Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Beneavin Lodge Nursing Home
Name of provider:	Beneavin Lodge Limited
Address of centre:	Beneavin Road, Glasnevin, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	04 October 2018
Centre ID:	OSV-0000117
Fieldwork ID:	MON-0025184

About the designated centre

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	94

How we inspect

To prepare for this inspection the inspector or 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
04 October 2018	08:30hrs to 18:00hrs	Ann Wallace	Lead

Views of people who use the service

Inspectors spoke with just under 10% of residents, who all said they felt happy living in the centre and felt that there were enough staff to assist them when they needed it. Several residents told the inspectors they noticed that staff were largely the same now on a day to day basis, and they like the consistency this gives them.

Residents said they had enough to do during the day, and reported that they liked spending time at the group sessions of their units in addition to watching TV and chatting with others on their on units. Visitors were welcome in the centre and residents who had visitors regularly said they had enough privacy to see them and that they were welcomed by staff.

Residents reported they liked the food and had the option to have a range of snacks and drinks throughout the day. Residents spoken too also confirmed that they had seen the Doctor and other specialists when they needed to, including an optician who was on site on the day of the inspection.

Residents liked their bedroom area, and also their en-suite toilets and shower rooms. many reported that they liked looking out the windows towards the grounds, and none mentioned any impact or influence of the building works taking place on the site, on their day to day lives.

Capacity and capability

Inspectors found that significant improvements had been made since the previous inspection in relation to capacity and capability in the centre. Improvements were found in the management and reporting structures, communications with residents and families, the management of complaints, the systems that were in place to monitor the quality and safety of care and services and in staffing. However further improvements were still required in the supervision of staff in their day to day work on one unit and in establishing the resident and family feedback processes in the centre to ensure that all residents and their families were included.

The person in charge is a registered nurse who was appointed to the role in May 2018 and works full time in the centre. This inspection found that she was sufficiently involved in the operational management and administration of the designated centre and that she had a clear role in the effective governance of the centre. The person in charge met regularly with the registered provider representative and with the newly appointed Group Operations Director. Records showed that she was fulfilling her role and responsibilities across the centre and that

clear reporting structures were now in place.

The person in charge was supported in her role by the assistant director of nursing and the clinical nurse managers on each unit. Staff who spoke with the inspectors were clear about the reporting structures in the centre and said that senior nurses and managers were approachable and were available to them.

Following the previous inspection the provider had implemented a comprehensive staffing plan to improve staffing levels in the centre and reduce the use of agency staff. On the day of the inspection inspectors found that planned rosters matched the staff on duty and that one short notice absence had been covered by existing staff on the unit. Records showed that the use of agency staff had reduced since the last inspection and that no agency staff had been used in the centre for the previous two weeks. Staff who spoke with the inspectors were knowledgeable about the residents they were caring for and were familiar with their needs and preferences for care and daily routines. Families who spoke with the inspectors reported that they had noticed a reduction in the use of agency staff and that; overall, staffing levels on the units had improved since the last inspection.

In order to improve the levels of supervision and support for staff the provider had increased the number of supervisory hours available for clinical nurse managers on each of the units. In addition the centre had employed five experienced care staff as team leaders to provide support and supervision for care staff. Records showed that staff performance was being actively managed and where improvements were needed this was identified with the member of staff and managed through the designated centre's performance management systems. Additional training and support was available for staff when required.

As a result inspectors found that supervision processes and staff development had improved since the last inspection. However improvements were still required as inspectors observed two incidents of poor communications with residents on one of the units which were not identified by the nursing and senior care staff working on the unit.

Training records showed that staff access to fire safety training and fire drills had improved since the last inspection. All staff who spoke with the inspectors were able to articulate the fire safety and emergency procedures for the units they were working on. Records showed that when agency staff had been employed in the centre they had completed an induction programme that included the fire safety and emergency procedures. This was a requirement from the previous inspection.

Training in dementia care and challenging behaviours continued to be rolled out in the centre. Staff who had attended the training reported that the sessions had increased their knowledge and skills in these areas. However records showed that there were a significant number of staff who had not completed this training at the time of the inspection.

Significant improvements had been implemented in relation to the systems that were in place to monitor the quality and safety of care and services in the designated centre. Monthly audits had been further developed to include data

analysis and this was being used to identify trends and areas for improvements. Records showed that complaints, incidents and audit findings were discussed at the weekly senior management meetings and improvement action plans were agreed and followed up at subsequent meetings. The provider representative and the Group Operations Director attended these meetings and were knowledgeable about recent incidents and complaints that had occurred in the designated centre. The required actions from the previous inspection were also agreed, implemented and reviewed through these meetings.

The management of complaints and communications with residents and families had improved in the centre since the last inspection. There was a clear complaints procedure in place and information in relation to the complaint's procedure was available in the resident's guide and was displayed in the reception area. Following the previous inspection managers and staff had received training in the management of complaints.

The person in charge maintained a log of formal complaints that were received in the centre and staff recorded complaints and concerns that were raised with them on the units. The records of formal complaints recorded; the nature of the complaint, how it was investigated and managed, and the complainant's satisfaction with the outcome. The person in charge had received a number of complaints since the last inspection and was working with residents, staff and families to investigate and make the necessary improvements.

A number of resident and family meetings had been held on the units since the last inspection. Attendance at, and minutes of these meetings were recorded. Records showed that suggestions from residents in relation to meals/menus and activities had been communicated to the relevant departments.

In addition the person in charge and the assistant director of nursing had completed a number of individual family meetings with residents and their families as part of a schedule of annual family/resident meetings. Feedback from residents and families was communicated to the relevant staff or department head by the person in charge or the assistant director of nursing and any changes to care or services were agreed and where possible implemented.

Although significant improvements had been made in relation to communications with residents and families in the designated centre these changes were recent and were not yet well established. A number of families had not attended a meeting with senior staff in the centre. For example one relative reported that she had been informed about the recent changes but had not been invited to a family meeting at the time of the inspection and was not scheduled to do so.

Regulation 14: Persons in charge

The person in charge is a registered nurse with more than three years experience in working with older persons in a residential setting. The person in charge has a

management qualification. She was engaged in the effective governance, operational management and administration of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of staff was appropriate for the needs of the residents and the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Overall staff had access to relevant training and appropriate supervision systems had been put into place. However improvements were required;

- to ensure that appropriate supervision was provided consistently across all units.
- in the numbers of staff who had training in dementia and the management of challenging behaviours.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents contained all of the information required in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

There was a clearly defined management structure that identified the lines of authority and accountability. Staff were clear about their roles and responsibilities and about the reporting structures in the centre.

Management systems were in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored. Further improvements were required to ensure that resident and family feedback systems were extended to all residents in the designated centre and to their families.

There was an annual review of the quality and safety of care and services provided and this was available for residents and their families.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Not all contracts for care contained a record of the fees as agreed with the resident and/or their family on admission to the centre. This was an outstanding action from the previous inspection.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The revised statement of purpose dated September 2018 included the information required in schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector found that one incident relating to challenging behaviours had not been notified to the office of the Chief Inspector as set out in Schedule 4 of the regulations.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place. Information in relation to the complaints procedure was available for residents and families. Managers and staff had received training in the management of complaints.

Complaints were recorded. Formal complaints were investigated by the person in charge and the outcome communicated to the complainant. The complainant's level of satisfaction with how the complaint was managed was recorded. Residents and families knew who was responsible for managing complaints in the centre.

Judgment: Compliant

Quality and safety

Overall improvements were noted in the quality and safety of the services provided in the centre. Care was being provided by consistent staff members with the well-being and needs of resident's in mind.

The inspector sampled a variety of care plans across all five units in the centre. The care plans were found to reviewed regularly and mostly captured the detail required for staff to provide good care to residents. However there were inconsistencies in the use of care plans from unit to unit; for example in the care plans drawn up to manage a residents challenging behaviour.

In the sample reviewed regarding the management of nutrition and weight loss, residents were found to have had their weight measured, had assessment by suitable specialist professionals and accurate day to day food and fluid charts were being maintained. In the case where residents displayed challenging behaviours, care plans were largely detailed to reflect this, although key information regarding the specific behaviour a resident tended to display was not always immediately clear. Additional behavioural charts were being maintained however not every incident involving challenging behaviours was being captured with this additional paperwork, which limited staff ability to reflect on and learn from the behaviours. Care plans with different titles were being maintained across units, for example information about bedrails could be found in sections called bedrails or mobility or safety. This poses a risk that resident's information may be duplicated or not accessible for staff who are looking for the information in different places.

In the majority of plans reviewed regarding the use of bedrails, an assessment had been completed, and whilst alternative to bedrails were listed as being trialled, no further information was available as to what was trialled and the rationale for them to not be used was not clear. However alternatives to bedrails were in use in the centre across all units. There was evidence that bedrails use was discussed with

families and the resident themselves in some cases, and there was also evidence of the check being used at night to ensure the equipment was safely in use.

Residents had access to specialists as they required it. Evidence was seen of specialist input from dieticians and other allied health professionals, in addition to specialist consultants for the care of older people. Since the previous inspection the allocated hours of occupational therapy had increased to address resident's needs.

Residents who displayed challenging behaviours were being closely observed by the staff, however the care plans to address and deal with the behaviours and staff practices around same did vary from unit to unit. In one unit residents were being managed in a friendly and attentive manor, however in another the allocation of a particular space in the day room to manage the residents behaviour was not deemed satisfactory for the residents who lived there. This was discussed with the assistant director of nursing in detail on the day.

Residents and families who spoke with the inspectors said that they felt safe in the centre and that staff were respectful and kind. Residents said that could talk to staff if they had any concerns or were worried about anything.

Residents reported they were sufficiently busy and had options to attend some group activities and outings (as detailed further in the residents views section earlier in the report). Their social activity care plan included detail of their likes and dislike and day to day records were being maintained by either nursing staff of the activity or care team. The activity team consists of three different members of staff, and the programme runs across the full seven days a week. Some on ward activity was observed in some unit while the inspector went through care plans with nursing staff. These activities consisted of ball games, and table top crafts. Large format group activities (for example music sessions) took place in a large activity room on the ground floor. Residents with challenging behaviours often remained on their units.

All units had area where resident could sit and relax in the company of others. In most cases these large rooms, also doubled as an area for dining and watching the TV. These rooms contained the nurses stations also, the area where ward staff nurses were expected to observes residents and maintain their documentation in addition to answering calls and queries.

The inspector observed that the layout of furniture in these rooms was often conducive to staff observing resident's and not always cognisant of resident's desire to have a window view or direct line of site towards the TV. The privacy aspects of managing and maintaining residents data at an open desk in a communal room remained an issue on this inspection. The practice around taking telephone calls outside of these rooms varied from unit to unit. As a staff member was expected to be in attendance in these rooms for observation and support it was not always possible to engage in conversation or calls about resident's care and their condition outside of the room.

Overall the premises' was observed to be clean, well ventilated and bright. The inspector was able to visit some resident's accommodation with their permission,

and all reported being satisfied by their space and furnishing. The facility to safely and securely store medication in one unit had been fixed and was satisfactory. Adaptive equipment was viewed to be mostly well maintained, and an additional hoist had been purchased and was in use to assist residents who required its support. A small number of wheelchairs were observed that required repair and despite evidence of their faults being reported they were still in use and no immediate action plan available to indicate when they may be repaired. A finding of the last inspection was that that alarms sounding on wards were intrusive and during this inspection almost no alarms were heard on units throughout the day. Meal times was observed and during this time the TV remained off, with music playing in the background, and staff were able to move freely between residents who required assistance without any interruption.

The inspector viewed manual handling practices by staff on the different units, and these occasions were deemed satisfactory. Almost all staff were trained in manual handling, and staff members who required training had training scheduled in the coming weeks. Staff who spoke with the inspector were knowledgeable about key risks in the centre. Staff who spoke with the inspectors gave a clear description of the plan they would follow in the event of a fire alarm activation. Managers recorded incidents relating to near misses, medication errors. falls and responsive behaviours. Improvements had been made in how these incidents were reviewed with the relevant staff and what steps were taken to reduce the likelihood of recurrence in the future. However the number of falls in the centre had only slightly improved and there was no clear falls strategy to ensure that residents who had more than one fall were reviewed by the appropriate health care professional and a clear falls prevention plan put into place.

Regulation 17: Premises

Noise levels had improved across the centre.

An additional hoist had been purchased and was in use for the transfer of residents.

Some wheelchairs were observed to be in use that required urgent repair. Repairs had been requested however no timeline was available for this and the chairs remained in use.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Meals and snack were available throughout the day and residents reported they

could access food when they wished.

Records were seen indicting that weigh loss was being closely monitored through the use of assessments, daily charts and referals to specialists.

Judgment: Compliant

Regulation 26: Risk management

Improvements had been made in how these incidents were reviewed with the relevant staff and what steps were taken to reduce the likelihood of recurrence in the future. However the number of falls in the centre had only slightly improved and there was no clear falls strategy to ensure that residents who had more than one fall were reviewed by the appropriate health care professional and a clear falls prevention plan put into place.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Staff were found to be knowledgeable and consistent in their response to questions on fire and evacuation. Training records showed that staff access to fire safety training and fire drills had improved since the last inspection. All staff who spoke with the inspectors were able to articulate the fire safety and emergency procedures for the units they were working on. Records showed that when agency staff had been employed in the centre they had completed an induction programme that included the fire safety and emergency procedures. This was a requirement from the previous inspection.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

One sub regulation on the storage of medication was assessed.

Medication storage was found to be safe and secure on this inspection.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Overall care plans were regularly reviewed, included recommendations from specialists and were referred to in daily notes. There was evidence that aspects of some care plans had been shared with residents and their families where appropriate.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Challenging behaviours were well managed in some units in the centre.

In one unit the assessment, documentation of and impact of techniques used with residents who displayed challenging behaviour required improvement.

When restrictive practices were used, evidence was seen that these had been assessed and consultation with residents and families had taken place. The rationale around not using alternatives to the restraint was not being captured on the assessment form.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The privacy aspects of managing and maintaining residents data at an open desk in a communal room remained an issue on this inspection. The practice around taking telephone calls outside of these rooms varied from unit to unit. As a staff member was expected to be in attendance in these rooms for observation and support it was not always possible to engage in conversation or calls about resident's care and their condition outside of the room.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Beneavin Lodge Nursing Home OSV-0000117

Inspection ID: MON-0025184

Date of inspection: 04/10/2018

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Supervision continues to be provided by CNM's and Team Leaders, and supported by the ADON and PIC. Supernumerary hours are allocated to the people in these roles to ensure supervision is available on a consistent basis. Feedback is provided to supervisors and staff across all floors to ensure a consistent approach is taken. The PIC meets with the CNMs and Team Leaders every two weeks to provide guidance and agree actions.

Every 3 months, the PIC completes a night check including walk around of all units, checking on each resident as well as the check list on each floor. This was last completed on 12th October 2018.

Beneavin Lodge is supported by a Training Coordinator who works closely with the PIC and ADON. Training needs that have been identified are prioritized with an agreed timeframe for rollout. This occurs on a continuous basis and reviewed at the scheduled monthly meetings with the Training Coordinator and PIC, the latest meeting held on 05th November 2018.

Training specific to Dementia is scheduled for HCA and nurses, with the was latest training provided on 6th November and another scheduled for 13th November 2018. Training for staff on responsive behaviours and management of these behaviours is scheduled for the 15th November; and Manual handling was held on 08th November 2018.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Residents, families and staff meetings continue which includes relevant updates and reminders such as the management structure, role of PIC and ADON.

Family meetings for all residents have been completed for all 5 units (25th October 2018) and next schedule of meetings commence on 31st October 2018.

Residents meetings are scheduled for every month; within the first two weeks of the month, with the next meeting scheduled for the 12 November 2018. Residents with cognitive impairment are facilitated through the use the visual aids to elicit their feedback.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
Contracts for the Provision of Services are undergoing a review, and if any require updates, the appropriate follow up with our resident and/or family will be arranged.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All incidents are completed in our incident recording system and in line with our policies. The particular incident noted at the time of the inspection on 04th October was reviewed on the day and the required notification submitted to HIQA.

The PIC is aware of the requirement of notifications as set out in Schedule 4 of the regulations and will ensure the required follow up is completed.

The PIC provides regular updates to the Group Director of Operations on incidents, incident management and notifications to HIQA.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Maintenance staff ensures regular checks are completed. Staff reminders are in place to report any issues immediately to Maintenance personnel and the PIC. An order for replacement wheelchairs has been placed, with an expected delivery no later than the 30th of November 2018.

The PIC will continue to monitor the maintenance requests and meet with the Maintenance staff weekly to oversee requests, work completed and any outstanding items to be addressed and agree actions.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
All staff are aware of the guidance as set out in the policy, including assessment following two falls in any given rolling month and/or following any significant change in status of the resident. Reassessment occurs immediately after any recorded falls, with the care plan and residents action plan amended as appropriate. This is undertaken in collaboration with their GP and include multidisciplinary input as indicated according to the needs of each individual resident as appropriate. Review of care plans are ongoing and will be completed by end of 30th November 2018.

The PIC will continue to audit and monitor falls and falls management, providing feedback to CNMs for agreed actions to be implemented. The Falls Audit for October indicates that falls reduced from 34 falls to 12 falls within one month.

To further enhance falls management and prevention, the Training Coordinator is reviewing falls management training programs with the intent of making this available to staff in FirstCare Homes, including Beneavin Lodge.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
CNMs through clinical supervision are reviewing all components from assessment to documentation of responsive behaviours, and the impact of techniques used, for consistency across all units including the consistent utilization of forms, paperwork and sections of EPIC that are recorded specific to responsive behaviours and management of behaviors that challenge.

The PIC will continue to monitor the review and agree actions with the CNMs to ensure consistent practice across all units.

Further training on responsive behaviours and management is booked for 15th November 2018.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Handovers are being completed in appropriate areas away from open communal rooms with the use of the clinical and doctor's rooms available and used for meetings and phone calls. The PIC has reviewed the environment and is in the planning phase of redesign of areas that will address the use of space including areas for clinical/care communications.

All staff are aware of the requirement to use private spaces to conduct meetings and phone calls relevant to residents and their care. This will continue to be an item on staff meeting agendas and through supervision processes.

Staff have been reminded of confidentiality and GDPR. The employee handbook has been updated in relation to GDPR and our policies are under review with updates specific to GDPR being completed. A training program on GDPR has been created and a planned roll out has been agreed.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/12/2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2018
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/11/2018
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe,	Substantially Compliant	Yellow	31/10/2018

	appropriate, consistent and effectively monitored.			
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Substantially Compliant	Yellow	31/12/2018
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	30/11/2018
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	05/10/2018
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour	Substantially Compliant	Yellow	31/12/2018

	that is challenging.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/12/2018