residents' rights	Substantially Compliant

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

• All Residents are respected, safeguarded and their privacy and dignity are protected at all times.
• In compliance with Regulation 9, all doors with 3-panel glass have a curtain ordered to be fitted to the back of the door, which allows staff to observe residents without disturbing them and also allows residents control of their privacy. These are scheduled for delivery in November.
• Ducal opaque cover are used to cover two lower glass panels to provide private and dignity for Residents.
• Extra Storage space is been allocated to the two triple bedded rooms and work is due to commence on these.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	28/02/2025
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	31/10/2024
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure respecting complaints, including external complaints processes such as the Ombudsman.	Substantially Compliant	Yellow	31/12/2024
Regulation 21(1)	The registered provider shall	Not Compliant	Orange	31/12/2024

	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.			
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.	Substantially Compliant	Yellow	28/02/2025
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	31/10/2024
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about	Not Compliant	Orange	31/10/2024

	the resident is provided to the receiving designated centre, hospital or place.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	31/12/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/10/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/12/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not	Substantially Compliant	Yellow	31/12/2024

	exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(3)	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.	Substantially Compliant	Yellow	31/12/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	31/10/2024
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	30/11/2024