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Drumderrig House, OSV-0004457, 09 December 2019

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Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

Name of designated centre:	Drumderrig House
Name of provider:	Drumderrig House
Address of centre:	Abbeytown, Boyle, Roscommon
Type of inspection:	Unannounced
Date of inspection:	09 December 2019
Centre ID:	OSV-0004457
Fieldwork ID:	MON-0028114

About the designated centre

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

Drumderrig House Nursing Home is a purpose-built facility that provides care for 107 male and female residents who require long-term care or who require care short periods due to respite, convalescence, dementia or palliative care needs. Care is provided for people with a range of needs: low, medium, high or maximum dependency. The centre is located approximately 2 kilometres outside the town of Boyle, Co. Roscommon and is a short drive from Lough Key Forest Park. The centre provides an accessible and suitable environment for residents. Bedroom accommodation consists of 55 single and 26 double rooms all of which have ensuite facilities. There are additional toilets including wheelchair accessible toilets located at intervals around the centre and close to communal rooms. There are four sitting areas where residents can spend time during the day. There are dining rooms in two locations and an oratory, visitors' rooms and conservatory areas provide additional spaces for residents' use. In the statement of purpose the provider describes the service as aiming to enhance the quality of life of residents by providing good standards of health and social care within a peaceful and tranquil setting. The staff seek to develop, maintain and maximise the full potential of each resident.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	94
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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
Monday 9 December 2019	11:00hrs to 18:30hrs	Geraldine Jolley	Lead
Monday 9 December 2019	11:00hrs to 18:30hrs	Brid McGoldrick	Support
Monday 9 December 2019	11:00hrs to 18:30hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

The majority of residents told inspectors that they were well cared for and were satisfied with the services and facilities in the centre. They said that their rooms were comfortable, that staff were kind and responded to call bells when they rang for attention. Residents said that the food served was very good and that snacks and drinks were served regularly during the day.

Some residents were concerned about their equipment particularly their specialist chairs which they felt were not comfortable and did not fit them well. Other residents was concerned about how they would call for help in the sitting rooms as they did not have a call bell nearby.

Residents told inspectors that when they raised concern or complaints with staff that they were addressed and resolved promptly.

Relatives the inspectors met and visitors spoken with during the course of the inspection were complimentary of the care and service provided however some visitors said the regular changes of staff concerned them and the restricted visiting times were inconvenient as they had been used to visiting early in the day.

Capacity and capability

This unannounced inspection was undertaken following the receipt of unsolicited information provided to the Office of the Chief Inspector that described poor communication arrangements regarding resident care, a lack of staff and inflexible visiting times. A review of the non compliance identified at the last inspection was also completed as the provider's response did not assure the office of the Chief Inspector that adequate action was taken to address staffing levels, governance and management and risk management. A cautionary meeting was held with the provider representative and person in charge on 1 October 2019 when the non compliances were discussed and that action was required to bring the centre into compliance. The inspectors found during this inspection that there is continued non compliance in the areas identified. The unsolicited information was considered during this inspection and was substantiated. The findings of this inspection did not assure the inspectors that the governance and management arrangements in place could ensure that the service was safe, appropriate, consistent and effectively monitored and did not demonstrate it's capacity and capability to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

The inspectors found that while the leadership, governance and management

personnel remained consistent since the previous inspection the arrangements which contribute to residents experiencing a safe and good quality service required significant improvement and development. A defined management structure was in place and reporting relationships were described, however, the structure was deficient as critical areas such as the deployment of staff was not based on a comprehensive assessment of residents needs. For example the assessment of residents' dependency was largely based on physical care requirements and did not take into account the staff input required to address dementia care needs or mental health problems. There was no social care assessments completed. This deficit meant that over 50% of residents were assessed as low or medium dependency. The inspectors found that oversight of residents' care was poor and there were inadequate staff resources allocated to deliver effective safe care that met the full range of residents' needs. The inspectors found that the nursing processes required review to ensure the information on dependency levels reflected residents' needs fully and was accurate indicator on which to base the deployment of staff. For example the inspectors found in the sample of records viewed that residents with dementia, anxiety and mental health problems were all assessed as low or medium dependency while requiring significant supervision from staff to ensure their safety and well being.

The inspectors found the following areas of non compliance:

- Training records were not up to date and the programme of training and professional development of staff could not be verified
- The recruitment of staff was ongoing however staff nurses recruited did not have a background in elderly care and the induction programme did not confirm what areas of practice were included or competence in the care of older people
- The record of complaints was not complete as it did not contain reference to all the interactions that had taken place in relation to the management of a complaint.

As a result of non-compliance's found, the inspectors were not assured that the registered provider and the person in charge had appropriate management and administration systems in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

The provider had made significant efforts to recruit nurses and carers to address the staff shortfall described in the last inspection report. The recruitment process had been strengthened and vetting disclosures were obtained for all staff prior to them commencing employment. However the inspectors found that a number of nurses recruited had not had experience in the care of older people and that the induction programme and supervision system was not adequately detailed to ensure that they achieved the appropriate competences and skills to deliver evidenced based care. While the provider representative verbalised her understanding the deficits in staffing caused the admission of new residents had continued with four new residents being admitted the week prior to the inspection. This demonstrated poor leadership and a lack of oversight of the service.

Regulation 14: Persons in charge

The person in charge was an experienced nurse with a qualification in gerontology. She has been in this role several years.

Judgment: Compliant

Regulation 15: Staffing

At the last inspection the inspectors found that there were inadequate care and nursing staff employed to meet the needs of residents. Nine additional carers and a nurse had been employed since August 2019. A further four nurses were due to commence employment. These nurses would require time, supervision and an intensive induction to the care of older people as the inspectors were told that nurses recruited had mainly worked in acute care settings. The action plan on staffing in the last report was not addressed satisfactorily.

The deployment of staff was based on an assessment of care needs that was flawed and did not take into account the range of health and social care needs relevant to residents' health and conditions. The inspectors found that the day to day allocation of care, nursing and social care staff was based on this assessment model. The inspectors found that the allocation and skill mix of staff required review. There was just 6.5 hours allocated each afternoon to meet the social care needs of the 94 residents accommodated. Two nurses were on duty with the person in charge during the day for four out of five shifts shifts worked during the four weeks prior to the inspection. This allocation did not enable the person in charge to undertake her legislative responsibilities to a standard that ensured compliance was achieved and appropriate supervision and guidance was provided to staff.

The inspectors found for example:

- The allocation of staff to social care was inadequate to meet the needs of residents in a meaningful way particularly where residents had dementia care needs or enduring mental health problems. Residents' choice of social care opportunities was limited. Organised activity was scheduled for a four hour period in the afternoon. Residents were observed to be sitting for long periods of time without anything to do.
- There was insufficient qualified staff employed to meet the needs of the current number of residents (94). The statement of purpose described 14 WTE nurses however there were 11.5 W.T.E.s actually available which was a deficit of 2.5 W.T.Es. The roster evidenced that nursing staff were working a 48 hour week. The complement of three nurses for night duty was not

consistently maintained. During the previous week there were three nights when two nurses were rostered for duty.

- There were three nurses on duty during the day most days of the week. On four days a week this included the person in charge who has legislative responsibilities for the management of the service. She was supported by a senior nurse who worked two days a week and who covers her absence from the centre. The inspectors found a number of indicators that confirmed this allocation of nursing staff was not adequate to meet the needs of residents. For example a complete assessment of health and social care needs including continence assessments were not routinely completed for all residents.
- The person in charge has inadequate support from experienced nurses to support her in her role. The senior nurse who covers her off duty works two long days each week and the ongoing nursing shortage has meant that she has been undertaking direct care duties which has impacted on her capacity to undertake her legislative duties for example completing and maintaining records, ensuring appropriate deployment of staff and the completion of accurate clinical assessments.

The inspectors observed that most areas where residents were during the day were supervised and residents were observed to have appropriate assistance at meal times and when personal care was required. However there were some areas where highly dependent residents spent time during the day that were not supervised and contact with staff was limited to greetings as staff walked through to other areas. Care staff interviewed knew residents well and new staff confirmed that they had a period of induction that included training on the mandatory topics.

The inspectors observed staff to be busy at all times and observed that staff were frequently interrupted to answer the front door or to deal with telephone calls.

A full review of the staffing model is required to ensure that staff are deployed appropriately to meet the dependencies of residents taking into account their physical, psychological, social and dementia care needs.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff completed an induction period when they started work and staff interviewed confirmed that they spent time shadowing other staff and undertaking training. Four new nurses recruited from abroad were due to start work in the days following the inspection. These nurses and nurses recruited since the last inspection who do not have experience in elderly care settings require support and supervision to competently provide care in this setting. Confirmation to demonstrate staff were sufficiently experienced and suitably trained was not available or demonstrated for all staff working. The induction programme needed revision to include a full orientation to the care of older people that included training on assessment,

determining the needs of residents with dementia and mental health problems and the provision of quality care that included social care. The reliance on a tick box format to assess that staff are appropriately informed does not ensure that an appropriate skill level and competence has been achieved.

Judgment: Not compliant

Regulation 21: Records

A sample of staff files were reviewed against the requirements of schedule 2. An action plan in the last report identified that vetting disclosures had not been obtained for some staff prior to commencement of induction. This had been addressed. The records viewed contained the schedule 2 documents and the inspectors found that vetting disclosures were obtained before the date staff commenced work. Information on display included emergency fire procedures, floor plans with evacuation routes and the registration certificate.

The following records were not fully complete:

- The training record had not been updated and gaps in the record meant that training completed for all rostered staff could not be verified. Staff interviewed confirmed they had training on the mandatory topics and on the personal care of residents.
- The daily records completed by nurses did not convey the care and treatment provided to residents on a daily basis. Records did not confirm for example that the daily exercises /manoeuvres recommended by a physiotherapist were completed as instructed.
- Allied health professionals using the system to input their interactions and treatment interventions did not have their own access identification

Judgment: Not compliant

Regulation 23: Governance and management

There was a defined management structure in place, however the inspectors found the following indicators of ineffective governance and management:

- the oversight of clinical care and the assessment of residents' health and social care needs required improvement. This was a finding at the last inspection and the action plan did not assure the office of the Chief Inspector that the actions taken would result in achieving compliance with the regulations. An action plan to require compliance with Regulation 23- Governance and management is repeated in this report .

- adequate resources were not provided to ensure the effective delivery of care in accordance with the aims and objectives outlined in the statement of purpose and to implement the centre's policies. Gaps were found within staff training, the way records were maintained, the assessment of risk, communication systems and social care provision. The findings of this inspection did not assure the inspectors that the governance and management arrangements in place could ensure that the service was safe, appropriate, consistent and effectively monitored.
- the management structure required review and improvement to ensure residents' safety, well being and the delivery of good quality of life outcomes. The person in charge for example did not have adequate time to devote to her legislative responsibilities due to the ongoing shortage of nurses and deficits in the assessments process had not been identified which had led to inadequate allocation of resources for the delivery of evidenced based health and social care.

The internal reporting mechanisms were understood by staff. Members of the staff team interviewed were aware of their roles, responsibilities and reporting procedures to the person in charge.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose had been reviewed and a further review was required to ensure the whole time equivalent staff employed was described correctly.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents that required notification within three days and at quarterly intervals had been supplied.

Judgment: Compliant

Regulation 34: Complaints procedure

Residents and visitors interviewed confirmed that any complaints they had were listened to and addressed. The complaints policy identified the person nominated to

address complaints. A summary of the complaints procedure was included in the statement of purpose and residents guide. The complaints record was reviewed as this was referred to in the unsolicited information provided to the office of the Chief Inspector. Varied issues had been addressed and there was evidence that responses to complaints were timely and appropriate.

However the record was not fully complete as a range of correspondence that formed part of some complaints was not referred to in the record and the actions taken to resolve the issue were not recorded.

Judgment: Not compliant

Quality and safety

The capacity of staff to deliver quality evidence based care was hindered by the inadequacy of the assessments of residents' care needs referred to throughout this report. The lack of information on the impact of dementia, mental health problems or other disability on day to day life, an absence of assessments or evaluations of social or emotional well being, cognitive impairment and limited continence care assessments meant that staff did not have information or care plans to guide their practice and ensure that safe good quality care was delivered. The need for specialist equipment was not reviewed following residents' admissions to ensure that equipment was suitable and continued to meet residents' needs. Services that residents were entitled to in accordance with medical card provision was not accessed on their behalf.

Residents told inspectors that staff were kind and friendly in their approach. Residents said their choices were respected and they could for example sit where they wished during the day. The inspectors saw that the overall aim in the centre was to provide a relaxed, homely and comfortable environment for residents. The centre was located in a residential area and had several safe and secure outdoor areas with seating that were visible from bedrooms and from the communal areas. There was a decorating programme underway with office areas and bedrooms being refurbished at the time of the inspection. However there was a lack of signage or information displayed to remind residents and visitors that works were underway.

Information supplied to the office of the Chief Inspector conveyed concern about restricted visiting times. The inspectors found that visiting times had been discussed with residents who had expressed the view that some control over visiting times would be beneficial to them as they did not like visitors very early in the morning or being disturbed at meal times. The person in charge and provider representative said that in practice there were very few restrictions and that individual preferences were accommodated.

The inspectors saw that the fire safety instructions and floor plans were on

display. While fire training was completed annually and supplemented by training undertaken by the person in charge twice a year and when new staff came into post the inspectors concluded that additional fire training sessions were required due to the large number of new staff recruited during the last three months and the ongoing recruitment drive.

Accidents and incidents were recorded and were reviewed by the person in charge. Some reviews included prevention measures to prevent further falls however prevention strategies were not consistently described.

Residents were observed to take part in activities during the afternoon and the inspectors saw residents engaged in playing games that they enjoyed. However social care was mainly confined to the afternoon and the four hour time frame allocated did not ensure that all residents had an opportunity to engage in a social activity that was suitable to their needs.

Regulation 11: Visits

Numerous visitors were seen visiting residents at different times during the inspection. Staff were observed to greet family members and visitors when they arrived. Residents told inspectors that their visitors were made welcome and that there were areas in the centre to visit in private, if they wished to. Visitors said they were made welcome however some visitors said they found the restriction on visiting times inconvenient.

The specific visiting time periods were displayed at the entrance door to the centre. The inspectors judged that the issue of visiting hours appeared to cause distress and inconvenience to some people and formed the view that the reasons for the restriction should be clearly communicated and that this should be discussed and reviewed at residents' meetings.

Judgment: Substantially compliant

Regulation 12: Personal possessions

There was adequate wardrobe and other storage spaces in bedrooms to enable residents to store a good range of personal items. Bedrooms viewed had a range of personal items on display and some residents showed the inspectors how they had decorated their bedrooms with Christmas decorations.

Judgment: Compliant

Regulation 13: End of life

In the review of care records the inspectors found that end of life care was referred to but that personal choices and wishes were not described in a way that would guide staff on how to provide informed person centred care at this time.

Judgment: Not compliant

Regulation 17: Premises

The centre is a large expansive building that comprises of four units on the ground floor. The standard of decoration and maintenance was good with all areas furnished in a home like way. There were good colour contrasts between walls and floors and handrails were visible against the background colours to improve accessibility. Furniture that included arm chairs were provided in a range of styles and colours. There was a redecoration programme underway and some bedrooms and office areas were being refurbished and reorganised. A new hallway had been added to improve accessibility in the centre and this increased footprint was in the process of registration.

The communal sitting rooms, bedrooms and hallways were visibly clean. A review of the specialist chairs that residents required for their comfort and safety was required. The inspectors observed that some chairs did not support residents effectively and there were chairs that showed signs of wear and tear as the internal fabric was visible. The inspectors noted that residents did not have side tables near them to put their drinks and personal items on when sitting in communal areas. Residents told inspectors that call bells were not within reach residents which caused them concern at times.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents described the food as very good and said that there were plenty of snacks and drinks served during the day. Some residents chose not to have their meals in the dining rooms and preferred to stay in the sitting areas for their meals. There was a varied menu provided and additional portions of food were offered and available for residents.

Judgment: Compliant

Regulation 26: Risk management

There were renovation works underway to some bedrooms, floors and to an office area. However there was limited information provided to advise residents or visitors of this and no caution notices were displayed in areas where workmen were wall papering or replacing floors.

The inspectors found that accidents and incidents were recorded however there was a lack of information on how further falls would be prevented. This was described for attention in the last inspection report and the response from the provider did not assure the office of the Chief Inspector that adequate action was taken to achieve compliance and ensure good risk management. An action to improve risk management is repeated in this report.

Judgment: Not compliant

Regulation 28: Fire precautions

The fire procedures were on display and there were clear routes to the fire exits with emergency lighting to guide staff, residents and visitors to the exits. An action plan in the last report had been addressed. Bedroom doors were not propped open.

There were fire training sessions facilitated by an external trainer and these were supplemented by training and fire drills undertaken by the person in charge. Activation of the fire alarm causes exit doors to open to ensure free access to fire exits if needed and compartments within the centre were clearly defined. Training was provided annually by an external company and the person in charge conducted fire drills twice a year. In view of the number of new staff recruited the inspectors formed the view that fire drills should be undertaken more frequently and at times when the least number of staff are on duty such as weekends and at night to ensure that staff are fully familiar with the layout of this large building and the varied needs of residents.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A sample of electronic care plans was reviewed. The inspectors found that assessments of care needs were not comprehensive and did not provide adequate guidance to enable staff to deliver good standards of evidenced based care. Assessments of residents' health and conditions that included dementia, mental health problems and intellectual disability were not completed and therefore

staff were not informed of the problems associated with these conditions and the care inputs required to ensure residents had appropriate care and treatment. Care plans were not sufficiently detailed in other areas. For example, when residents care needs or moving and handling requirements changed the care plans did not reflect that seating arrangements may require review and specialist input from professionals that include occupational therapists and physiotherapist may be required to ensure good outcomes for residents.

Care plans did not provide guidance on how the social care needs of residents were to be addressed. In the sample of care records reviewed the inspectors found that there were no assessments or care plans that outlined how social care needs were to be fulfilled.

Judgment: Not compliant

Regulation 6: Health care

The inspectors found that the provider had not ensured that residents had access to specialist health services to which they were entitled from the Health Service Executive. For example some assessments for specialist chairs had not been reviewed since admission despite residents' specialist chairs not supporting them correctly.

Residents who required specialist assessments for new chairs or a review of their seating arrangements had not been referred to the Health Service Executive services despite residents having an entitlement to these services. The inspectors were told this was because professionals had indicated that they did not provide a service to residents living in private nursing homes. Specialist advice had been sought privately in some cases. The inspectors saw that professionals such as dieticians visited the centre and provided advice and guidance on dietary matters.

Judgment: Not compliant

Regulation 8: Protection

Staff had been provided with training on the protection of vulnerable people and staff interviewed were aware of the procedures to follow should they have concerns or suspicions about abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors found that residents were provided with local and national newspapers. There were televisions and radios in communal rooms and in bedrooms. Many had access to telephones if they wished to have them. There was access to an independent advocacy service which had been accessed on behalf of residents.

There was a planned social care schedule however this was very limited and was confined to the afternoons Monday to Friday. Residents were observed participating in games that included dominos and bowls. There were activity sessions aimed at the needs of people with dementia that included Imagination Gym and Sonas (a therapeutic sensory activity aimed to engage people with dementia) however, the inspectors observed that there were missed opportunities for social interaction as residents had no planned social care early in the day or at weekends. The social care needs of residents were not routinely assessed and the inspectors observed that some residents spent long periods without staff interaction or social contact that was meaningful.

Residents told inspectors that if they were not interested in participating in an activity they could be without conversation or social contact for long periods.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Drumderrig House OSV-0004457

Inspection ID: MON-0028114

Date of inspection: 09/12/2019

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	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: We have engaged in expert advice to review our current practices and processes regarding, recruitment, induction, supervision and competencies of staff. An independent review of current staffing levels, supervision of residents, current holistic assessments was carried out on 23.01.2020. A full report can be provided upon request.</p> <p>In summary, actions taken so far to come into compliance with regulation 15 include:</p> <p>Staffing Levels Increase in current staffing ratios for the following disciplines Nursing Staff</p> <ul style="list-style-type: none"> • December 2019: 3 Staff nurses. • February 2020: 3 Staff nurses. • March 2020: 3 Staff nurses. • April 2020: 2 Staff nurses. <ul style="list-style-type: none"> • For the time period of: 08:00 to 14:00 there was a ratio of: <ul style="list-style-type: none"> o 13 staff (3 staff nurses 10 care staff) o Best practice / bench marking; (18 staff: 4 Nurses & PIC and 12 carers) Ratio: 1 nurse: 2 carer. o Timeframe: March 2020 • For night time: (20:00-08-00) <ul style="list-style-type: none"> o 6 staff (3 nurses and 3 carers) o Best practice / bench marking; would be 10:1. – (9 staff: 3 nurses and 5 carers). o Timeframe: March 2020 <p>The review identified need for ancillary support staff. A Human Resources administrator has been employed full time and a Clinical Support Manager has been employed two days per week to support new staff nurses.</p>	

A recruitment strategic plan was agreed on 23.01.2020. The recruitment drive includes two open recruitment days, links with local colleges, social media and a refer a Health Care Professional incentive which shall encourage existing staff to link with professionals.

The current induction programme has been revised in line with best practice guidance the programme will be extended to all disciplines including staff not involved in direct care activities by April 2020.

All nursing staff appointed will undergo an induction programme which includes support and mentoring oversight by Clinical Support Manager and external regulatory support adviser.

Timeframe: Programme Development completion 27.02.2020.

Responsibility: HR administrator for induction, Clinical Support Manager for supervision, guidance, training and competency assessments of new nursing staff.

Oversight: Person In Charge.

Deployment and allocation of staff:

A staff and allocation of staff programme has been developed based on resident holistic needs and the skill mix of staff. The deployment and allocation programme is linked with the activities programme to ensure supervision and support to all residents. We are currently in the process of revising all resident assessments and care plans to identify 1:1 activities for residents which will also affect the deployment and staff allocation.

Validated assessment tools will be used during the review to assess residents holistic care needs which will include mental health needs/supports and dementia or cognitive needs/supports. Following assessment care plans will be revised or introduced. The review will include the resident, relative where appropriate, and the care team.

Timeframe: Completion timeframe 27.02.2020. The programme will be subject to daily review in line with resident changing needs and identified assessment findings.

Responsibility: Care team, Activities team and Nursing staff.

Oversight: Nursing Staff. Person In Charge.

Meaningful activities for residents:

Effective immediately an activities organizer will deliver meaningful activities to residents in communal areas from 13.00hrs-17.30hrs Monday to Friday. A second assistant activities organizer commenced employment 27.01.2020 and delivers activities from 9.00am-4 p.m. Monday to Friday and every second Saturday. Residents have requested that group activities are not delivered on Sundays.

A Health Care Assistant has been allocated to deliver group activities to residents from 14.00hrs-16.00hrs daily for residents. Activities assistant will deliver one-to-one to residents who do not wish to participate in group activities. Health Care assistants undertaking one to one activities will follow the programme developed by the Activities Coordinator which will be based on their social care plan.

A meaningful activities programme has been developed and is displayed in the reception area. The meaningful activities programme has been informed by completion of a validated evidenced based assessment "A key to me" for each resident. Staff communicate activities planned for the day to resident during personal care activities and mealtimes. Upon appointment of the new activities' assistant the programme will be further expanded to include local community links (27.03.2020)

Timeframe: Programme Development completed. Expansion of Programme 27.03.2020.
 Responsibility: Activities Team.
 Oversight: Person In Charge.

Administration/Reception:

A staff member has been appointed to the post and is starting induction on February 24th 2020. Their role will ensure that staff are not frequently interrupted and will include support to the Person In Charge and nursing staff for general administrative duties.

Preventative actions and monitoring:

Following implementation of the staffing model, a programme of regular oversight and monitoring/measuring will be put in place which will include an audit schedule and monthly key performance indicators. The results will be reported and recorded during monthly management team meetings. Learnings will be communicated to staff during monthly staff meetings with due regards to GDPR.

Timeframe: 24.02.2020
 Responsibility: Registered Provider, Person In Charge.
 Oversight: Registered Provider.

Regulation 16: Training and staff development	Not Compliant
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Outline how you are going to come into compliance with Regulation 16: Training and staff development:
 Support and Supervision:
 We have engaged in the services of an external regulatory support company to ensure that the supervision and competency arrangements are evidence based and in line with guidelines. The current induction programme is currently being revised and will be completed by 07.02.2020.

The programme will include a presentation outlining a full orientation to the care of older people including assessments. Skill set and competency shall be evaluated by the competency assessment framework. The induction will be delivered by the newly appointed HR administrator. Role specific induction will be delivered by appropriately

qualified individuals; for example, nursing staff will be delivered by the newly appointed Clinical Support Manager. Additional training needs for nursing staff for example; best practice in nursing documentation and care planning will be supported by the external regulatory support company. The training to be provided is approved INMB category 1 approval and is granted Continuing Education Units. Following a three-month induction and supervision period staff will receive an appraisal. As part of the personal and professional development plan staff nurses are now required to engage in further education. Staff nurses that do not have experience in Care of the Older person are now required to do a Gerontology course. Existing staff nurses that do not have experience have been registered on a course.

Care staff have, as part of their Fetac course, completed care of the older person module. Existing long term care staff who have yet to complete the older person module have been identified and will partake in the Assessment in the Care of Older Persons on HSELand.

Timeframe: Course differs in dates for staff. All current staff to have undertaken the respective training / education by 27.03.20.

Responsibility: Registered Provider, Person In Charge.

Oversight: Registered Provider.

Meetings and Learnings:

Staff upskilling and learning will be supported through meetings to discuss and share learnings, best practices, incidents, complaints, risk management activities including additional training needs. Two meetings have been held with minutes circulated.

Timeframe: Meetings have commenced and will continue every two weeks.

Responsibility: Person In Charge, CSM.

Oversight: Registered Provider.

Preventative actions and monitoring:

Following implementation of the staff induction, supervision and competency framework, a programme of regular oversight and monitoring/measuring programme will be put in place which will include an audit schedule and monthly key performance indicators. The results will be reported and recorded during monthly management team meetings. Learnings will be communicated to staff during monthly staff meetings with due regards to GDPR.

Timeframe: 29.02.2020

Responsibility: Registered Provider, Person In Charge.

Oversight: Registered Provider.

Regulation 21: Records

Not Compliant

<p>Outline how you are going to come into compliance with Regulation 21: Records: All staff have up to date mandatory training completed. Training records have been updated, a copy of certificates of completion will be kept in staff files which will be overseen by the HR administrator. An individual staff file audit will be completed by the HR administrator prior to a staff member commencing induction. The staff file audit is a safeguard to ensure that all records are in place prior to working.</p> <p>As part of the measures outlined in the response plan for regulation 16, all nursing staff will receive training on recording of daily nursing notes, assessments and care planning activities to ensure that the documentation is reflective of the care delivered. Training is scheduled for 11th and 14th February. All allied health professionals have been given their own log in codes on the electronic patient record system. Where there is a recommendation from an allied health professional, care plans will be revised with the recommendations and communicated to staff in handover report.</p> <p>Preventative actions and monitoring: A programme of regular oversight and monitoring/measuring programme will be put in place. The audit will monitor the quality of care plans to ensure that they are reflective of the needs, preferences and supports of residents and monthly key performance indicators. The results will be reported and recorded during monthly management team meetings. Learnings will be communicated to staff during monthly staff meetings with due regards to GDPR.</p> <p>Timeframe: 29.02.2020. Responsibility: Registered Provider, Person In Charge. Oversight: Registered Provider.</p>	
<p>Regulation 23: Governance and management</p>	<p>Not Compliant</p>
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management: The management structure has been revised, the revision includes an increase in nursing staff and introduction of administrative roles.</p> <p>The specific increases are detailed in the response plan outlined under regulation 15 staffing the expansion of the management structure includes five additional nursing staff, increase of CMM2 to 3, increase activities staff, introduction of Clinical Support Manager, HR administrator and reception/administrator role. Current resources have also been reviewed and the maintenance role will now be expanded to include elements of health and safety.</p> <p>The revised Management structure was overseen by an external regulatory support</p>	

agency and is required to ensure effective oversight and management requirements by the Person In Charge as required by regulation.

The oversight and supervision of staff will be delivered by the Clinical Support Manager and overseen by Person In Charge. The introduction of additional administrative roles will provide administrative support to the Person In Charge enabling further engagement in monitoring activities.

Completed.

Regulation 3: Statement of purpose	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose has been updated to reflect the updated management structure and staffing levels

Status: Completed and will be subject to regular review upon appointment of new nursing staff planned for February and March.

Regulation 34: Complaints procedure	Not Compliant
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints process was reviewed on 23.01.2020 a new process was proposed and agreed. The policy and procedure for complaints will be processed mapped and agreed on 14.02.2020 and communicated to all stakeholders and staff. All feedback and suggestions are welcomed, and facilities are available for all stakeholders to make a complaint to any member of staff or record a complaint/suggestion.

The complaints officer (registered provider) will be responsible for ensuring that all complaints are closed out including the relevant documentation at monthly management team meetings.

Complaints will be subject to monthly independent audits and quality checks to ensure appropriate actions and complainant satisfaction. Quality initiatives include the introduction of formal trending mechanisms to identify learnings and preventive initiatives. External advocacy services are available for residents and their representatives to avail of and there is an internal appeals procedure outlined in the resident's guide.

Learnings identified from incidents will be communicated to all staff.

Status: Meeting will be held with staff week of 28.02.2020 to inform them regarding the revised policy and identify training needs of staff.

Preventative actions and monitoring:
 A programme of regular oversight and monitoring/measuring programme will be put in place which will include a monthly audit of complaints to ensure that the complaint has been recorded appropriately by staff and managed in line with regulatory requirements and the guidance on a human rights based approach in health and social care services HIQA 2019. The results will be reported and recorded during monthly management team meetings. Learnings will be communicated to staff during monthly staff meetings with due regards to GDPR.

Timeframe: 29.02.2020.
 Responsibility: Registered Provider, Person In Charge.
 Oversight: Registered Provider.

Regulation 11: Visits	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 11: Visits:
 Visiting hours and this has been discussed and agreed at a residents meeting resulting in unrestricted visiting times between 11 am and 9pm. Protected meal times have been put in place to ensure nutritional needs of residents are met and their dignity is safeguarded.

Families are welcome to visit during meal times but they will be asked to wait until the resident has completed their meal. Where residents wish to be assisted by a relative with their meal an area has been identified to ensure the dignity and privacy of other residents is not compromised.

Status: completed and subject to ongoing review based on resident feedback and monitoring activities.

Regulation 13: End of life	Not Compliant
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Outline how you are going to come into compliance with Regulation 13: End of life:
 Additional training on end of life care for staff. Training will be provided by the Palliative Care team on 11th and the 19th February 2020. Following training from the Palliative

Care Team, residents wishes regarding end of life care will be discussed with the resident and their relative where applicable. The residents GP and MDT team will be included as required. Where resident express their wishes regarding end of life care a plan will be developed, agreed and subject to regular review. The care plan will also include the emotional and spiritual support requirements and support services for their representatives or relatives. Where residents do not wish to discuss their end of life care or actions to be taken such as resuscitation this shall be documented and reviewed respectfully.

Timeframe: 29.02.2020.

Responsibility: Registered Provider, Person In Charge.

Oversight: Registered Provider.

Regulation 17: Premises	Not Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:
Furnishings:
 A referral has been made to an occupational therapist to review appropriate seating arrangements for residents. Specialist chairs for residents that required replacement have been ordered and we are awaiting delivery. Existing chairs with minor wear and tear will be refurbished and or replaced where necessary. An ongoing preventative maintenance programme will be put in place for equipment and facilities by 30.01.2020.

Tables:
 Tables were put in place on 30.01.2020 have been put in place to facilitate resident's needs

Call Bells and Supervision:
 The additional staff and supervision arrangements have been outlined in regulation 15 in addition. Call bells have been added to all residents private seating areas. .

Regulation 26: Risk management	Not Compliant
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Outline how you are going to come into compliance with Regulation 26: Risk management:
Renovation works:
 All residents are made aware of the maintenance taking place in the home. This is discussed at residents meeting and daily updates are given. In the future where

renovations or refurbishments are taking place a risk assessment and caution notice will be displayed in the affected areas.

Incidents and Accidents:

A formal trending and monitoring programme will be implemented on 30.01.2020 to enable senior management oversight of prevention strategies implemented for all incidents and accidents including falls. Incidents and accidents will be reviewed and discussed at Management Team Meetings. New or emerging risks will be added to the risk register with mitigating actions to reduce the impact and risk. Consultation will be made with external allied health professionals for risk mitigation strategies including; falls prevention, restrictive practices, medication management, infection prevention and control, end of life care and care of residents with cognitive impairments or mental health supports. Risks identified will be added to the risk register and managed as per the Risk Management Cycle.

Preventative actions and monitoring:

A programme of regular oversight and monitoring/measuring programme will be put in place which will include a monthly review of high risks identified on the risk register and identification of risks to ensure compliancy with risk management practices.

The Guidance for Designated Centres Risk Management HIQA 2014 and HSE Risk Management Policy HSE 2017 training and guidance supports will be used as the framework to guide practice. The results from audits and risks assessments will be reported and recorded during monthly management team meetings. Learnings will be communicated to staff during monthly staff meetings with due regards to GDPR.

Timeframe: 30.01.2020.

Responsibility: Registered Provider, Person In Charge.

Oversight: Registered Provider.

Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions: As part of the revised induction programme all new staff as part of their induction will be trained regarding fire precautions and prevention activities in place to mitigate the risk of fire. A person with appropriate skill set has been identified to conduct fire drills, daily checks and maintenance of associated fire checking records, he will be trained to deliver the training to staff internally as part of induction on 11.02.2020 by external provider Fire drills have now been increased from twice yearly to four times per year.</p> <p>An unplanned fire drill is scheduled for the beginning of 11th February 2020. The findings from fire drills will be used as an opportunity for learning, the fire officer will use the information gathered as part of the fire drills for education. Residents and staff will be included in education sessions.</p>	

Preventative actions and monitoring:

A programme of regular oversight and monitoring/measuring programme will be put in place which will include a monthly review of high risks identified during fire drills.

The Fire Precautions Guidance for Designated Centres HIQA 2016 will be used as the framework to guide practice. The results from audits and risks assessments will be reported and recorded during monthly management team meetings. Learnings will be communicated to staff during monthly staff meetings with due regards to GDPR.

Timeframe: 29.02.2020.

Responsibility: Registered Provider, Person In Charge.

Oversight: Registered Provider.

Regulation 5: Individual assessment and care plan	Not Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

All nursing staff as part of their induction will have training on the scope of assessments for residents, development of person-centered care planning and professional record keeping. Existing nursing staff shall also be trained on the Assessment and Care Planning Module to mitigate the risk inappropriate care planning and a lack of adequate guidance to staff. The training commenced on 06.02.2020 and is scheduled for 11.02.2020 and 14.02.2020. Best practice and guidance documents available shall be used to develop evidenced based holistic care plans for residents that are specific to their abilities, needs and required supports.

In addition, health care assistants and activities staff shall also be trained on the care planning process and the importance of their involvement in the care planning and re-evaluation process. The staff deployment and allocation system will enable a consistent level of care delivery supervision and enhance a person-centered focus to care practices including social care needs of each resident.

A multidisciplinary approach to care planning shall ensure that where the input of allied health services is sought; that their recommendations and input are included in care practices and the residents care plan. A review has been undertaken to ensure residents have been referred where required for example; psychiatry of later life, dietician. Allied Health Professionals that are involved in residents care now have access to document their recommendations in the electronic resident record.

As part of the competency assessment framework being implemented where staff training needs will be identified through supervision activities which shall be addressed by the Clinical Support Manager and external regulatory support.

Preventative actions and monitoring:

A programme of regular oversight and monitoring/measuring programme will be put in place which will include a monthly review of assessment and care planning activities.

A suite of guidance and best practice documents including national guidelines and HIQA will be used as the framework to guide practice. The results from assessment and care planning audits, risks assessments, and staff competency assessments will be reported and recorded during monthly management team meetings. Learnings will be communicated to staff during monthly staff meetings with due regards to GDPR.

Timeframe: 29.02.2020.

Responsibility: Registered Provider, Person In Charge.

Oversight: Registered Provider.

Regulation 6: Health care	Not Compliant
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Outline how you are going to come into compliance with Regulation 6: Health care:
Care Planning

A part of the staff deployment and allocation system implementation all residents shall have their assessments and care plans reviewed every three months. The review will encompass the following;

- Comprehensive assessment of care needs and care plans
- Access to screening programmes
- Review of seating arrangement where required
- Medication review and pharmacy review of medications special consideration to high risk activities as per 3.4.7 of standards
- Review of MDT referrals and external allied health professional input
- Restrictive practices, resident rights
- Safeguarding
- This list is not exhaustive

All assessment and care plan reviews will be completed with the resident and or their relative where consent has been obtained. The review shall involve the residents assigned staff member of deployment and allocation system.

Specialist seating

Any resident who requires seating assessment will be assessed by an OT. The referral for assessment may be made privately by referral to HSE or privately by the resident/family. All current residents who require specialist seating have been referred to the HSE. Existing seating shall be refurbished or replaced. A review of current entitlements under the HSE scheme has been completed. As part of the comprehensive assessment and care

plan review referrals will be made by the appropriate health professional for the required professional services through HSE or private services.

Preventative actions and monitoring:

A programme of regular oversight and monitoring/measuring programme will be put in place which will include a monthly sample review of resident care plans, risk assessments and documentation.

A suite of guidance and best practice documents including national guidelines and HIQA will be used as the framework to guide practice. The results from assessment and care planning audits, risks assessments, and staff competency assessments will be reported and recorded during monthly management team meetings. Learnings will be communicated to staff during monthly staff meetings with due regards to GDPR.

Timeframe: 29.02.2020.

Responsibility: Registered Provider, Person In Charge.

Oversight: Registered Provider.

Regulation 9: Residents' rights	Not Compliant
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Outline how you are going to come into compliance with Regulation 9: Residents' rights: Meaningful activities for residents:

Meaningful activities are now delivered to residents in communal areas from 13.00hrs-17.30hrs Monday to Friday. A second assistant activities organizer delivers activities from 9.00am- 4 pm Monday to and alternative Saturdays. Residents have requested that group activities are not delivered on Sundays.

A Health Care Assistant is allocated to deliver activities to residents from 14.00hrs-16.00hrs.

A meaningful activities programme has been developed and is displayed in the reception area. The meaningful activities programme has been informed by completion of a validated evidenced based assessment "A key to me" for each resident. Upon reviewing the resident current care plans where one to one opportunity for activities are identified they shall be discussed with the activities team and facilitated.

Staff communicate activities planned for the day to resident during personal care activities and mealtimes. Upon appointment of the new activities assistant the programme will be further expanded to include local community links and expand one to one activities for those residents who do not wish to participate in group activities.

Preventative actions and monitoring:

A programme of regular oversight and monitoring/measuring programme will be put in place which will include a monthly sample review of resident social and activity care plans, risk assessments and documentation.

The results from audits, resident surveys/feedback risks assessments, will be reported and recorded during monthly management team meetings. Learnings will be communicated to staff during monthly staff meetings with due regards to GDPR.

Timeframe: Programme Development completed. 29.02.2020 for monitoring and auditing.

Responsibility: Registered Provider, Person In Charge.

Oversight: Registered Provider.

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 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Substantially Compliant	Yellow	09/01/2020
Regulation 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Not Compliant	Orange	01/04/2020
Regulation 13(2)	Following the	Not Compliant	Orange	01/04/2020

	death of a resident the person in charge shall ensure that appropriate arrangements, in accordance with that resident's wishes in so far as they are known and are reasonably practical, are made.			
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.	Not Compliant	Orange	01/05/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	01/04/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	09/01/2020
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	13/01/2020

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	Orange	13/01/2020
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	01/04/2020
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Yellow	01/02/2020
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	01/02/2020

Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	14/01/2020
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	01/02/2020
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Not Compliant	Orange	01/02/2020
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	Not Compliant	Orange	01/02/2020

	involving residents.			
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Orange	01/04/2020
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	01/04/2020
Regulation 28(2)(i)	The registered provider shall make adequate	Not Compliant		01/08/2020

	arrangements for detecting, containing and extinguishing fires.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	13/01/2020
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Not Compliant	Orange	13/01/2020
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their	Substantially Compliant	Yellow	13/01/2020

	complaint and details of the appeals process.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	10/04/2020
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	13/01/2020
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord	Not Compliant	Orange	13/01/2020

	Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	01/02/2020
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	01/04/2020
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	01/04/2020