

eDeposit Ireland

Carna Nursing and Retirement Home, OSV-0000398, 20 February 2020

Item Type	report
Citation	Ireland. Health Information and Quality Authority, 'Carna Nursing and Retirement Home, OSV-0000398, 20 February 2020', [report], Health Information and Quality Authority, 09/07/2020, Nursing Homes, Designated Centre for Older People
Publisher	Health Information and Quality Authority
Download date	2026-06-11 20:16:24
Link to Item	https://hdl.handle.net/20.500.14765/100817



Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

Name of designated centre:	Carna Nursing and Retirement Home
Name of provider:	Dr. Michael & Mrs. Sally Casey, T/A Carna Nursing and Retirement Home
Address of centre:	Carna, Connemara, Galway
Type of inspection:	Unannounced
Date of inspection:	20 February 2020
Centre ID:	OSV-0000398
Fieldwork ID:	MON-0028774

About the designated centre

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

Carna Nursing & Retirement Home is a single storey, modern, spacious, purpose built facility established in 2003 set in the Connemara village of Carna. It is located beside the sea and has view of the mountain-scape and a fishing harbour. The centre accommodates both male and female residents with nursing care needs, dementia, physical and mental disability, respite care, convalescence and palliative care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	45
--	----

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
Thursday 20 February 2020	10:00hrs to 18:30hrs	Una Fitzgerald	Lead
Friday 21 February 2020	10:00hrs to 16:30hrs	Una Fitzgerald	Lead

What residents told us and what inspectors observed

Resident feedback was mostly positive. Residents said that they felt their care needs were met by staff who knew their likes and dislikes. Staff referred to residents by their first name and conversed with them on topics that were of interest asking questions about family members. The majority of residents spoken with said that they felt they were listened too. However, the inspector was informed by one resident of a complaint that they had made. This complaint was not logged on the complaints register. The resident told the inspector that they felt their view on the issue raised had not been listened too. The inspector brought this to the attention of the management team who met with the resident to discuss the complaint.

Residents were happy with their bedrooms and said that staff were respectful of their personal belongings. Staff were observed knocking on doors and waiting for a response. Residents were satisfied with the laundry service.

The inspector spent time on day two observing the dining room and the dining experience had by residents. The observations concluded that an immediate review of current practices was required. The room was not large enough to accommodate the number of residents. At one stage there was thirty five resident in the dining room. There was insufficient space for residents to sit at a table and wait for their meal to be served. The inspector observed that a resident who was sitting at a table waiting for his meal was moved and placed in the passage way between tables facing the back of other residents chairs because of the limited space available. The staff had maneuvered the resident as they required space to assist another resident with their meal. There was insufficient space for staff to sit and engage with residents while assisting them with their meals. This meant that the resident was assisted by the staff member standing over them. This was not conducive to a pleasant dining experience and was an affront to residents dignity.

Capacity and capability

The centre is managed by Dr. Michael & Mrs. Sally Casey Partnership T/A Carna Nursing and Retirement Home. The inspector found that there was inadequate governance and management arrangements coupled with poor oversight in place to ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored to meet regulatory requirements.

This was an unannounced inspection. The registered provider has a general manager on site who is supported by the person in charge and an assistant director of nursing. Since the last inspection unsolicited information was received into the Chief Inspector relating to an alleged incident. The provider was issued with a

provider assurance report (PAR). The response did not provide the required assurance that all matters had been investigated and examined adequately. The office of the Chief inspector wrote to the provider to highlight the areas which required a more comprehensive examination. On foot of the correspondence issued, the provider responded by advising the Chief Inspector that an independent investigation would occur. The report of this investigation was submitted on 21 January 2020. This inspection was to follow up on the findings of this report and ensure that the actions that the provider had taken were completed. The investigation report concluded that the allegations were not substantiated. However, the inspector was concerned that the actions taken by the senior management team were not comprehensive and sufficiently robust to ensure that residents are protected. This is evidenced by;

- Staff files reviewed evidenced that not all staff had a Garda vetting on file. An urgent compliance plan was issued as a result.
- Staff were not appropriately supervised. For example; the inspector observed residents being assisted with feeding that was inappropriate.
- The inspector found clear evidence that there was a disconnect between the staff delivering the care and the nursing management team monitoring the care. For example; care plans that clearly identified that resident care needs required two persons to assist had their care delivered by one staff member.
- There was no risk management in place to control the management of abuse as is required by regulation 26(1)(c).
- Resident complaints were not always recorded and appropriate follow up taken as a result. This is a repeated non compliance.
- Restated non compliance from the last inspection. For example; the provider had committed to ensure that CCTV was not used in communal rooms where residents have an expectation and the right to privacy. On arrival to the centre there was CCTV in operation in the main dining room.
- Recruitment practices required improvement.

The inspector followed up on the PAR and the investigation outcome report that was submitted to the Chief Inspector. The allegation was not substantiated. The response submitted by the registered provider outlining the actions taken or actions that would be completed were not all actioned. The registered provider had committed to outline an improvement strategy for providing a better and safer care to all residents and to protect the staff. This document was not available for review.

The senior management team had ensured that staff had training in safeguarding and safety. During the investigation process the centres management had held meetings with individual staff members. The inspector spoke with multiple staff during the two day inspection. Staff were very clear on the definition of abuse and on what immediate action was to be taken in line with the policy. However, the inspector was concerned on the culture of reporting issues of concern and staff practices that were known to staff. For example; the internal investigation report clearly identified that a junior staff member was directing care outside of their level of seniority in the governance structure as per the statement of purpose. The impact for residents was that their care plan identified they required two staff members but

this guidance was not adhered too. From the documented conversations between the management team and staff members it was evident that there was not an open reporting culture. The inspector acknowledges that the registered provider has taken steps to address this culture. For example; the management team have commenced supervision during night time to ensure that all staff are met with regularly. In addition, the management team have put in an additional staff member to cover the evening roster. Following the last inspection the management team had committed to commence staff appraisals. The person in charge had started this process and had a plan in place to complete same.

The effectiveness of the reporting structures and processes required improvement to ensure the quality and safety of the service is being consistently monitored and reviewed accordingly. The management team informed the inspector that they meet upto four times a week to discuss all clinical and operational issues. These meetings are not routinely recorded. In the absence of recorded minutes the inspector was not assured that the management team were aware of the level of non compliance found with the regulations. The inspector concluded that significant improvement is required to ensure that those in charge are monitoring the service and have the necessary oversight to ensure that residents are receiving a safe and appropriate services.

Regulation 15: Staffing

As part of the investigation outcome measures the management team identified a shortfall in the staffing numbers on duty for the evening time and as a result have increased the numbers of staff on duty. Staff spoken with confirmed that this has had a positive impact on the ability to attend to resident needs. In addition, the nursing management team had further developed the staff allocation list.

The centre has two large spacious communal rooms where the majority of residents pass the day time hours. The South day room and the West day room. Both of the rooms are supervised by a staff member. The inspector was informed that only one day room is in use upto three days a week for residents that require supervision. This is because of the availability of staff to supervise residents.

The person in charge had completed a needs analyses on the staffing requirement and had concluded based on current resident dependency needs that further review of the staffing numbers and allocation of duties is required. This review was in process during the inspection and was for discussion within the senior management team.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A detailed training matrix was available for review. Staff had access to appropriate training and records reviewed evidenced that all staff had received training in fire precautions, management of behaviour that is challenging and manual handling practices. The inspector found that one staff member did not have training in safeguarding and safety. The inspector acknowledges that there was a plan in place to address any gaps.

Lines of responsibility as outlined in the Statement of Purpose were not clearly understood by staff. Supervision of the staff, practices and procedures required immediate action. The reporting structure required bedding down to ensure that all staff were clear. The internal investigation report identified that the most senior clinical staff member on duty was not always supervising the direct provision of care. For example; staff were working in isolation despite the resident care plans directing that care was to be delivered by two persons based on the assessed need of the resident.

The inspector reviewed the safeguarding and safety training that had been delivered. Records evidenced that all staff (except one) had attended. The policy on the prevention, detection and response to abuse was last updated in December 2019. The inspector spoke with multiple staff on what actions they would take if they had knowledge or concerns of an allegation of abuse. The inspector acknowledges that the immediate actions described by staff were appropriate. The inspector judged that not all staff were clear that all incidents/concerns must be reported to the senior management as they have responsibility to monitor the service as a whole. This requires management to be cognisant of all issues so that patterns can be identified and appropriate management steps taken if necessary by the senior management team.

Judgment: Not compliant

Regulation 21: Records

A number of staff files were viewed. The registered provider had failed to ensure that all staff had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016 available for inspection. In the absence of the required documentary proof of vetting the provider was issued with an urgent compliance plan in this regard.

As part of the internal investigation report the management team had spoken with multiple residents and reassessments of need had been completed and care plan reviews completed. Resident files specific to this information was reviewed. The inspector found that Schedule 3 requirements relating to the recording of any referrals and subsequent detail of nursing assessments and care plan updates were not recorded and so not available for review.

Judgment: Not compliant

Regulation 23: Governance and management

Governance and Management was found to be substantially compliant on the last inspection. Overall the centre is moving away from regulatory compliance. Improvements were required in the capacity and capability of the management team to ensure that the quality and safety of the care delivered to resident is in line with the requirements of the regulations. This was evidenced by;

- Poor recruitment practices
- Poor record keeping in relation to schedule 2 and schedule 3 records
- Failure to implement learning on foot of completion of an investigation related to an incident.
- Poor supervision of staff delivering care to residents
- Repeated non compliance found under seven of the regulations from the last inspection in May 2019.
- The lines of responsibility on who is accountable for actioning and close out on operational risks was not clear.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspector found that an action from the previous two inspections had not been addressed. Contracts of care did not specify the number of residents in the multioccupancy bedroom.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The inspector reviewed the Statement of Purpose and found that further development was required to ensure that it contained all of the information as set out in Schedule 1 of the regulations. For example; the conditions of registration and the arrangements made for residents to attend religious services of their choice.

Judgment: Substantially compliant

Regulation 30: Volunteers

The role and responsibilities for volunteers was not set out in writing as is required by the regulations. In addition, volunteers did not have Garda Vetting disclosure available for review.

Judgment: Not compliant

Regulation 34: Complaints procedure

The majority of residents spoken with felt able to make a complaint if necessary and the procedure for doing so was prominently posted at the main reception in Gaelic and English. The management maintained a complaints register which detailed the subject of the complaint, investigation and engagement with the complainant, and notes on whether or not the person was satisfied with the outcome. The management of the complaints that were logged was comprehensive. However, the inspector was informed by one resident of a complaint that they had made. This complaint was not logged on the complaints register. The resident told the inspector that they felt their view on the issue raised had not been listened too. The inspector brought this to the attention of the management team who met with the resident to discuss the complaint.

Judgment: Substantially compliant

Quality and safety

The inspector walked through the premises with the person in charge. The centre is purpose built. The premises were found to be clean. Overall, the communal rooms and corridors were welcoming and warm. The south wing communal room was a hub of activity and residents were seen chatting and enjoying each others company and relaxing in the seating. The inspector observed the dining experience. On examination, the inspector observed that further improvement was required to how the available space was utilised. This was evidenced by insufficient space for residents to sit at their table while waiting for their meal. There was insufficient space for staff to assist residents with their meals.

Residents are accommodated in single, double and one three bedded room. The design and layout of the single and double bedrooms met with current resident needs. The orientation of the privacy screens in the multioccupancy bedroom required review to ensure that all three residents accommodated there could undertake personal activities in private without impacting negatively on other

residents within the bedroom. The inspector observed that there were multiple bedrooms that had no functioning call bells available for use. The person in charge evidenced that maintenance had completed a check list on functioning call bells in January 2020. This evidenced that there were maintenance issues that required action. The inspector acknowledged that some action had been taken at the time. However, the inspector was concerned that there continued to be residents in the centre that had the ability to use a call bell but were not afforded this choice. A purchase order was actioned on the day.

There were appropriate assessments of residents' needs and interventions to ensure that residents had access to appropriate health and social care. The registered provider is also the GP and visits the centre multiple times a week and is available 24 hours on call in the event of an emergency. Overall, the inspector found that care plans in place to guide staff where residents displayed behaviours associated with dementia or other conditions were of a good standard. Staff were well informed about how to intervene and manage behaviours to ensure the wellbeing of residents. However, the inspector reviewed the files of residents that had been reassessed as a result of the alleged incident and found that the care records required improvement as reviews and evaluations of care were not always recorded.

The management of risk required improvement to ensure residents' wellbeing and safety. Risk management was the responsibility of all staff. The management team held a risk register in the head office. The lines of responsibility on who is accountable for actioning and close out on operational risks was not clear. Operational risk identified during this inspection was not identified on the risk register and appropriate action taken within an acceptable timeframe. For example; gaps in the recruitment processes.

Regulation 26: Risk management

A review of all risk identified within the centre was required. The person in charge had responsibility for the management of clinical risk. It was unclear who had responsibility for operational risks within the centre. Risk identified on this inspection that were not included or updated appropriately on the live risk register included the risk associated with;

- There was no risk management in place to control the management of abuse as is required by regulation 26(c)(1).
- The management arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents as is required by 26(1)(d)
- The risk associated with an insufficient availability of resident call bells
- The risk associated with poor escalation processes when issues/concerns are raised relating to the provision of resident care.

- The risk associated with gaps in the recruitment processes.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Not all aspects of the regulation were reviewed. The inspector reviewed the files of residents that had been part of the investigation process. The inspector was informed that resident files were updated. There was insufficient evidence that the residents care plans had been reviewed. In addition, there was clear evidence that the direction in the care plan as per the assessed need of the residents were not followed.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The inspector reviewed the file of multiple residents who exhibited responsive behaviours and found that the care plans in place were detailed, comprehensive and person centered. The staff were familiar with the needs of resident's and were knowledgeable on the triggers that may cause any distress. In addition the staff knew how to deescalate any behaviour in a manner that was not restrictive.

The nursing management team is working towards a restraint-free environment. There were systems in place to assess if a restrictive practice, such as bedrails, was appropriate to support a resident. The inspector spoke with one resident who clearly articulated that the bedrail was in use at her request. All bedrails in use had been appropriately assessed by the nursing team. Alternative measures were tried.

Judgment: Compliant

Regulation 8: Protection

Following a recent alleged incident the senior management team were required to conduct an investigation into an allegation of elder abuse. While the internal and external investigation report outcome was that the allegations was not substantiated, the inspector evidenced serious gaps in the investigation process relating to staffing and in relation to monitoring the quality of the service delivered. The office of the chief inspector was concerned about some aspects of the report that was not fully investigated. For example: the requirement of Schedule

2 documents prior to any staff member commencing employment in the centre. Further development of management skills on investigation and audit process and what actions need to happen as a result of findings is required. The inspector was informed of interviews with staff members, meetings with individual residents and senior management meetings that had occurred as a result of the investigation. The conclusion of the meetings led the investigation team to determine that the allegation was not substantiated. The minutes of a number of these meetings were not recorded and so the inspector judged that this was a missed opportunity for lessons to be learned to improve care.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were aware of their right including civil, political and religious rights. Residents had been accommodated to vote in the recent election.

The inspector had concerns that the privacy and dignity of the residents was negatively impacted due to the use of close circuit television cameras (CCTV) used in some of the communal areas of the centre. The monitoring cameras were intrusive as they were used in areas where residents and visitors would have a reasonable expectation of privacy. The use of the cameras referenced in the Statement of Purpose was not reflective of the actual use.

The design and layout of the multioccupancy bedroom required review to ensure that all three residents accommodated there could undertake personal activities in private without impacting negatively on other residents within the bedroom.

The inspector found that not all residents had the use of a functioning call bell. The inspector acknowledges that an order to have a sufficient supply in stock was actioned on the day of inspection.

Resident advocacy service has been further enhanced following the recent alleged incident. An advocate that had been appointed into position by the registered provider now visits the centre frequently. The advocate meets residents as a group and is also available for individual meetings if requested by any resident.

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	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 26: Risk management	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Carna Nursing and Retirement Home OSV-0000398

Inspection ID: MON-0028774

Date of inspection: 21/02/2020

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
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: .We continue to recruit health care staff to resolve the deficits identified in the analysis done on the staffing requirements for the current dependency levels of residents.</p> <p>2.We strive to have both dayrooms open for residents 7 days a week at least until 2pm.</p>	
Regulation 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>1. Outstanding mandatory training for the employees has been booked and will be completed by the 31st of May, 2020.</p> <p>2. We had a staff nurses meeting since the inspection and reiterated the importance of reporting any issues/ concerns to the management, even after resolving the same. All staff are aware that they must take directions from staff nurse on duty as they are in charge of the shift and the staff nurses are to report back to the management promptly.</p>	
Regulation 21: Records	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:</p>	

The General Manager (GM) has completed an audit of every employee file re: Gardaí Vetting disclosure. Employees whose file did not meet schedule 2 were put off duty from 20/02/2020, until full compliance with Schedule 2 was achieved and alternative staffing arrangements were put in place to ensure that all staff rostered to work in the nursing home had Garda clearance. This action, now completed on 27/02/2020, means a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 is in individual files for all employees.

2.The Registered Provider has developed a fail-safe standard operating tool for recruitment process, thereby ensuring that no start date will be agreed with a prospective employee until the Garda Vetting disclosure is received, assessed and is satisfied that such an appointment does not pose a risk to residents, and employees.

3.It has been reiterated to all GP’s and staff nurses that all referrals made for residents and details of any review has to be documented in the medical notes and in their respective care plans.

Regulation 23: Governance and management	Not Compliant
--	---------------

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

1. Registered Provider has developed a fail-safe standard operating tool for recruitment process, thereby ensuring that no start date will be agreed with a prospective employee until the Garda Vetting disclosure is received, assessed and is satisfied that such an appointment does not pose a risk to residents, and employees.
2. It has been reiterated to all GP’s and staff nurses that all referrals made for residents and details of any review has to be documented in the medical notes and in their respective care plans.
3. Lessons learned has since been completed.
4. All staff nurses are reminded of the importance of supervising staff while delivering care. We had a staff nurses meeting since the inspection and reiterated the importance of reporting any issues/ concerns to the management, even after resolving the same. All staff are aware that they must take directions of staff nurse on duty as they are in charge of the shift and the staff nurses are to report back to the management promptly.
5. The general manager is accountable for actioning and closing out on operational risks.
6. A root and branch review of the organizational structure is planned and will be completed by 30/06/2020.

Regulation 24: Contract for the provision of services	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:</p> <p>Contracts of care are now updated with bed capacity of bedrooms.</p>	
Regulation 3: Statement of purpose	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 3: Statement of purpose:</p> <p>Statement of purpose is updated with the conditions of registration and arrangements for access to religious services.</p>	
Regulation 30: Volunteers	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 30: Volunteers:</p> <ol style="list-style-type: none"> 1. The roles and responsibilities of the independent advocate has since been set out in writing. We have also been in contact with a national advocacy service to have additional support for residents. 2. Garda Vetting disclosure for the independent advocate is in file. 	
Regulation 34: Complaints procedure	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 34: Complaints procedure:</p> <p>The complaint raised by the resident was logged into the complaints log. Discussed with the resident regarding the concern, alternative measures offered, Resident's right to refuse was respected and the risk assessment is in place.</p>	

Regulation 26: Risk management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management:</p> <ol style="list-style-type: none"> 1. The general manager is accountable for actioning and closing out on operational risks. 2. The Risk register was updated immediately to include the risk assessment for management of abuse. 3. A plan has been drawn up stating the management arrangements for the identification, recording, investigation and learning from serious incidents. Lessons learned has since been completed. 4. The risk assessment for insufficient availability/ faulty resident call bells is completed. Call bells are in place in every bedroom and in working order. Buffer stock is kept to replace any faulty bells immediately. Monthly audits are done on call bells to ensure the provision of safe care to the residents. 5. Registered Provider has developed a fail-safe standard operating tool for recruitment process, thereby ensuring that no start date will be agreed with a prospective employee until the Garda Vetting disclosure is received, assessed and is satisfied that such an appointment does not pose a risk to residents, and employees. 	
Regulation 5: Individual assessment and care plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</p> <ol style="list-style-type: none"> 1. Individual care plans are now completely reviewed and updated. 2. All staff nurses are reminded of the importance of supervising staff while delivering care to ensure that care provided is in line with the individualized care plan. 3. All staff are aware that they must take directions of the staff nurse on duty as they are in charge of the shift and the staff nurses are to report back to the management promptly. 	
Regulation 8: Protection	Not Compliant

<p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <ol style="list-style-type: none"> 1. A vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 is in individual files for all employees. The Registered Provider has developed a fail-safe standard operating tool for recruitment process, thereby ensuring that no start date will be agreed with a prospective employee until the Garda Vetting disclosure is received, assessed and is satisfied that such an appointment does not pose a risk to residents, and employees. 2. A plan has been drawn up stating the management arrangements for the identification, recording, investigation and learning from serious incidents. 3. All meeting minutes will be documented for reference henceforth. 	
Regulation 9: Residents' rights	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 9: Residents' rights:</p> <ol style="list-style-type: none"> 1. CCTV is disconnected from all communal areas. 2. Additional screening has been purchased, in order to provide adequate privacy for all residents in the three bedded room. 3. Call bells are in place in every bedroom and in working order. Buffer stock is kept to replace any faulty bells immediately. 	

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	30/06/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	03/03/2020
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Red	28/02/2020
Regulation 23(b)	The registered provider shall	Substantially Compliant	Yellow	30/06/2020

	ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
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	03/03/2020
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Not Compliant	Yellow	28/02/2020
Regulation 26(1)(a)	The registered provider shall ensure that the risk management	Not Compliant	Orange	28/02/2020

	policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	28/02/2020
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Not Compliant	Red	28/02/2020
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Not Compliant	Orange	27/03/2020
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to	Substantially Compliant	Yellow	21/02/2020

	the designated centre concerned and containing the information set out in Schedule 1.			
Regulation 30(a)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre have their roles and responsibilities set out in writing.	Not Compliant	Orange	02/03/2020
Regulation 30(c)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.	Not Compliant	Red	28/02/2020
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Substantially Compliant	Yellow	20/02/2020
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into	Substantially Compliant	Yellow	20/02/2020

	the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			
Regulation 5(4)	The person in charge shall formally review, at intervals not 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.	Not Compliant	Orange	31/03/2020
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	27/03/2020
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.	Substantially Compliant	Yellow	05/03/2020
Regulation 9(3)(b)	A registered	Substantially	Yellow	13/03/2020

	provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Compliant		
--	--	-----------	--	--