Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>St Phelim's Nursing Home</th>
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<tbody>
<tr>
<td>Name of provider:</td>
<td>Flanagan's Nursing Home Limited</td>
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<tr>
<td>Address of centre:</td>
<td>Dromahair, Leitrim</td>
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<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Date of inspection:</td>
<td>25 November 2019</td>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000395</td>
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<tr>
<td>Fieldwork ID:</td>
<td>MON-0027217</td>
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About the designated centre

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

St Phelim’s Nursing Home is a purpose-built centre which opened in 1996. The centre is located in a rural area approximately 1km outside the town of Dromahair in County Leitrim. It is currently registered for 85 residents. Most of the residents have lived in the surrounding area prior to their admission to the centre. The centre provides care and support for female and male adult residents mainly from 65 years of age. Respite and convalescent care may be provided to both under and over 65 years. Day care services are also provided to residents from the local community. The building has two floors with all residents accommodated on the ground floor. Bedroom accommodation comprises a mix of single, double and multiple occupancy rooms, in four units: Lough Gill, Railway View, Railway Court and Inisfree. The provider is currently in the process of extending the premises. A secure courtyard garden is available. Nursing and care staff are available 24 hours per day and the management team are all based in the centre to oversee care.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 82 |


How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (hereafter referred to as inspectors) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.
This inspection was carried out during the following times:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday 25 November 2019</td>
<td>08:30hrs to 19:00hrs</td>
<td>Catherine Sweeney</td>
<td>Lead</td>
</tr>
<tr>
<td>Monday 25 November 2019</td>
<td>08:30hrs to 19:00hrs</td>
<td>Geraldine Jolley</td>
<td>Support</td>
</tr>
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</table>
What residents told us and what inspectors observed

Inspectors spoke with seven residents during the inspection.

The residents were familiar with the provider representative. Most of the residents who met with inspectors told the inspectors that staff were kind and respectful to them. However, residents' comments on the availability of staff to attend to their needs in a timely manner concerned the inspectors.

Inspectors observed that residents' rights were significantly impacted by the care environment. Details of this impact is described under Regulation 9, Residents rights.

Capacity and capability

This report sets out the findings of an unannounced inspection by the Office of the Chief Inspector to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

Inspectors also reviewed the detail of an application made by the registered provider to remove the following condition from the registration of the designated centre:

*Condition 8: Existing Laundry – Room 31 will become a twin room with en-suite from 30 November 2018 and at which time Room 2 in Innis free currently a 4 bedded room will be reduced to 3 occupancy and Room 1 Railway currently a 5 bedded room will be reduced to 4 occupancy.*

Inspectors found that the schedule of works referenced in Condition 8 had been completed.

The organisational structure of the centre was not clear and there was a blurring of the roles and responsibilities within the management team. The registered provider representative (RPR) was also the person in charge. According to the Statement of Purpose, the role and responsibilities of the person in charge was shared by three members of the management team. The registered provider representative confirmed that this was the case.

Some of the documents requested by inspectors on the day of inspection were not produced in a timely manner. For example, a number of policies set out in Schedule 5 of the regulations, were not included in the policy folders. Inspectors requested the policies on complaints and protection at the start of the inspection. The
complaints policy was made available eight hours later. The centres protection policy was not made available on the day. The policies were not organised in a way that they were easily retrieved. The documents, when they were received, were acceptable.

Inspectors found that there was ongoing improvement in relation to the premises. Deficits in the premises are being addressed through the phased building programme, part of which has been completed and a planned extension is expected to be completed in December 2021. This plan will significantly enhance the lives of the residents in the centre.

The registered provider representative worked in the centre on a day-to-day basis which ensured that a member of the management team was available to respond to any issues or queries. Inspectors reviewed a sample of staff files. These contained the required information including vetting disclosures.

Staffing levels required review. Inspectors observed that care staff were very busy throughout the morning and were at all times fully engaged with assisting residents' to get up. However, many residents were not assisted to get up until lunch time and this did not reflect the wishes of these residents.

Inspectors concluded that the governance and management of the centre needed to be strengthened and improved. This was supported by the following findings:

- The organisational structure of the centre was not clear and there was a blurring of the roles and responsibilities within the management team. There was a lack of accountability as three senior staff members shared the role and regulatory responsibilities of the person in charge.
- the documented monitoring and oversight through audits of the service did not reflect the findings on this inspection.

### Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The registered provider had submitted an application on the 25 October 2019 for the removal of Condition 8 from the registration of the designated centre.

The registered provider had converted the existing laundry to a twin room with en-suite shower facilities, and had reduced the occupancy of Room 2 Innisfree from four to three and Room 1 Railway view from five to four.

This application was made in line with regulatory requirements.

Judgment: Compliant
Regulation 15: Staffing

Inspectors found that the staffing levels, especially in the morning, were not adequate to meet the needs of the residents.

The centre provided long term care for 85 residents with varying dependencies. On the day of inspection there were 82 residents accommodated in the centre. Of these, 33 residents were assessed as having high dependency needs, 39 residents had medium care needs and 10 were assessed as low dependency.

A review of the rosters found that the person in charge and the Assistant director of nursing (ADON) were rostered daily from 8am to 5pm including weekends. There are four qualified nurses on duty during the day and two on night duty from 10pm until 8am. The nurses are supported by 11-12 care assistants in the mornings until 2:30pm, and 10 in the afternoon. There are three care assistants on night duty from 10pm-8am.

The centre had an activity coordinator on duty from 10am until 4pm from Monday to Friday.

From observations and residents feedback, the inspectors concluded that a review of staffing was required to ensure that staff were appropriately delegated and supervised when providing care for residents. For example, inspectors observed the following:

- residents waiting extended periods to be assisted with their care needs. Inspectors observed that although staff were working hard, at least seven residents were not up at 12.30pm. Inspectors found that this was not because residents requested a line on in bed. One resident informed the inspectors that they had waited three hours for assistance to get up and dressed. Staff confirmed that the situation on the inspection day was not unusual.
- residents with bed rails was attempting to get up from their bed. A review of the resident's file found that the bed rails had been used without appropriate assessment.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents was reviewed and included all the information required by Schedule 3 of the Regulations.
Judgment: Compliant

**Regulation 22: Insurance**

A certificate of valid insurance until 31 May 2020 was in place.

Judgment: Compliant

**Regulation 23: Governance and management**

The organisational structure of the centre was not clear and there was a blurring of the roles and responsibilities within the management team. The person in charge in the centre did not appear to understand the obligations of a Person in Charge in relation to meeting the requirements under the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013.

The registered provider, Flanagan's Nursing Home Limited had nominated the person in charge to also be the registered provider representative. The person in charge told inspectors that the responsibility of the person in charge was shared between the three members of staff. The statement of purpose also identified the three members of staff (Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Clinical Nurse Manager (CNM) as the person in charge. A review of the registration certificate confirmed that the registered provider representative was listed as the Person in Charge of the designated centre. The two other members of staff were listed as 'Persons Participating in Management (PPIM's).

There was confusion as to who held the authority, accountability and responsibility for the provision of services and this resulted in poor oversight of the service. For example, the person in charge was not able to explain the significant gaps found in the centre’s restraint register. All questions relating to restraint management were referred by the person in charge to the assistant director of nursing.

The centre had a audit schedule in place for 2019. Audits had been completed in medicine management, resident satisfaction, restraint, nutrition and a call bell audit. However, the audits required strengthening, including data analysis and action plans to inform quality improvements in the centre. The audits reviewed did not reflect the findings of this inspection.

Regular meetings were held and documented, including, nurse and carer meetings, management meetings, and health and safety meetings. These meetings included updates in relation to fire safety upgrades and person-centred care.

An annual review for 2018 was completed.
<table>
<thead>
<tr>
<th>Regulation 3: Statement of purpose</th>
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<tbody>
<tr>
<td>A review of the Statement of Purpose is required to ensure that the organisational structure in the centre is clearly identified. The narrative that describes the layout of the centre also requires review.</td>
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<tr>
<th>Regulation 34: Complaints procedure</th>
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<tr>
<td>The centre had a complaints policy in place. The complaints procedure was displayed prominently in the reception area and detailed in the residents' guide. The policy contained inaccurate information in relation to supports available to residents and their families who made a compliant or who wished to make a complaint.</td>
</tr>
<tr>
<td>Inspectors were not assured that all complaints were recorded. A review of the complaints log found that three complaints had been recorded in 2019. The complaints related to missing items. Furthermore, for some complaints, details of the investigation and any action taken on foot of the complaint had not been recorded.</td>
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<tr>
<td>Inspectors spoke with a number of residents who stated that they had made verbal complaints to staff in relation to care issues. These issues had not been documented. The person in charge confirmed that issues in relation to residents care needs are resolved at local level and were not documented.</td>
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<tr>
<th>Regulation 4: Written policies and procedures</th>
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<tr>
<td>A number of policies and procedures required under Schedule 5 of the regulations were not organised in a way that they were easily retrieved. Oversight required to ensure that policies were implemented was poor. The complaints policy and the protection policy were not implemented.</td>
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<tr>
<th>Judgment: Not compliant</th>
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Quality and safety

Overall, the quality and safety of care delivered to residents in some parts of the centre was compromised by the following:

- the design and layout of multi-occupancy rooms,
- lack of access to toilet and shower facilities for some residents,
- the failure to ensure the privacy and dignity of some residents,
- the provider's failure to respond appropriately to a disclosure from a resident of an alleged incident of abuse,
- poor restrictive practice management,
- the lack of storage available to some residents.

The issue identified in relation to the design and layout of multi-occupancy rooms, the lack of access to toilet and shower facilities for some residents, and the failure to ensure the privacy and dignity of some residents are restated from previous inspections. In contrast the residents accommodated in the new part of the centre had their privacy and dignity needs met.

All residents in the centre had an up-to-date assessment and care plan in place. A review of the assessment and care planning process was required to ensure that all care plans were comprehensive and informed by the assessments.

The provider had recently upgraded the fire safety systems throughout the centre. A review of the fire safety documentation found that all fire safety procedures, equipment maintenance, staff training and drills were well maintained and documented.

There was a social care programme and the inspectors saw that staff engaged with residents and encouraged them to take part in conversations about the news and current events. There was good access to primary care services and allied health professionals including the general practitioner (GP) and pharmacist.

Regulation 12: Personal possessions

There was a labelling system for clothing that the inspectors noted was clear and durable. Clothing was laundered on site and there was appropriate equipment to ensure clothing and other laundry was maintained in good condition.

The wardrobe in some bedrooms did not ensure that there was adequate space to store and maintain residents clothes and other personal possessions.

- Room 5 (Innisfree) which had four beds only had storage for three residents.
- Room 1 (Lough Gill) had a small bedside cabinet used as a wardrobe.
• Room 10 (Railway view) had two small wardrobes for 2 residents. There were two shelves fitted within the wardrobes. One resident had clothes folded in the bottom of the wardrobe.

Judgment: Not compliant

Regulation 17: Premises

The centre was a purpose built, two-storey building. All residents were accommodated on the ground floor. There was appropriate signage throughout the centre. The centre has three 4-bedded rooms, seven 3-bedded rooms, 10 double rooms and 32 single rooms. The centre was comprised of four units called Lough Gill, Innisfree, Railway View and Railway Court. The centre was extended to accommodate 85 residents. The new extension called Railway Court, had 20 single en-suite bedrooms, with associated living and dining facilities.

The new unit, Railway Court was finished to a high standard. This area of the centre was well decorated, warm and well ventilated. There was suitable flooring throughout the centre. The lighting in the single rooms was appropriate to meet the needs of the residents. A new laundry facility had been added and was appropriate to meet the needs of all residents. However, the quality of the premises is not consistent throughout the designated centre.

The inspectors found that the quality and safety of care in the Lough Gill Unit, the Innisfree unit, and River View Unit in the centre continued to be compromised by the space and layout of multi-occupancy rooms and a lack of toilet and shower facilities.

The registered provider had completed an extension to the premises in 2018. This area where 20 residents are accommodated provided a high quality care environment where residents had the benefit of large well furnished single bedrooms with en-suite facilities. A plan to further develop the designated centre had been submitted to the Chief Inspector. The plan included the addition of single bedrooms with en-suite facilities and additional communal living areas. This development is due for completion by December 2021 and when completed will significantly enhance the quality of life for residents.

However, the layout of residents' accommodation in the original building adversely impacted on residents' privacy and dignity. For example, there are a number of rooms where, while they meet minimum space standards, privacy and dignity is difficult to maintain and there is inadequate space for a bedside chair and insufficient storage facilities. This is illustrated by the issues identified in the following rooms:

• Room 1- Lough Gill Unit, located beside reception is a bedroom with doors opening into a communal visitors room. These doors have blinds in place covering the window to this bedroom. The blinds can only be accessed and altered from the communal side of the door. The doors are not sound
proof. All sound made in the bedroom can be heard in the communal room. Inspectors, sitting in the communal room overheard carers whispering to the resident accommodated in the bedroom. There is a windowed panel above the double doors which allows light to enter the residents bedroom from the communal room. The resident had no control over the brightness of this room. The resident in this bedroom needs to travel through the reception areas to access a toilet and a shower. A sink unit in this bedroom blocks access to the window and one side of the resident’s bed where the residents locker is situated. There was limited wardrobe space available to the resident.

- Room 12- Lough Gill Unit is a 3-bedded room that lacked adequate natural light. There is one small window located beside one of the beds. When the privacy screen is used around this bed there is no natural light available to the other two residents.
- Room 8, 9, 10 and 11- Lough Gill Unit, inspectors noted a strong smell of tobacco smoke in these rooms. These rooms are located behind the designated centre’s smoking room.
- Room 2- Lough Gill Unit, a 3-bedded room that was not adequate in size to meet the needs of the residents. Three residents were accommodated in this room however, only two comfortable chairs and one bed table was available. One resident required the use of a hoist to transfer from chair to bed. Staff informed the inspectors that furniture including the beds of other residents needed to be moved to facilitate care delivery.
- Room 9, a 3-bedded room located beside the dining room in the River View unit, was laid out in a manner which impacted on the privacy and dignity of the residents. The room was not adequately warm. A resident in this bedroom complained to the inspectors that he felt cold. The residents accommodated in this bedroom did not have close access to a bathroom or a shower. The nearest toilet facilities were located on Lough Gill Unit which required residents to move through the communal areas and the reception area in order to access these facilities.
- Room 5- Innisfree Unit, a 4-bedded room had two comfort chairs available. Beds were situated in close proximity to each other. Privacy screens in this room did not extend correctly between beds leaving significant gaps.
- Bedroom 4 and 5 - Railway view. Residents in these rooms did not have close access to a toilet or shower. Residents in these rooms had to move through two units in the centre to access a toilet facility.

Judgment: Not compliant

Regulation 20: Information for residents

A residents guide that contains all the information required under Regulation 20 is available in an accessible format for residents. Notice boards are in place throughout the centre detailing the activities scheduled, resident information and community
Regulation 27: Infection control

The centre was visibly clean and cleaning staff interviewed had a good knowledge of cleaning methods that ensured good infection control practice. They were knowledgeable about the chemicals used for cleaning and the safety precautions they had to observe. Staff were observed to move furniture when cleaning and to leave areas safe when they finished their cleaning duties.

Judgment: Compliant

Regulation 28: Fire precautions

The centre had a robust fire safety interventions in place. The centre had recently upgraded the fire safety system to an L1 addressable system and work to reduce the size of the zones in the centre had been completed. The centre was divided into 15 zones. Each zone had a fire safety notice board with the fire procedure clearly described. There was way finding maps displayed prominently and each map clearly displayed the nearest emergency exit location. The location of fire fighting equipment was also clearly identified.

Inspectors reviewed the fire safety system and equipment maintenance records and found that they were serviced on an annual basis.

Each resident had an personal emergency evacuation plan and this was filed in an accessible place for use in an emergency.

The staff team had completed comprehensive zone evacuation drills. Drills were timed and learning from each drill was identified and used to inform subsequent drills. The records of fire drills were reviewed and were noted to be comprehensive with details of the scenario and any learning form the event clearly outlined.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Each resident had an up-to-date assessment and a care plan in place, however, some records did not reflect a person-centred care approach and some information
in assessments conflicted with the information in care plans. There was an informative summary of what residents had described as important to them which was used to guide staff practice. The inspectors found that where assessments indicated a particular need, there was an associated care plan to address this and to promote health and well being.

Residents and relatives were consulted about care plans and there was information in the care records that confirmed this consultation.

The contribution of allied health professionals including a physiotherapist was described in care records. These interventions had contributed positively to residents’ quality of life. For example, improvements to mobility were described. The encouragement, exercises provided and progress were all outlined and illustrated an improving quality of life for some residents.

There were some records where assessment information did not reflect the information in care records, which could cause confusion for staff. For example, a moving and handling assessment indicated that two staff were needed for moving and handling manoeuvres but the care plan indicated that one staff was required. There was no information to indicate if residents were able to negotiate the step into the showers in en-suites in the records inspected.

Judgment: Substantially compliant

**Regulation 6: Health care**

The residents had good access to a general practitioner (GP) services, allied health professionals and specialist services. Residents told inspectors that their health needs were addressed promptly.

Judgment: Compliant

**Regulation 7: Managing behaviour that is challenging**

The restraint register in the centre did not accurately document the use of restraint. Inspectors observed staff using bed rails in the delivery of care to two residents who had not been assessed for their safe use. The two residents were not included on the restraint register as requiring bed rails to maintain their safety. Staff did not demonstrate knowledge of safe practice in relation to the use of bed rails. Bed rails were available for use on every bed in the centre. The inspectors observed that one resident had a bed rail in place during the morning and the resident's feet were protruded through the rail. This was brought to the attention of the nurse on duty who addressed this. This resident was not included on the restraint register.
Residents who displayed responsive behaviours (how persons with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had care plans in place. Responsive behaviours were recorded to inform and guide staff practice and ensure appropriate monitoring of incidents took place. Inspectors saw that the records were up to date and completed to a good standard.

Judgment: Not compliant

Regulation 8: Protection

All staff had received up-to-date training in the Safeguarding of Older Adults. The person in charge informed the inspectors that they were a designated safeguarding officer.

On the day of inspection, a resident disclosed an allegation of abuse to inspectors. The person on charge was informed of this disclosure during the inspection. The initial response of the person in charge and the actions taken were not in line with the centres safeguarding policy and did not provide assurance that the alleged incident would be properly managed, in line with best practice.

The safeguarding policy was not made available for review on the day of inspection. It was forwarded to inspectors the day following the inspection.

The provider was requested to submit a notification of the alleged incident with details of the action taken to respond to the incident.

Judgment: Not compliant

Regulation 9: Residents' rights

A number of residents informed the inspectors that issues and concerns that they had voiced had not been responded to by the management team. For example, a resident described the delay in getting up each morning. They stated that it was normal to be waiting until after midday to receive assistance to get ready for the day. They stated that they felt that 'the day was wasted' waiting for help. They stated that they had reported their concern to the nursing team. Three other residents described similar experiences of having to wait from breakfast time to midday before staff were available to help them get washed and dressed. Another resident said that while they liked to get up and leave the bedroom they often chose not to as staff were not available to help them back to their room when they wished to return there.

The use of multi-occupancy rooms and the lack of shower and toilet facilities for
residents without en-suite bathrooms, continued to impact on the privacy and dignity of the residents accommodated in these rooms. This includes the newly converted twin room.

Previously stated non-compliances in relation to this regulation had not been addressed. For example,

- each resident's wardrobe was not in close proximity to the resident's bed space,
- residents who required the use of a hoist or equipment to mobilise such as a wheelchair could not negotiate safely around their bed space without impeding on other residents' personal space,
- some residents did not have appropriate access to a toilet or shower.

Furthermore, inspectors observed a number of additional issues that impacted on resident's rights. For example,

- a care record reviewed described a resident as liking to be well groomed, however, the care plan indicated that a shower was to be provided once a week
- could not exercise personal choices in relation to when they wished to get up and go to bed or when they had baths or showers. Inspectors spoke with a resident who had stayed in bed for the day. The resident informed inspectors that they would like to get up but they feared that there would be nobody available to put them back to bed when they wished to return.
- Staff were observed to enter residents rooms without knocking.
- Inspectors observed a resident in their bed in the afternoon. The resident asked the inspectors for a blanket and stated they were cold. The resident was lying on their bed with a sheet over them. They did not have access to a blanket, a duvet or a pillow. Staff addressed this when it was brought to their attention, however, the inspectors formed the view that residents' rights to a comfortable, safe environment that protected their dignity was compromised by a lack of attention to factors that promote quality of life.

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:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 19: Directory of residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 22: Insurance</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 4: Written policies and procedures</td>
<td>Not compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
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<tr>
<td>Regulation 12: Personal possessions</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 20: Information for residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 27: Infection control</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Compliant</td>
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<tr>
<td>Regulation 5: Individual assessment and care plan</td>
<td>Substantially compliant</td>
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<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
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<tr>
<td>Regulation 7: Managing behaviour that is challenging</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 9: Residents' rights</td>
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Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action **within a reasonable timeframe** to come into compliance.
Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be SMART in nature. Specific to that regulation, Measurable so that they can monitor progress, Achievable and Realistic, and Time bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider’s responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider’s response:

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15: Staffing</td>
<td>Not Compliant</td>
</tr>
</tbody>
</table>

Outline how you are going to come into compliance with Regulation 15: Staffing:
A staffing level review has been undertaken to ensure the appropriate number of staff are rostered at all time to provide the appropriate level of care. The review identified opportunities for improvement to address the issues found during the inspection. The review identified the care staff resident ratio and allocated care hours were reflective of current best practice, however SPHN intends to reduce the number of beds, and thus residents, by 4 beds, (reduction from 85 beds to 81), while maintaining the level of staff. This will see an improvement of care staff resident ratios and care hours available.

Responsibility: CEO (Registered Provider Representative)
Timeframe: 28th February 2020

The staffing review also identified the need for more defined staffing and area allocations throughout the day to ensure appropriate staff to assist residents in getting up and engaging in activities.
Appointment of two additional Clinical Nurse Managers to ensure effective floor management, and responsibility, of all care staff 7 days a week.

Responsibility: Director of Care (Person in Charge)
Timeframe: Completed

Development of daily care staff area allocation plan, relating to the times of day, to ensure the maximum use of care staff to support resident activities including getting up, dinning, and activities of daily living.

Refocusing of Senior Health Care Assistants role to ensure the identification, and support, of responsibilities for Health Care Assistants allocation in line with daily staffing area allocation plan.

Responsibility: Director of Care (Person in Charge)
Timeframe: 28th February 2020
An independent audit of compliance to these specific aspects of Regulation 15: Staffing shall be undertaken and all resultant actions followed up and closed out.

Responsibility: CEO (Registered Provider Representative)
Timeframe: 30th April 2020

<table>
<thead>
<tr>
<th>Regulation 23: Governance and management</th>
<th>Not Compliant</th>
</tr>
</thead>
</table>

Outline how you are going to come into compliance with Regulation 23: Governance and management:
An externally facilitated review has been undertaken of the governance and management structures to ensure the management of the centre is strengthened and improved. Changes have been identified to ensure that the organisational structure of the centre is clear in relation to the roles and responsibilities within the management team and beyond.

The CEO role has been revised and shall incorporate the responsibilities of Registered Provider Representative, but not the responsibilities of the Person in Charge.
The Assistant Director of Nursing shall be appointed as the Director of Care, (Person in Charge), and will incorporate all the obligations of a Person in Charge in relation to meeting the requirements under the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013.
Two additional Clinical Nurse Managers have been appointed, and will be identified as Persons Participating in Management (PPIM's) to support the Director of Care (Person in Charge).

Responsibility: CEO (Registered Provider Representative)

The organisational line management structure has been revised and redeveloped to include:
Demarcation between the responsibilities of the CEO (RPR) for support services and the Director of Care (PIC) for care services.
Clinical Nurse Managers direct line responsibility for care staff including nursing staff and Senior Healthcare Assistants
Senior Healthcare Assistants direct line responsibility for Healthcare Assistants

The teams and committee’s governance structure has been revised and redeveloped to include:
Management Team – Defined Terms of Reference, membership and agenda updated
Residents Committee – Defined Terms of Reference, membership and agenda updated
Multidisciplinary Care Team – Established, Defined Terms of Reference, membership and agenda developed
Support Services Team – Established, Defined Terms of Reference, membership and
The Internal Quality Audit programme has been reviewed and revised to ensure a more robust programme focusing on immediate corrective and preventive actions, and continuous improvement through data analysis and shared learning. This has resulted in:

- New Internal Quality Audit Management Policy and Procedure
- Revised Internal Quality Audit Plan to cover all aspects of regulations, standards and policies and procedures

Responsibility: Director of Care (Person in Charge)
Timeframe: Completed

The Internal Quality Audit Programme shall be supported by:
- Externally Facilitated Internal Quality Auditor Training Day
- Quarterly Independent Quality of Care Audits

Responsibility: Director of Care (Person in Charge)
Timeframe: 30th April 2020

An independent audit of compliance to these specific aspects of Regulation 23: Governance and Management shall be undertaken and all resultant actions followed up and closed out.

Responsibility: CEO (Registered Provider Representative)
Timeframe: 30th April 2020

<table>
<thead>
<tr>
<th>Regulation 3: Statement of purpose</th>
<th>Substantially Compliant</th>
</tr>
</thead>
</table>

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose shall be updated in line with organisational, and structural changes. Version control shall be maintained and all out of date versions shall be
Responsibility: CEO (Registered Provider Representative)

An independent audit of compliance to these specific aspects of Regulation 3: Statement of purpose shall be undertaken and all resultant actions followed up and closed out.

Responsibility: CEO (Registered Provider Representative)
Timeframe: 31st May 2020

<table>
<thead>
<tr>
<th>Regulation 34: Complaints procedure</th>
<th>Not Compliant</th>
</tr>
</thead>
</table>

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
A review of complaints management identified opportunities for improvements, in line with the Inspectors findings, in relation to the complaints process, under recording of complaints, and undertaking of the necessary follow up actions and shared learning.

The complaints policy and procedure has been revised to ensure it is in keeping with best practice including ‘Your Service, Your Say’ HSE Complaints Policy (2015), the relevant supports available to residents and their families who made a compliant or who wished to make a complaint, including internal supports from Clinical Nurse Managers, the Director of Care, independent advocacy, and the Office of the Ombudsman.

Revised policy and procedure includes necessary steps for immediate corrective and long term actions. This include responsibilities, timeframes and oversight.

Staff communication re the need to record all complaints verbal, written, formal and informal by any member of staff.

The provision of complaint logs in multiple locations to assist in the record of all complaints verbal, written, formal and informal by any member of staff.

All complaints, related actions, and trends to be review monthly at the Management Team meetings.

Responsibility: Director of Care (Person in Charge)
Timeframe: Completed

The provision of externally facilitated staff education on Complaints Management – Complaints and Feedback -

Responsibility: Director of Care (Person in Charge)
Timeframe: 31st March 2020

An independent audit of compliance to these specific aspects of Regulation 34:
Complaints Procedure shall be undertaken and all resultant actions followed up and closed out.

Responsibility: CEO (Registered Provider Representative)
Timeframe: 31st May 2020

<table>
<thead>
<tr>
<th>Regulation 4: Written policies and procedures</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:</td>
<td></td>
</tr>
<tr>
<td>The presentation and availability of all policies and procedures has been restructured and rolled out. This includes:</td>
<td></td>
</tr>
<tr>
<td>3 sets of policies and procedures are now available within the nursing home. One at each nurses’ station and one in the staff area, to allow for ease of retrieval by all staff. Schedule 5 policies and procedures have been clearly labelled and grouped to ensure staff are aware of the key policies and procedures.</td>
<td></td>
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<tr>
<td>Responsibility: CEO (Registered Provider Representative)</td>
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<tr>
<td>Timeframe: Completed</td>
<td></td>
</tr>
<tr>
<td>To enhance the oversight of the implementation of the policies and procedures the following shall been undertaken:</td>
<td></td>
</tr>
<tr>
<td>Monitoring of sign off of Schedule 5 policies and procedures, on a monthly basis, by the Management Team.</td>
<td></td>
</tr>
<tr>
<td>The Internal Quality Audit programme has been reviewed and revised to ensure a more robust oversight of the implementation of the policies and procedures. This has resulted in:</td>
<td></td>
</tr>
<tr>
<td>Revised Internal Quality Audit Plan to cover all aspects of regulations and standards, and the related policies and procedures</td>
<td></td>
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<tr>
<td>Responsibility: Director of Care (Person in Charge)</td>
<td></td>
</tr>
<tr>
<td>Timeframe: 30th April 2020</td>
<td></td>
</tr>
<tr>
<td>An independent audit of compliance to these specific aspects of Regulation 4: Written Policies and Procedures shall be undertaken and all resultant actions followed up and closed out.</td>
<td></td>
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<tr>
<td>Responsibility: CEO (Registered Provider Representative)</td>
<td></td>
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<tr>
<td>Timeframe: 30th June 2020</td>
<td></td>
</tr>
<tr>
<td>Regulation 12: Personal possessions</td>
<td>Not Compliant</td>
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</tr>
<tr>
<td>Outline how you are going to come into compliance with Regulation 12: Personal possessions:</td>
<td></td>
</tr>
<tr>
<td>A review of the residents wardrobes identified opportunities for improvements in line with the Inspectors findings, regarding adequate space for, and proximity to, some residents personal belongings.</td>
<td></td>
</tr>
<tr>
<td>Room 1 (Lough Gill) - Redevelopment to a full resident suite incorporating exclusive use of the sitting room, (removal of communal room). Inclusion of a full size wardrobe.</td>
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</tr>
<tr>
<td>Room 5 (Innisfree) - Storage redevelopment to provide storage for all four residents.</td>
<td></td>
</tr>
<tr>
<td>Room 10 (Railway view) - Redevelopment of wardrobes to provide necessary space for the two residents.</td>
<td></td>
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<tr>
<td>Responsibility: CEO (Registered Provider Representative)</td>
<td></td>
</tr>
<tr>
<td>Timeframe: 31st March 2020</td>
<td></td>
</tr>
<tr>
<td>An independent audit of compliance to the specific aspects of Regulation 12: Personnel Possessions shall be undertaken and all resultant actions followed up and closed out.</td>
<td></td>
</tr>
<tr>
<td>Responsibility: CEO (Registered Provider Representative)</td>
<td></td>
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<tr>
<td>Timeframe: 30th April 2020</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 17: Premises</th>
<th>Not Compliant</th>
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<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 17: Premises:</td>
<td></td>
</tr>
<tr>
<td>A review of the structures, utilisation and layout of resident’s rooms, to maximise privacy and dignity of the residents, was undertaken which identified opportunities for improvements in line with the Inspectors findings.</td>
<td></td>
</tr>
<tr>
<td>Room 9 - River View unit. Due to the impacts on resident privacy and dignity in this room it shall no longer be a residents bedroom, and will be deregistered. This will reduce the overall occupancy from 85 residents to 81.</td>
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</tr>
<tr>
<td>Room 5- Innisfree Unit – New privacy screens shall be erected to ensure that they extend between the beds, leaving no gaps. Beds shall be moved to maximise the room available in relation to the distance between the beds.</td>
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</tr>
<tr>
<td>Due to the impact on the Residents Privacy and Dignity we proffer to reduce the occupancy by one single bed. In an effort to protect the rights in this multi-occupancy room, but where a permanent vacancy arises a single bed will be removed from the individual bedroom. This will reduce the overall occupancy from 85 residents to 81.</td>
<td></td>
</tr>
<tr>
<td>Room 1- Lough Gill Unit - This shall be redeveloped to a suite incorporating exclusive use</td>
<td></td>
</tr>
</tbody>
</table>
of the sitting room for the resident and their family only, thus no communal room. Inclusion of a full-size wardrobe. Blinds shall be accessed from the resident’s bed area. The windowed panel above the double doors from the resident’s sitting room to the resident’s bedroom shall be covered. The sink unit shall be removed.

Room 12 - Lough Gill Unit – The privacy screen shall be rehung so that it does not block the light from the window when it is in use. The screen will now come around the bed, rather than to the wall.

Room 8, 9, 10 and 11- Lough Gill Unit - The ventilation in the smoking room has been re-directed and does not impact on these rooms.

Bedroom 4 and 5 - Railway View – Individual risk assessments shall be carried out to ensure the availability of dressing gowns, slippers and mobility assessments to identify and provide necessary support.

Responsibility: CEO (Registered Provider Representative)/Director of Care (Person in Charge)
Timeframe: 31st March 2020

An independent audit of compliance to these specific aspects of Regulation 17: Premises shall be undertaken and all resultant actions followed up and closed out.

Responsibility: CEO (Registered Provider Representative)
Timeframe: 31st May 2020

<table>
<thead>
<tr>
<th>Regulation 5: Individual assessment and care plan</th>
<th>Substantially Compliant</th>
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</thead>
</table>

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Review of all resident’s manual handling assessments and related care plans to ensure an accurate reflection of residents needs and abilities.

Responsibility: Director of Care (Person in Charge)
Timeframe: 28th February 2020

An independent audit of compliance to these specific aspects of Regulation 5: Individual assessment and care plan shall be undertaken and all resultant actions followed up and closed out.

Responsibility: CEO (Registered Provider Representative)
Timeframe: 31st March 2020
Regulation 7: Managing behaviour that is challenging

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

We will work towards minimal use of restraint in the centre. Where it has been deemed appropriate to use bedrails, we will ensure that this measure is a last resort and a record of the decision to use the bedrail will be documented.

The use of any form of restraint in the centre will be in accordance with the centre’s policy & national guidelines. We have updated our restraint register. We have formed a restrictive practice committee and we will continue to roll out training in restrictive practice.

A review of restrictive practices was undertaken, which identified opportunities for improvements in line with the Inspectors findings.

A review of all resident restraint / restrictive practice assessments shall be undertaken. Identification and implementation of alternatives to bed rails, including but not limited to, low beds and sensor mats.

Update of the restraint register to include all forms of restraint including, but not limited. Any beds where the bed rails are not identified as specifically required for that resident shall be locked down and shall only be unlocked by the Person in Charge / Clinical Nurse Manager following a restraint / restrictive practice assessment and inclusion on the restraint register.

Responsibility: Director of Care (Person in Charge)
Timeframe: 28th February 2020

Externally facilitated care staff education on restrictive practices in line with - Guidance on promoting a care environment that is free from restrictive practice Health Information and Quality Authority (2019).

Responsibility: Director of Care (Person in Charge)
Timeframe: 31st March 2020

An independent audit of compliance to these specific aspects of Regulation 7: Managing behaviour that is challenging shall be undertaken and all resultant actions followed up and closed out.

Responsibility: CEO (Registered Provider Representative)
Timeframe: 31st March 2020

Regulation 8: Protection

Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection:
A review of safeguarding practices was undertaken, which identified opportunities for improvements, in line with the Inspectors findings.

A review and development of the SPNH policy and procedure - Safeguarding and Protection of the Resident in line with best practice including National Standards for Adult Safeguarding. Health Information and Quality Authority and Mental Health Commission (2019). This is now available within the nursing home.
Undertook a systems analysis in relation to the alleged incident of abuse identifying key causation factors, necessary actions and learnings.
Submission of an NF-06 to the Health Information and Quality Authority in relation to alleged incident, investigation and actions taken.
All safeguarding issues to be addressed at the monthly Management Team meetings, and related learnings at the Multi-Disciplinary Care and Service Team meetings.

Responsibility: Director of Care (Person in Charge)
Timeframe: Completed

Externally facilitated staff education on safeguarding of vulnerable adults in line with - National Standards for Adult Safeguarding. Health Information and Quality Authority and Mental Health Commission (2019).

Responsibility: Director of Care (Person in Charge)
Timeframe: 31st March 2020

An independent audit of compliance to these specific aspects of Regulation 8: Protection shall be undertaken and all resultant actions followed up and closed out.

Responsibility: CEO (Registered Provider Representative)
Timeframe: 30th April 2020

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<table>
<thead>
<tr>
<th>Regulation 9: Residents’ rights</th>
<th>Not Compliant</th>
</tr>
</thead>
</table>

Outline how you are going to come into compliance with Regulation 9: Residents’ rights:
A review of the issues raised, in relation to residents’ rights, identified opportunities for improvements in line with the Inspectors findings.
Staff communication re the need to record all complaints verbal, written, formal and informal by any member of staff. The provision of complaint logs in multiple locations to assist in the record of all complaints verbal, written, formal and informal by any member of staff. The complaints policy and procedure has been revised to ensure it is in keeping with best practice including ‘Your Service, Your Say’ HSE Complaints Policy (2015), the relevant supports available to residents and their families who made a complaint or who wished to make a complaint, including internal supports from Clinical Nurse Managers, the Director of Care, independent advocacy, and the Office of the Ombudsman. Revised policy and procedure includes necessary steps for immediate corrective and long term actions. This include responsibilities, timeframes and oversight. All complaints, related actions, and trends to be review monthly at the Management Team meetings.

Responsibility: Director of Care (Person in Charge)
Timeframe: Completed

The provision of externally facilitated staff education on Complaints Management – Complaints and Feedback -

Responsibility: Director of Care (Person in Charge)
Timeframe: 31st March 2020

A review and development of the SPNH policy and procedure - Safeguarding and Protection of the Resident in line with best practice including National Standards for Adult Safeguarding. Health Information and Quality Authority and Mental Health Commission (2019). This is now available within the nursing home.

Responsibility: Director of Care (Person in Charge)
Timeframe: Completed

Externally facilitated staff education on safeguarding of vulnerable adults in line with - National Standards for Adult Safeguarding. Health Information and Quality Authority and Mental Health Commission (2019).

Responsibility: Director of Care (Person in Charge)
Timeframe: 31st March 2020

The staffing review identified the care staff resident ratio and allocated care hours were reflective of current best practice, however SPHN intends to reduce the number of beds, and thus residents, by 4 beds, (reduction from 85 beds to 81), while maintaining the level of staff. This will see an improvement of care staff resident ratios and care hours available.

Responsibility: CEO (Registered Provider Representative)
Timeframe: 28th February 2020

The staffing review also identified the need for more defined staffing and area allocations.
throughout the day to ensure appropriate staff to assist residents in getting up and engaging in activities.

Appointment of two additional Clinical Nurse Managers to ensure effective floor management, and responsibility, of all care staff 7 days a week.

Responsibility: Director of Care (Person in Charge)
Timeframe: Completed

Development of daily care staff area allocation plan, relating to the times of day, to ensure the maximum use of care staff to support resident activities including getting up, dining, and activities of daily living.

Refocusing of Senior Health Care Assistants role to ensure the identification, and support, of responsibilities for Health Care Assistants allocation in line with daily staffing area allocation plan.

One week audit to identify residents who were still in bed after specific times, (10am,11am,12pm), to determine appropriateness. Develop, implement and review, action plan arising from findings.

Responsibility: Director of Care (Person in Charge)
Timeframe: 28th February 2020

Reemphasis with staff at monthly Multi-Disciplinary Team meetings on the constant need to focus on all residents privacy and dignity.
Reemphasis with care staff on need to for specific consideration of residents privacy and dignity who do not have ensuite bathrooms and need to leave their bedrooms to use the toilet. This includes, but is not limited to, availability of dressing gowns, slippers and mobility assessments to identify and provide necessary support.

Responsibility: CEO (Registered Provider Representative)/Director of Care (Person in Charge)
Timeframe: 28th February 2020


Responsibility: Director of Care (Person in Charge)
Timeframe: 31st March 2020

Room 1 (Lough Gill) - Redevelopment to a full resident suite incorporating exclusive use of the sitting room, (removal of communal room). Inclusion of a full size wardrobe.
Room 5 (Innisfree) - Storage redevelopment to provide storage for all four residents.
Room 10 (Railway view) - Redevelopment of wardrobes to provide necessary space for the two residents.
Room 2- Lough Gill Unit – This room will not be utilised for residents requiring to be
transferred with the use of a hoist.

Responsibility: CEO (Registered Provider Representative)
Timeframe: 31st March 2020

Review of all activities of daily living and personal choices assessments and related care plans to ensure an accurate reflection of residents likes, wants and needs. Discussion with all residents and/or families on their activities of daily living plan to ensure they specifically reflect the likes, wants and needs of each resident, evidenced by signing.

Responsibility: Director of Care (Person in Charge)
Timeframe: 28th February 2020

An independent audit of compliance to these specific aspects of Regulation 9: Residents' rights shall be undertaken and all resultant actions followed up and closed out.

Responsibility: CEO (Registered Provider Representative)
Timeframe: 30th April 2020
Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 12(c)</td>
<td>The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>30/12/2019</td>
</tr>
<tr>
<td>Regulation 15(1)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>19/12/2019</td>
</tr>
<tr>
<td>Regulation 17(2)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>01/01/2022</td>
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<tr>
<td>Regulation 23(b)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>19/12/2019</td>
</tr>
<tr>
<td>Regulation 23(c)</td>
<td>The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>19/12/2019</td>
</tr>
<tr>
<td>Regulation 03(1)</td>
<td>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.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>19/12/2019</td>
</tr>
<tr>
<td>Regulation 34(1)(f)</td>
<td>The registered provider shall</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>19/12/2019</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Regulation 34(2)</th>
<th>The registered provider shall ensure that all complaints and the results of any investigations into 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.</th>
<th>Not Compliant</th>
<th>Yellow</th>
<th>19/12/2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 04(1)</td>
<td>The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>19/12/2019</td>
</tr>
<tr>
<td>Regulation 5(3)</td>
<td>The person in charge shall</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>19/12/2019</td>
</tr>
<tr>
<td>Regulation</td>
<td>Description</td>
<td>Compliance Status</td>
<td>Colour</td>
<td>Date</td>
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<tr>
<td>7(3)</td>
<td>The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>19/12/2019</td>
</tr>
<tr>
<td>8(1)</td>
<td>The registered provider shall take all reasonable measures to protect residents from abuse.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>19/12/2019</td>
</tr>
<tr>
<td>9(3)(a)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>19/12/2019</td>
</tr>
<tr>
<td>9(3)(b)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>19/12/2019</td>
</tr>
<tr>
<td>personal activities in private.</td>
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