Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

Name of designated centre:	Sancta Maria Nursing Home
Name of provider:	Ronnach Teoranta
Address of centre:	Parke, Kinnegad, Meath
Type of inspection:	Unannounced
Date of inspection:	24 June 2020
Centre ID:	OSV-0004589
Fieldwork ID:	MON-0029724

About the designated centre

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

Accommodation is provided for a maximum of 78 residents, over 18 years of age, in a recently extended single-storey premises in a rural location. There are nine shared twin rooms and 60 single rooms (55 with en-suite facilities). Residents are admitted on a long-term residential, respite, convalescence, dementia and palliative care basis. Care is provided for residents with conditions that affect their physical and psychological function. Each resident's dependency needs are regularly assessed to ensure their care needs are met. The provider employs a staff team consisting of registered nurses, care assistants, maintenance, housekeeping and catering staff. The provider states that the centre's ethos is to provide individualised care, encouraging and fostering a caring atmosphere. The main objective of the service is to ensure continued delivery of high-quality and consistent person-centred care to all residents. A major emphasis is on the provision of meaningful activity and individualised care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	55

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 24 June 2020	13:45hrs to 19:45hrs	Manuela Cristea	Lead
Thursday 25 June 2020	09:45hrs to 17:45hrs	Manuela Cristea	Lead
Wednesday 24 June 2020	13:45hrs to 19:45hrs	Noel Sheehan	Support
Thursday 25 June 2020	09:45hrs to 17:45hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

At the time of inspection, the designated centre was COVID-19 free. This inspection was carried out over two days, and the inspectors spoke with numerous residents and a small number of relatives who were visiting the centre at the time. Most residents reported that they were satisfied with the care they were receiving in the centre, that they were enjoying the activities available to them and that the staff were kind and attentive. Some residents mentioned that on occasions they had to wait for their calls to be answered, but they were also quick to accept that staff were busy and did the best they could.

Residents and families were unanimous in expressing satisfaction and relief that the visiting had resumed after the imposed restrictions brought on by the COVID- 19 pandemic, and were accepting of the alternative arrangements and controls introduced. They all described how difficult the last couple of months had been and how much they valued the efforts made by staff to ensure they could see and hear their loved ones regularly via telephone or video calls. One resident mentioned that she was as happy as she could be and that she felt staff were like nieces and nephews to her. Other residents mentioned that the isolation period was difficult and that despite the availability of TV and media, the days were long and lonely.

Most residents however, stated they had choice over how they spent their time and had access to daily activities, daily newspapers, regular entertainment, TV and radio. In particular female residents mentioned how much they missed the hairdresser and were eagerly following the national updates in this respect. Some residents mentioned that they missed the outings in the community and the resident's meetings. Residents told the inspectors that they felt safe in the centre and that they could talk to a member of staff if they had any concerns.

While most residents reported that they were happy with the quality of food and that the catering staff would accommodate special requests as much as possible, some residents mentioned that they had to wait for staff to be available to assist them at mealtimes. A small number of residents reported that they did not like and could not get used to the food serving arrangements, with the main meal of the day being served in the evening.

A large sheltered area was designated for smoking and many residents were observed spending time together in this space while social distancing.

Overall most of those residents and families who were met during the two days were positive about the care and services that they received in the designated centre. Families said that nursing and care staff on the units were approachable and kept them up to date with any changes in residents' condition. However, since the last inspection, 15 relatives had contacted the Office of the Chief Inspector with concerns regarding the care of their loved ones, some on more than one occasion.

This information was also followed on this inspection.

During the two days of inspection residents were seen participating in bingo, quizzes and crosswords, attending a birthday party or enjoying the garden.

Capacity and capability

This was an unannounced risk inspection carried out over two days following a sharp increase in the amount of unsolicited information received by the Chief Inspector of Social Services in relation to the quality and safety of care provided to the residents living in the designated centre. The registered provider had a poor history of regulatory compliance, as the last inspection carried out on 29 August 2019 identified non compliance in eight regulations.

As a result, since the last inspection there had been ongoing close monitoring of the governance and management arrangements in the centre and the registered provider had been in regular contact with the Chief Inspector to provide monthly updates in respect of the staffing and governance arrangements in the centre.

The inspectors found little progress in addressing key areas of concern such as: staffing, training and staff development, governance and management, records, infection control, medication management and risk management. Improvements were noted in respect of fire safety, residents' rights, restrictive practices and the layout of the premises.

The designated centre had been affected by a COVID- 19 outbreak in April 2020 and one resident had died. A small number of the staff and residents who contracted the virus had made a successful recovery. The registered provider had liaised closely with the public health and local crisis management team to ensure appropriate measures were put in place to safeguard the welfare of staff and residents and ensure continued access to personal protective equipment (PPE). Staff were familiar with the COVID- 19 pathway in the event of a suspected case.

This inspection identified significant risks to the safety and welfare of the residents accommodated in the centre and consequently two urgent action plans in respect of medication management and infection control, were issued to the provider and completed on the first day of inspection. Two additional immediate action plans were also issued following the inspection in respect of infection control and governance and management arrangements including staff supervision, with the dates for completion set out by the Chief Inspector.

Inspectors found that while there was a management structure in place, it did not align to the governance structure as per the statement of purpose, which had not been updated in the past six months to reflect the current organisational arrangements. Improvements were required to ensure there were clear lines of accountability and responsibility and appropriate staff supervision arrangements and

practice oversight in place.

While there was clear evidence of ongoing efforts to actively recruit staff in all departments, the high levels of staff turnover negatively impacted residents' lived experience in terms of continuity of care and the loss of established relationships.

The consistently high levels of staff turnover also extended to the senior management levels. Two successive assistant directors of nursing (ADON) had been recruited and left in the previous six months. On the day of inspection, the person in charge was supported by one Clinical Nurse Manager (CNM) and a regional healthcare manager in supernumerary capacity. During the feedback meeting, the registered provider representative informed the inspectors that they were actively recruiting and committed to appoint a new ADON and a second CNM to strengthen the governance arrangements.

In addition to challenges in retaining staff, the staffing levels had been severely impacted by the outbreak of COVID- 19 throughout the months of April and May 2020, as extended sick leave absences had further depleted the management structures. Inspectors acknowledged that some controls were put in place to ensure service oversight was maintained which included remote working for the person in charge, on call management availability at the weekends. However, the inspection found that the current supervisory arrangements in practice did not ensure that public health guidance and local policies were consistently implemented by staff. Despite comprehensive policies written and available in the centre, there was little evidence to show that they had been read, understood and implemented by staff.

Inspectors found that more than half of the workforce had recently been recruited, with a large number still completing their probation period at the time of inspection. Although a buddy system was in place, improvements were required in the oversight and supervision arrangements to ensure that there were sufficient staff with the rights skills, competence and seniority at all times to provide safe and appropriate care for the residents. For example, some supervisory roles had been delegated to the nursing and domestic staff, who did not have all the required skills and experience for the role.

There were comprehensive quality assurance systems in place to monitor the quality and safety of care and services provided. However, clear action plans were not always in place to address the areas identified for improvement and recurrent under-performance in key areas such as care planning and infection control were not being appropriately managed by the management team.

Regulation 14: Persons in charge

The designated centre was managed by a suitably qualified and experienced person with the authority, accountability and responsibility for the provision of the service. She worked full-time in the centre and had the overall clinical responsibility for the delivery of all healthcare services and departments operating in the centre. She was

well-known to residents and their families. The person in charge had more than three years' experience in management of a long-term health and social care service and held a post-registration qualification in management. She was actively engaged in the governance and operational management of the centre.

Judgment: Compliant

Regulation 15: Staffing

The centre is registered for 78 beds and at the time of inspection there were 55 residents accommodated in the centre. A review of rosters showed that there were always a minimum of two registered nurses on duty.

The person in charge told inspectors that staffing levels were maintained under regular review and were adjusted in line with identified needs. However, based on observation, talking with the residents and a review of the rosters, inspectors found that staffing levels were not sufficient to meet residents' needs and the skill-mix required review, particularly in respect of housekeeping and care staff.

Inspectors observed prolonged periods where residents who required enhanced supervision due to a high risk of falls or who were assessed as being at risk of leaving the premises, were not adequately supervised. In addition the introduction of staggered mealtimes to allow for social distancing, meant that staff were busier organising and delivering meals and had less time to assist and supervise the residents, particularly those who chose to remain in their rooms. Some residents also told inspectors that on occasions they had to wait for their call bells to be answered.

In line with current guidance, a dedicated staff was identified on the roster to care for the residents that required isolation in accordance with admission protocol.

While there was a dedicated activities staff for the whole centre identified during the week days, the weekend arrangements were not consistently identified on the roster. Inspectors were not assured that such arrangements could consistently meet the psychosocial needs of each resident in the context of infection control restrictions imposed by the pandemic.

A sample of staff files were examined and were found to contain the information required by Schedule 2 of the regulations, including proof of professional registration and An Garda Síochana vetting..

Judgment: Not compliant

Regulation 16: Training and staff development

In discussion with inspectors staff demonstrated that they were knowledgeable in fire safety procedures, safeguarding vulnerable adults and infection control and prevention.

However, the training records available on the day did not provide satisfactory assurances that most staff had their training up to date in particular in respect of manual handling, with gaps also identified in relation to infection control training and safeguarding.

Updated records received following the inspection showed that the provider took immediate action and where gaps were identified training had been put in place provided or a scheduled for a date in the near future.

From conversation with staff and a review of records, inspectors were satisfied that regular drills in the management of a COVID-19 outbreak were carried out. While refresher training in infection control was provided by an external company, the inspectors were not assured that all staff were familiar with procedures consistent with infection prevention an control, such as the decontamination of equipment.

Additional training relevant to the catering and domestic department was also required to ensure practices in the centre were safe.

Staff supervision and performance management arrangements required significant review. The provider had already identified the need for nursing staff leadership and development and had introduced a four week training course specific to the nursing staff. However, due to the high volume of newly recruited staff, enhanced training and robust supervision arrangements were also required for the domestic, catering and care staff to ensure policies were consistently implemented in practice.

Judgment: Not compliant

Regulation 21: Records

The inspectors found that not all records to be kept in the designated centre were maintained in accordance with the requirements of the legislation. For example, inspectors found confidential records inappropriately left in vacated rooms ready to admit other residents.

In addition, inspectors found that other care records were incomplete, inaccurate or not completed in a timely manner. For example, the 15 minutes safety checks for residents at risk of leaving the centre unsupervised were signed and completed retrospectively, which was not in line with current policy or residents' individual care plan.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that the provider had tried to mitigate the identified deficits in governance and leadership in the centre with the appointment of a healthcare manager and a CNM in supernumerary capacity to support the person in charge. However, continuing high levels of staff turnover, compounded by unscheduled absence of senior management and inadequate oversight and supervision arrangements, had led to the provider failing to adequately address most of non-compliances identified in the previous inspection. As a result, inspectors were not assured that there were effective governance and management arrangements in place in the designated centre to drive the improvements required and to ensure compliance with the regulations and standards.

Staff meetings occurred regularly and brief records showed items of agenda discussed. The person in charge collated key performance indicators to monitor the standard of care such as accidents and incidents, falls, restraints, pressure sores and infections. As a quality improvement initiative, weekly focused meetings were carried out with multidisciplinary personnel where falls, restraints and incidents were discussed.

Nevertheless, the systems were inadequate to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example, there was a wide range of clinical audits in place which were robust, comprehensive and regularly completed. However recurrent areas of under-performance identified were not appropriately and effectively managed and the audit findings were not consistently followed up to drive improvement. As a result, improvements required in key areas of health and safety such as infection control, risk management, staffing, clinical documentation and clinical risk, although identified by provider in their risk register had not been appropriately mitigated and addressed.

Inspectors were not assured that resources in the designated centre were sufficient and appropriately managed. A full review of the management structure and delegation systems was required to ensure the service provided was safe, appropriate, consistent and effectively monitored. The supervisory roles and arrangements also required review as the current levels of cleaning and environmental oversight did not give the staff team on the ground the direction and supports they needed. At the feedback meeting the registered provider gave assurances that all matters raised would be dealt with.

There was an annual review completed for 2018 and one was in development for 2019.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors were satisfied that the matters that required to be notified to the Chief Inspector had been appropriately notified. However, not all incidents were notified in a timely manner within 3 days of occurrence as per regulatory requirements.

In addition, the six monthly nil reports had not been submitted.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a policy in place to manage complaints, and residents reported that they knew who to complain to if they needed to and were empowered to do so. A summary of the complaints procedure was displayed prominently at the centre's reception area. The person in charge was the designated person to deal with complaints, and an additional nominated person was in place to ensure records of complaints were appropriately maintained. Residents had access to an appeal process in accordance with the regulatory requirements.

Inspectors reviewed a large sample of the recently received complaints and found that overall they were well and comprehensively managed. However, two of the closed complaints did not document whether the final outcome had been communicated to the complainant and if this was to their satisfaction, in line with regulatory requirements. A third complaint had not been responded to in a timely manner, in accordance with the local complaints policy.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The written policies to inform and guide staff practice when supporting residents and to ensure the safe operation of the services were available. They were comprehensive and had all been reviewed in the past three years in line with regulatory requirements. Relevant policies had been updated to include guidelines around the management of COVID-19.

However, while the person in charge informed the inspectors that policies were communicated to staff and discussed at the staff meetings, records showed that only a small number of staff had signed that they had read and understood them. In addition from observation of and communication with staff, the inspectors were not

assured that all local policies were being consistently implemented practice.

Judgment: Substantially compliant

Quality and safety

Inspectors acknowledged the efforts made by the provider to enhance the quality of care that the residents received in the centre, particularly in respect of premises, falls management and restrictive practices, fire safety, food and nutrition, end of life care, visiting arrangements and personal possessions. However, the ongoing challenges in providing adequate staffing levels and consistent governance and management arrangements negatively impacted on the quality and safety of care delivered to residents. This is supported by findings in relation to substandard infection control practices, inadequate management of identified risk, non-compliant medication management practices, and poor nursing documentation used to support care delivery.

As an action plan from the last inspection, changes made to the layout of the Memory unit had effectively enhanced the quality of life for the residents accommodated there. The residents had now direct access to the internal sensorial garden while also having wider corridors available to navigate, allow for purposeful walking and prevent responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). In addition the use of restraints in the centre had reduced significantly.

Staff were noted to be person-centred, kind and empathetic in their interactions with the residents and this was confirmed by the many residents and relatives who spoke with the inspectors. Policies and procedures to ensure the residents were protected from abuse were implemented.

Throughout the two days, the inspectors found that infection prevention and control practices in the centre were not safe as further elaborated under Regulation 27. Infection control audits from February and early June 2020 showed that while these risks had been consistently identified, at the time of inspection the provider had failed to implement the corrective measures to address it.

Inspectors observed that residents were provided with good quality, nutritious food and that food choices were also extended to modified diets. Two new chefs had been recently recruited and there have been some adjustments to the food menu. The decision to have the main meal of the day in the evening and a lighter lunch had been made in consultation with residents as a quality improvement initiative to reduce falls. However, not all residents reported to the inspectors that they were happy with these food arrangements and some stated that they had not had a residents' meeting in a long time. At the time of inspection there was no evidence that formal feedback on residents' meal experience had been sought since the

implementation of these changes.

Evidence of consultation and minutes of the residents' meetings were submitted following inspection. Inspectors found that while the meetings had been stopped as a result of social restrictions imposed by the pandemic, the process of actively seeking feedback on the quality of life from residents' perspective needed to resume in order to actively inform the quality improvement processes in the centre.

A review of residents' care planning arrangements showed that improvements were still required to ensure that they were initiated on admission, were based on validated risk assessments, comprehensive and regularly updated to reflect residents' current condition.

While the care planning records were not sufficiently clear to guide care, those staff who spoke with inspectors were knowledgeable and were able to verbalise the residents current needs, their preferences for care and daily routines and what self-care abilities the resident did have. The inspectors observed good handover practices such as the midday safety pause, where any changes in condition or any medical updates were shared to ensure staff could be vigilant and provide safe care. Staff were seen to support residents appropriately, for example when residents became anxious or upset.

Medicine practices in the centre required proactive and stronger oversight. Regular medicine reviews and audits were carried out by pharmacist, a general practitioner (GP) and the nursing management, and there was evidence that medication errors, when identified, were appropriately reported and responded to. Inspectors were satisfied that the medication errors identified on the first day of inspection, had been appropriately followed up and investigated by the provider. The pharmaceutical services to residents were satisfactory but the prescribing and administration of medicines required further improvements to ensure the staff practices were in line with best practice guidelines and local policies and procedures.

While robust risk management policies were available, the inspectors found that they were not consistently implemented in practice. In addition, where risks were identified, inspectors were not assured that adequate controls were implemented to ensure the risks would be timely, consistently and appropriately addressed. For example, a live risk register was available which identified most of the risks identified on this inspection. However, it did not provide satisfactory assurances that the risks had been adequately followed up and in line with proposed action plans.

Since the last inspection, the fire safety arrangements in the centre had significantly improved, and there were comprehensive records of weekly fire evacuation drills, up to date personal emergency evacuation sheets, and regular maintenance checks of the fire management systems in the centre.

Regulation 11: Visits

An open visiting policy had been in place until the imposed restrictions on visiting as per public health advice. In line with guidance, visiting arrangements had recently resumed and there was a clear protocol in place to ensure they were happening in a safe manner. Information about visiting arrangements in line with public health guidance had been communicated to residents and relatives, and it was reinforced upon arrival to the centre. The visiting policy had been updated and clear logs were maintained of all visitors.

There were arrangements in place for residents to receive visitors in private for a maximum period of 30 minutes, and the inspectors observed that the social distancing requirements were maintained.

Judgment: Compliant

Regulation 13: End of life

The end-of-life care provided in the centre met residents' needs. There was evidence of family involvement with resident's consent and a person-centred approach to end-of-life care. Each resident had been risk assessed for COVID- 19 and evidence showed that their plan of care had been discussed with the resident or their representative and the GP.

Where decisions had been made in relation to advanced care, such decisions were recorded. Records also showed that anticipatory prescribing and medication review took place to support symptom management and ensure residents remained comfortable and dignified.

At the time of inspection there was one resident at the end of life living in the centre. Inspectors reviewed the plan of care for this resident and found that it was comprehensive, had been appropriately reviewed and updated in consultation with their family. There were good systems in place for symptom control and the inspectors observed the resident was maintained comfortable throughout the two days. The resident was accommodated in a large palliative room with integrated facilities to allow for the relatives to stay over should they wish to.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents' dietary needs were reviewed on admission to the centre, and where a specific diet was required the information was passed to the kitchen and staff. Staff who spoke with inspectors were familiar with resident's specific dietary needs and this information was included in their handover sheets to ensure residents' safety.

Each resident was monitored for the risk of malnutrition during their stay and, where issues were identified, food intake was closely monitored and appropriate referrals were made, for example to a dietitian or speech and language therapist.

Most residents reported that they enjoyed the food in the centre and that it was provided in sufficient quantities. They mentioned that if they did not like the choices available they were provided with suitable alternatives, including vegetarian options.

Some residents mentioned to inspectors that on occasions they had to wait a long time to be assisted with their meals. This was also observed by inspectors, particularly in respect of the residents who chose to have their meals in their rooms.

The inspectors observed the food serving arrangements and found that with the introduction of staggered mealtimes to facilitate social distancing, a large proportion of staff's time was spent collecting and delivering the food to the residents. However, inspectors also noted that when assistance was provided to the residents it was provided in respectful, kind and unhurried manner. The atmosphere in the dining room was calm and relaxed.

Judgment: Substantially compliant

Regulation 26: Risk management

While the risk management policy did set out the identification and assessment of specific risks required by the regulations, the findings of this inspection show that the controls to minimise the identified risks were not consistently implemented to be effective. In addition, there was limited evidence that concrete action plans had been implemented in response to identified risks at the various audits carried out including environmental and infection control audits.

Inspectors accepted that the matter arising from the previous inspection in respect of the sluice facility in the Memory Unit had to be delayed due to the restrictions imposed by the pandemic and in order to protect the residents. Satisfactory assurances were provided in respect to the proposed refurbishment plan for the sluice with a concrete plan in place and expected completion date within the next month.

Inspectors found that there were robust policies, protocols and contingency planning arrangements in respect of suspected or potential outbreaks of COVID- 19, with an identified isolation area in place, clear protocols for active monitoring of staff and residents for early identification of signs and symptoms, referrals, staff trained in swabbing and fast-tracking arrangements with the testing labs affiliated to the nearby local hospital.

However, while the particular COVID-19 outbreak in April had been successfully managed and contained, the findings of this inspection show that further action was

required to ensure all the necessary precautions are taken and consistently implemented to actively promote and maintain residents' safety. At the request of inspectors, a serious incident review in the management of the COVID- 19 outbreak was submitted following the inspection, which identified the contingency plan, the learnings from the outbreak and how they would inform such future event.

As a result of the significant risks identified during this inspection a number of urgent action plans were issued to ensure the centre will come into compliance with the regulation, followed by a provider meeting.

Among other risks and hazards identified on inspection and that required attention:

- a bath in the memory unit was not fit for purpose due to rusty patches that presented a risk of grazes for residents and which could not been cleaned
- Faulty/ broken equipment due for disposal left in communal areas posed a risk to the residents or visitors
- Damaged flooring was observed in two bedrooms and in corridors which was a falls and infection control risk
- While a cleaning regimen had recently been introduced, records showed that it was not consistently implemented

Judgment: Not compliant

Regulation 27: Infection control

The registered provider did not ensure that standards of infection prevention and control were met and that Public health guidelines were consistently implemented in the centre.

Staff had completed infection control training and demonstrated good knowledge in respect of hand-washing techniques. Inspectors observed that the nurse prompted staff and residents to wash their hands on an hourly basis. There were appropriate staff changing facilities in the centre and staff's uniforms was laundered in the centre to prevent cross infection.

However, inspectors identified a significant number of considerable infection control concerns, which posed a risk to the welfare of the residents accommodated in the centre. Most of these issues had already been identified in an infection control audit carried out by public health two weeks prior to the inspection, however the registered provider had failed to act and address them in a timely manner.

Some of the issues identified on this inspection:

- Inadequate governance arrangements and supervision of cleaning and infection control practices in the centre
- Overall poor standards of environmental hygiene

- Hazardous waste management and disposal practices
- While a protocol was in place in respect of decontamination of equipment, it was not implemented in practice and staff were not familiar with it. Staff were observed using visibly soiled equipment such as zimmer frames, chairs, bed mattresses, used nebuliser masks
- Staff were observed congregating in the smoking area and not implementing social distancing measures; PPE use such as facemasks was not in line with the national guidelines
- Unhygienic practices in storing equipment: i.e electrical mattress found on the floor in a bathroom; housekeeping trolley left unattended in the corridor; slings on the floor in a resident's bedroom
- While appropriate supplies of cleaning solutions and personal protective equipment were available in the centre, they were not always within immediate reach, easily accessible and freely available to promote enhanced cleaning and decontamination practices;
- There were no sanitising wipes freely available to clean equipment such as keyboards, telephones, blood pressure cuffs, and other equipment
- Sharps bins were not disposed of in line with procedures

Judgment: Not compliant

Regulation 28: Fire precautions

The fire procedures and evacuation plans were prominently displayed and staff who communicated with the inspectors were knowledgeable and confident in what to do in the event of emergency. Staff had completed their annual fire safety training and had participated in regular fire evacuation drills, which included simulations with night time staffing levels.

A false alarm incident of suspected fire which resulted in a full evacuation of the designated centre had been carried out safely, timely and efficiently and had been appropriately notified to the Chief Inspector.

The fire safety certificates, including the daily, weekly, quarterly and annual checks were all up to date.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The matters arising from the last inspection in relation to crushed medicines had been satisfactory addressed.

Overall, the electronic medicine administration records which were overseen by pharmacy were clear and included all the required information for safe medicine administration practices. This included a photograph of the resident, the drug allergy status and unique residents' identifier.

However, inspectors found that many handwritten prescriptions were incomplete and did not provide sufficient detail for safe administration in line with local policy. For example the route, the dosage, or the time of administration was not consistently recorded for each individual medication and the nurses had not sought clarity prior to administering the medication in line with best practice guidelines.

Inspectors also found that in some instances, medication prescribed for a limited period of time did not include a discontinuation date. As a result, the inspectors identified a number of medication errors on the first day of inspection which had not been identified by the provider and which had resulted in residents' inappropriately receiving medications that they no longer required. An urgent action plan was issued on the day to ensure that medication no longer required was discontinued.

Medicines that required special control measures were appropriately managed and kept in a secure cabinet in keeping with professional guidelines. However, high risk clinical waste boxes that contained sharps and discarded medicinal products were not dated and labeled to allow for contact tracing and to be disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment. Inspectors found more than eight such boxes in the clinical room and the nursing staff could not account for the dates or their contents.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Resident's care planning arrangements required review to ensure they provided the relevant information to support staff in the care provided to the residents.

Admission to the centre was based on a pre-assessment to ensure that the centre could meet residents' needs, and residents were informed about the admission protocol that required 14 days of self-isolation in line with current guidance.

Although some key assessments were completed on admission, a sample of records reviewed showed that not all residents had their care plans initiated within 48 hours in line with regulatory requirement. In addition, the care plans were not consistently updated when residents' condition changed and not all care plans had been reviewed within four months.

Inspectors found that while a range of risk assessments were available, they were not regularly completed and did not appear to actively inform the residents' plan of

care in a consistent manner. For example:

- residents identified at high risk of falls did not have a falls prevention care plan in place although falls prevention measures were in use and there was evidence of post-falls reviews at the focused multidisciplinary meetings
- from a sample of care records reviewed, the inspectors also identified a number of inconsistencies in the documentation. By way of example, daily nursing notes contained comprehensive details of incidents and a behavioral log was maintained for a resident who presented with responsive behaviours. There was no behavioral care plan in place for this resident and the communication care plan stated that the resident had no difficulties to communicate.

On discussion with the inspectors, staff were familiar with appropriate interventions for individual residents and had good knowledge of individual needs. In respect of COVID- 19, the staff were knowledgeable of typical and non-typical presentation of COVID-19 and what symptoms and signs to look out for in residents, should they become unwell. There was active monitoring of residents for signs and symptoms.

Following a number of unsolicited concerns received by the Chief Inspector in relation to inadequate communication with relatives during the periods of restricted visiting, the registered provider had put in place adequate enhanced communication systems in response. Inspectors were satisfied from conversation with visitors and upon a review of family communication records that they were regularly consulted and appropriately informed of changes to resident's condition and plan of care.

Judgment: Not compliant

Regulation 6: Health care

A number of general practitioners (GP) visited the centre on a regular basis and out of hours medical cover was also available. Most residents reported that they were satisfied with the care they received in the centre and could access the doctor if they needed. Records showed that residents were appropriately referred, timely seen by GP when required and prescribed appropriate treatment.

A physiotherapist visited the centre weekly. Residents had access to other therapies provided by allied health professionals such as tissue viability, occupational therapists, dietitians, community Psychiatry services. The chiropodist services had also resumed following restrictions.

Judgment: Compliant

Regulation 8: Protection

There was a clear policy in place in relation to the detection of abuse and safeguarding the residents. All staff had received or had an immediate scheduled date for training in how to identify and report a concern in relation to abuse. Staff spoken with were very clear of the types of abuse residents may be at risk of and also the steps to take if they suspected, witnessed or had abuse reported to them. Residents who spoke with inspectors said they felt safe in the centre and that staff were respectful of their health and social care needs.

Inspectors reviewed a number of unsolicited information received in respect safeguarding concerns and found that they had been comprehensively investigated, appropriately reported and referred to relevant authorities. The person in charge understood her duty to investigate any incident or allegation of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Activities were available for residents seven days a week and the majority of residents who spoke with inspectors confirmed that they were satisfied with the activities available to them. The programme for activities had been adjusted to facilitate smaller groups and one to one activities in line with current public health guidance. However some residents also reported that the days could be long and lonely and there was not much to do.

The activity coordinator told inspectors of various activities programmes she was running for the residents in line with their identified needs. For example, in the Frail Elderly unit the activities were highly stimulating such as bingo, crosswords, quizzes, newspaper reading, walking clubs, while in the memory unit the profile of activities was more sensorial, gentle exercises, garden walks, music, reminiscence or low stimuli activities based on easily identifiable household chores to promote a calm atmosphere and prevent responsive behaviours.

Each resident had a completed key to me assessment that detailed their hobbies, past interests, relevant dates in their personal calendar. Activities were tailored to resident's needs and abilities and resident's participation and/or refusal was documented. Residents reported that staff treated them with kindness and that their privacy was respected.

Residents had unrestricted access to newspapers, TV, radio, and Wifi and many commented on how invaluable the use of social media and video calls had been during the lockdown to enable them to maintain contact with their families. Residents' lived experiences of residential care were diminished due to the COVID-19 pandemic restrictions, however, staff, as far as was practicable implemented a

social care programme to meet the individual needs of residents. Advocacy services were available to the residents who required.
Judgment: 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 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Sancta Maria Nursing Home OSV-0004589

Inspection ID: MON-0029724

Date of inspection: 24/06/2020

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
A comprehensive review of rosters has taken place to ensure that staffing levels and skill mix are sufficient to meet residents' assessed care needs.

The Person in Charge (PIC), supported by an Assistant Director of Nursing (ADON) and a Clinical Nurse Manager (CNM), will produce and monitor the staff roster, always ensuring that a suitable skill mix of staff are deployed and duties allocated appropriately, that there is a suitable ratio of clinical staff to residents, effective supervision and cohesive team working.

The PIC has reviewed the structure of the housekeeping team and a Housekeeping Supervisor has been appointed who will provide expertise and supervision to the team in ensuring that the home is maintained to a high standard of cleanliness and that there are sufficient housekeeping staff available to maintain high standards at all times.

The ADON and CNM will supervise workflow and practices to ensure that staff are facilitated to provide high quality, safe and effective care to all the residents in the centre.

A review of mealtimes has taken place with input from residents to ensure that the dining experience is an unhurried, enjoyable social occasion and that the residents who choose to take their meals in their own rooms are assisted in a timely and dignified manner.

A member of the Management team will be rostered at weekends to ensure consistent delivery of person-centred care, including a variety of interesting and meaningful activities, based on the expressed preferences of residents.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
All staff in the nursing home, including recently appointed staff, have completed all required mandatory training courses.

We will ensure that new staff are facilitated to complete mandatory training during the induction period and that refresher courses or updates are completed within set timelines.

We will ensure that the training matrix is kept up to date and that individual records of training are stored in each staff member's personnel file. The Administrator will maintain the training records up to date and will provide regular report to the PIC so that the training matrix is an accurate reflection of all training undertaken in the nursing home.

We will monitor the performance of staff who have completed mandatory training courses to ensure that they can appropriately apply their knowledge and skills to practice, including appropriate cleaning and housekeeping routines, in accordance with the evidence-based best practice and the centre's policies, procedures and guidelines.

We have facilitated all housekeeping and catering staff to complete a Clean Pass course which is an accredited QQI Level 3 qualification.

The PIC will ensure that appropriate levels of supervision are in place for all staff groups and that staff are encouraged to inform her if they feel they require additional support, time or training to assist them to undertake their duties.

As part of the daily walkabout the PIC will liaise with the Catering Manager and Housekeeping Supervisor to ensure that practices in the home are safe, effective and provided to a consistently high standard, and that there are robust supervision arrangements in place.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Resident records are now stored securely in a locked filing cabinet in the nursing home and staff are aware of the need to maintain confidentiality. The resident files will be kept securely locked in a suitable filing cabinet.

Completion of care records will be monitored daily by the ADON and CNM. They will

provide guidance and coaching to the named nurses so that they develop skills in writing person-centred care plans and comprehensive record-keeping.

Discussion on accurate documentation will take place at all handovers and safety pauses.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC is being supported by the Healthcare Manager and the Director of Care Services in the achievement of all required objectives and in ensuring that there are safe, high quality systems of governance and management in place. Key Performance Indicators and operational issues in the home are recorded and reviewed on a weekly basis by this senior management team to ensure sustainability of progress, to identify areas in need of improvement and take corrective actions if required.

There is a monthly management team meeting in the home which reviews all operational aspects of the home, including key performance indicators, risk management, audits and progress on identified actions and updates on quality improvement initiatives. This meeting is well attended and includes at least one representative from each department.

In addition to regular daily communication updates, the PIC has a scheduled weekly meeting with the ADON and CNM in order to agree priorities and improve the arrangements for clinical management oversight, including supervising, shadowing and coaching staff members on a one to one basis as part of competency assessment and performance development. The PIC attends handover daily to ensure that the entire team is aware of objectives, plans and developments and to hear from staff about any issues, concerns, suggestions and ideas.

We will improve the support provided to existing staff to enhance staff retention. The PIC and ADON now hold fortnightly clinical supervision meetings with the nursing staff to give them an opportunity to learn through reflection, and this has assisted staff in feeling safe to discuss how they are feeling and managing in the workplace. The nursing staff have evaluated these meetings very positively.

These supervision meetings contribute to the annual staff performance appraisal meetings which have been scheduled. We will provide staff members with self-assessment forms in advance of the individual staff appraisal meetings so that they have an opportunity to articulate their views and suggestions, including how they could feel valued in the workplace for their contribution to the team.

There is an active recruitment programme ongoing to replace vacant posts and interviews are scheduled regularly. Several of the vacancies are student nurses who are

returning to college full-time in September.

A Housekeeping Supervisor has been appointed and will provide environmental oversight so that the housekeeping team have the direction, guidance, supervision and support they need.

We have reviewed the way in which audits are conducted in the home to ensure that there is an accurate assessment of areas that are not compliant with expected standards and that an action plan is devised an implemented to resolve and improve these areas. For example, the PIC conducts more regular audits of Hygiene and Infection Control and although the overall level of compliance was initially lower than satisfactory, it is evident that the audit tool was being used in a more open and transparent manner, and that the corrective action plan was specific and measurable; therefore, over time we have seen an overall improvement in standards of hygiene and infection control in the home.
We have adopted a similar approach to reviews of the quality of clinical documentation and other audits.

The risk register will be reviewed and updated to ensure that identified risks are mitigated and appropriate actions taken to reduce and manage risks.

The 2019 Annual Review was presented on 30/07/2020 and copies of the review are available throughout the home for residents and their relatives to read.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All incidents will be notified in a timely manner as per regulatory requirements.
Notifications are discussed with Healthcare Manager during weekly visit and at monthly management meetings.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The PIC will be supported by senior management to investigate all complaints thoroughly and to ensure that a comprehensive response is provided to ensure that the complainant is satisfied that all aspects of the complaint were addressed.

The PIC is visible, accessible and actively engages with residents and their families to seek feedback regarding concerns or suggestions and to intervene as soon as possible to address and resolve their issues to their satisfaction.

All staff are encouraged to report and record all concerns and complaints at the earliest convenience, so that if possible, they can be resolved at a local level.

Complaints are managed in accordance with the Complaints Policy in the home and are discussed at the monthly Management meeting.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
All staff have now signed off to confirm that they have read and understood the policies. New staff are given time to review policies during their induction and the PIC is available to answer any questions that arise.

The ADON and CNM will ensure that all staff practice is in line with our policies, procedures and guidelines during their daily rounds.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
We will provide a dining experience that is a social, enjoyable and unhurried occasion for our residents, taking into consideration those residents that choose to have meals in their rooms.

We are continuing to consult with residents regarding their menu preferences and we will continue to work with the Catering Manager to ensure that there is a variety of nutritionally balanced and appetizing meals available for residents to enjoy.

The dining experience is supervised by a Staff Nurse with particular emphasis on ensuring those residents that require assistance are assisted in a dignified, respectful and timely manner.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
The COVID-19 contingency plan is reviewed weekly by the PIC. The HCM will conduct a COVID-19 audit in the home and will develop an action plan as necessary to address any identified deficits and will evaluate corrections taken to improve quality. The findings of this audit will be discussed at the monthly Management meeting and will be made available to all staff.

The bath in the memory care unit will be repaired.

Appropriate storage of equipment will be overseen by PIC and senior nursing team. All faulty / broken equipment will be disposed of as soon as it is identified as no longer fit for purpose.

Damaged flooring to two bedrooms and corridors will be replaced.

The PIC conducts targeted daily walkabout rounds specifically to monitor standards of cleaning. The PIC will check that the cleaning records are reviewed and updated daily. The completion of cleaning schedules is checked with the housekeeping staff and signed off by the PIC or a member of the senior nursing team.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Infection Prevention and Control are high priority areas for quality improvement in the nursing home. The Public Health guidelines are available and regular updates are discussed with staff when revised versions are published.

The training module issued by Health Information & Quality Authority will be made available to all staff and all appropriate staff will be required to complete this programme.

The ADON will be the designated Infection Control Champion for the nursing home.

An Infection Prevention & Control Committee will be established and will meet monthly; there will be representation on this committee from all departments.

The nursing home is well equipped with PPE and these items are stored appropriately and safely. Appropriate hand washing, hand sanitizing equipment and items of PPE are available for visitors to the home.

All staff are aware of the requirement to wear a face mask at all times when on duty in the nursing home and there is an abundant supply of hand sanitizing and handwashing facilities available throughout the home.

There is clear signage reminding staff and visitors to the home about the importance of hand hygiene, wearing of face masks and social distancing.

Staff are reminded and supervised in ensuring that they apply principles of social distancing as far as practicable in the workplace, and residents are encouraged to social distance within the home.

The Hygiene and Infection Control audit has been reviewed and undertaken more frequently and we can now see evidence of sustained improvements in infection control and hygiene standards in the home. All non-compliances are addressed in a timely manner.

The management of the disposal of general and hazardous waste material has been reviewed and is now in accordance with the home's policy and legislative requirements. Sharps bins are managed and disposed of in line with infection control and hygiene procedures.

All clinical and assistive equipment such as mattresses and slings are appropriately stored and all floor areas are kept clear and clean.

The housekeeping trolley is stored away from the corridors and communal areas, and when in use it is not left unattended.

Staff are instructed not to congregate in the smoking shelter; they are supervised to ensure that appropriate social distancing measures are implemented at all times, including break times.

There are newly appointed housekeeping staff in post; they have completed an extended period of induction and training specific to their role as well as all mandatory training requirements.

The PIC has appointed a Housekeeping Supervisor who is responsible for ensuring that the housekeeping and laundry duties are completed to a high standard.

The PIC, with support from the Housekeeping Supervisor will ensure that there is always a sufficient number of housekeeping and ancillary support staff available each day to complete all assigned duties and ensure the expected standard of service is maintained.

All housekeeping and catering staff have attended Clean Pass training in August 2020 and training will be provided on an on-going basis for all new ancillary staff to the home.

Cleaning and decontamination of equipment schedules have been put in place for completion by nursing and healthcare staff. The procedures for decontamination of equipment are included in the first week of induction for nursing and care staff. Staff already in post have been shown how to undertake these procedures correctly.

The PIC will conduct daily walk around of the building with ADON / CNM and will identify any deficits to the Housekeeping Supervisor; an action plan will be developed and implemented to address any identified deficits.

The PIC will ensure that sanitizing wipes and cleaning solutions are easily accessible and freely available to promote enhanced cleaning and decontamination practices.

Social distancing of staff and correct PPE use will be monitored by PIC and senior nursing team.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A review of medication management practices has taken place and all prescriptions and medication administration charts will be written clearly and in accordance with the prescriber's instructions and legislative requirements regarding the prescription and administration of medicinal products. Nurses will only transcribe in line with our policy. The ADON and CNM will ensure that all prescribed medications include the route, the dosage and the time of administration and the discontinuation date. Staff Nurses will seek clarity where necessary prior to administration of medication in line with best practice guidelines.

All nurses will undertake competency assessments via the HSELanD online learning system and evidence of completion will be maintained on the individual nurse's personnel file and recorded on the training matrix.

All medication errors will be logged as incidents on EpicCare and will be reviewed by PIC, any training deficits will be identified. Corrective action, reflective practice and refresher competency training will be provided as necessary.

Clinical waste boxes that contain sharps and discarded medicinal products will be dated and labelled to allow for contact tracing and to be disposed of safely in accordance with national guidelines' compliance with this policy and procedure will be monitored by the PIC during daily rounds.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A comprehensive review of clinical documentation will be undertaken by PIC to ensure that all assessments have been completed as required and that a person-centred care plan has been developed for each resident within 48 hours of admission to the home.

A weekly audit of clinical documentation will be completed by PIC to ensure that each resident's required care needs are addressed, that the care plan guides the delivery of care and that the care delivered is reviewed and evaluated appropriately.

Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings.
Any changes or developments in the resident's condition or plan of care will be updated as they occur.

Care plans will be developed in consultation with residents and/or their designated representative and will reflect each individual resident's preferences and choices.

For those residents identified at high risk of falls, a falls prevention plan will be included in the mobility section of the Daily Life care plan.

For residents that present with responsive behaviour, a plan of care will be included in the social section of the Daily Life care plan to include triggers for behaviour, information to guide staff on recognizing and responding to triggers and de-escalating said behaviour. The Antecedent, Behaviour and Consequence Chart will be used to establish and describe individual triggers and de-escalation techniques in order to ensure that all staff adopt a consistent and individualized approach to the management of responsive behaviours.

A record of consultation will be documented in the electronic care file.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Yellow	30/09/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/09/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2020
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other	Not Compliant	Orange	30/08/2020

	refreshments are served.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	30/08/2020
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	Red	30/09/2020
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	Orange	30/09/2020
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	Red	30/09/2020
Regulation 26(1)(a)	The registered provider shall ensure that the	Not Compliant	Orange	30/09/2020

	risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	30/09/2020
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Red	30/09/2020
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's	Not Compliant	Orange	30/08/2020

	pharmacist regarding the appropriate use of the product.			
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Not Compliant	Orange	30/08/2020
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Yellow	30/08/2020
Regulation 31(4)	Where no report is required under paragraphs (1) or (3), the registered	Not Compliant	Yellow	30/08/2020

	provider concerned shall report that to the Chief Inspector at the end of each 6 month period.			
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Substantially Compliant	Yellow	30/09/2020
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.	Substantially Compliant	Yellow	30/09/2020
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/08/2020
Regulation 5(3)	The person in	Not Compliant	Orange	30/09/2020

	charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/09/2020