Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

Name of designated centre:	Coral Haven Residential Nursing Home
Name of provider:	Coral Haven Residential Nursing Home
Address of centre:	Ballinfoyle, Headford Road, Galway
Type of inspection:	Unannounced
Date of inspection:	08 January 2020
Centre ID:	OSV-0000331
Fieldwork ID:	MON-0028262

About the designated centre

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

Coral Haven Residential Nursing Home is a purpose built facility located on the Headford Road, Co Galway. The centre admits and provides care for residents of varying degrees of dependency from low to maximum. The nursing home is constructed on three levels. There are four double bedrooms and 52 single bedrooms. There is adequate sitting and dining space to accommodate all residents in comfort. The second floor is dedicated to accommodate residents of high dependency. The provider employs a staff team consisting of registered nurses, care assistants, administration, housekeeping and catering staff.

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
Thursday 9 January 2020	10:00 amhrs to 7:00 pmhrs	Una Fitzgerald	Lead
Wednesday 8 January 2020	7:00 pmhrs to 10:00 pmhrs	Una Fitzgerald	Lead
Wednesday 8 January 2020	7:00 pmhrs to 10:00 pmhrs	Catherine Sweeney	Support
Thursday 9 January 2020	10:00 amhrs to 7:00 pmhrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Inspectors spoke with residents and their relatives. Overall, residents expressed satisfaction with the care they received, describing staff as caring. A common theme voiced was that staff were always very busy. Several residents said the food was good and said that staff gave alternative meals if the choice available was not something they liked. Residents also said that they were given drinks and snacks frequently during the day.

Relatives voiced that they felt there was not sufficient staff on duty in the evenings to supervise and support residents. Visitors said that when they raised issues and concerns they were not always addressed or resolved. In addition, some relatives reported that management had communicated that concerns and complaints could only be discussed with a residents next of kin. For relatives who had concerns, this meant that they felt they did not have a voice. In some instances, the next of kin did not visit as regularly and so would not always be aware of the issues that required attention and follow up for their loved ones.

Inspectors observed that visitors had made connections and built relationships with other relatives and residents. This added a sense that relatives and residents looked out for each other and were readily available to attend to small tasks and acts of kindness. For example, help a resident stand, alerting care staff that a resident required assistance.

Inspectors observed that supervision in all communal areas required review. For example, one resident could not mobilise as there mobility aid was kept in their bedroom out of their reach.

The centre is purpose built. Overall, residents were happy with their individual bedrooms. Inspectors observed that residents rooms were personalised with photographs and other personal possessions. The high dependency unit on the second floor had secure enclosed gardens.There were four doors that accessed the internal gardens. All doors were locked and required staff intervention to be accessed. This meant that residents were restricted in accessing the secure outdoor gardens.

Capacity and capability

Inspectors found that there was inadequate governance and management arrangements coupled with poor oversight in place to ensure that the

service provided to residents was safe, appropriate, consistent and met regulatory requirements.

This inspection was unannounced and had been triggered following receipt of three separate concerns from relatives in relation to the availability of staff to supervise residents. The information also raised concerns on the number of residents that had had a fall. In November 2019, the Chief Inspector issued the centre's management with a provider assurance report (PAR) requesting information on how the centre is meeting regulatory requirements. The provider submitted a staffing report, a complaints report and a report detailing the number of falls that had occurred. Despite this response, a further concern was received into the Chief Inspector office which identified ongoing concerns relating to the availability of staff to care for residents. The concerns alleged issues relating to the capacity and capabilities of the management team that were having a direct negative impact on the quality and safety of the care delivered to resident's. Findings from this inspection have substantiated the concerns and are detailed below.

Inspectors found that the systems in place to monitor the direct provision of care that affected all areas of the centre were not coordinated. Inspectors found clear evidence that there was a disconnect between the staff delivering the care and the nursing management team.

This was evidenced by:

- The management team had gathered statistical information on the number of complaints. However, on the days of inspection there was clear evidence of open complaints that were not addressed and had not been appropriately followed up as per the complaints policy.
- Inspectors were informed of an incident of responsive behaviour that had had a direct negative impact on multiple residents. The incident was logged on the system. Management had no knowledge the incident had occurred.
- Multiple risks that were identified during this inspection were not identified on the risk register. For example; the risk associated with gaps in the care plans.
- Risks identified on the risk register were not updated post significant events outlining additional steps required to keep a resident safe.

As previously stated the Chief Inspector issued a PAR in November 2019 as a result of information received. Inspectors followed up on the reply that was submitted at the time. The response submitted by the registered provider representative outlining the actions taken or actions that would be completed were not actioned. For example: the PAR stated that "Internal audits are reviewed and action plans developed and communicated to staff". Inspectors were told by the management team that there were currently no issues with residents weight management. The audit completed in October 2019 had identified significant unintended weight loss in multiple residents. Despite this, no appropriate actions or follow up had occurred to ensure that the appropriate intervention management occurred for residents.

The governance and management structure was clearly outlined in the Statement of purpose. Reporting structures were in place and incident management systems were

in place for the purpose of monitoring and informing management decisions. However, there was no evidence that the management team were actively reviewing the incidents logged and factoring this information into the overall running of the centre. Inspectors reviewed records on the system and found gaps in the detailing of relevant information and follow-up measures. Therefore the effectiveness of this process required improvement to ensure the quality and safety of the service is being consistently monitored and reviewed accordingly. For example; recorded incidents of aggression and violence were high. Records evidenced that staff had completed suitable training to respond to any incident of responsive behaviours. However, the care plans did not guide care and in some instances the entries and direction given was inappropriate and not in line with best practice. Additionally, the lack of awareness by management that the incidents had occurred did not demonstrate adequate oversight and review of the arrangements in place following incidents occurring.

From discussions with staff and observations, inspectors concluded that significant improvement is required to ensure that those in charge are monitoring the service and have the necessary oversight to ensure that residents are receiving a safe and appropriate service. As a result of the level of non compliance found during this inspection an urgent compliance plan was issued to the provider specific to regulations 16 Training and development, regulation 5 individual assessment and care plan and regulation 6 health care.

Regulation 15: Staffing

Sufficient numbers of staff with appropriate skills were rostered to meet the assessed individual and collective needs of residents in the centre. The roster reflected the staff on-duty on the day of inspection. The staffing whole time equivalent is currently supported by the use of agency staff due to the difficulties in recruitment. The person in charge verified that the centre had recently appointed new staff and once they have commenced the centre will have no further requirement for agency staff except in an emergency.

The newly appointed person in charge had recently rostered an additional health care assistant in the evening to ensure that the high dependency unit communal room was supervised. However further review of all units is required. This is evidenced by:

- there are extended periods of time in the evening whereby the ground floor is left unattended as the care assistant from this floor is required to also provide assistance to the first floor.
- health care assistants providing personal care are also assigned duties in the kitchen area. This is an infection control risk.

Judgment: Not compliant

Regulation 16: Training and staff development

A comprehensive and detailed training matrix was available for review. Staff had access to appropriate training and records reviewed evidenced that all staff had received training in safeguarding and safety, manual handling and fire safety. While gaps were seen in the number of staff trained to deliver CPR (Cardio pulmonary resuscitation) a plan was in place to address the gaps and staff were booked to attend the training.

Supervision of the staff required immediate action. Inspectors observed staff and resident engagement that was inappropriate. For example: a staff member was assisting a resident with feeding. The staff member was not engaging with the resident and had not observed that the resident was not swallowing the food. Despite this the staff member continued to feed more quantity of food to the resident.

Inspectors reviewed the fire training that had been delivered. Records evidenced that all staff had attended. Despite this multiple staff could not inform inspectors what action they would take in the event of the fire alarm sounding.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined management structure outlined in the Statement of Purpose. The management systems in place required review to ensure the service provided was safe, appropriate, consistent and effectively monitored. This is evidenced by:

- Failure to ensure that each resident is appropriately assessed and that the required intervention and follow up management is completed to ensure that residents receive safe levels of care.
- Failure to maintain a risk register that monitors known risk within the centre. For example: the risk associated with the staffing vacancies.
- Failure to adequately address the judgements of not-compliant found from the last inspection in August 2019. Three of the judgments of non compliance found on the last inspection are restated under regulation 34 Complaints procedure and regulation 23 Governance and Management. The centre is moving away from overall compliance with regulations.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was available. Further review of the detail is required to ensure that the Statement of purpose is accurate and contains all of the information set out in Schedule 1. For example, a more detailed description of how the centre supports residents to access services available through the medical card scheme.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Inspectors spent day one of this inspection observing activity in the communal rooms and speaking with residents and relatives. Information given by relatives combined with the records reviewed on day two gave clear evidence that the complaints process was not implemented appropriately. Inspectors reviewed the detail of complaints and followed up on the unsolicited information that had been received into the Chief Inspector. Complaints were logged on the home page as an event in the residents electronic file. Inspectors found complaints received were not appropriately documented and investigated. In addition, there was no learning identified. This is evidenced by;

- Inspectors found multiple examples of complaints in the electronic system that the management team were not aware of.
- A staff member had logged a complaint on how a resident with responsive behaviours had interacted with them. In addition, staff had also complained about how a relative had interacted with them following an incident that was distressing to the relative and resident concerned.
- In one resident file, there were six open complaints logged that had not been progressed. There was no evidence of any communication recorded or engagement between the management and the complainant to address the complaints. The complaints logged were in relation to the direct provision of care.

Judgment: Not compliant

Quality and safety

Overall, the quality of care delivered to residents required review to ensure that residents received person centered care in accordance with their individual assessed need, their choices and in line with evidenced based practice. The system in place to

ensure that staff are appropriately supervised requires attention to ensure that resident and staff engagements are patient and respectful.

A review of the care plans of ten residents found that care plans were not person-centred. Care plan interventions were generic and were not informed by the resident's assessments. The care plans for residents with behavioural and psychological symptoms of dementia contained interventions that were not evidence based or in line with best practice. For example: one care plan directed staff not to ask the resident any questions when assisting them with their meals.

There was no evidence that residents or their families had been consulted or involved in the development of the residents care plan. Families of residents spoken with confirmed that they had not been involved in the development of the residents care plans. A full review of the care planning system in place is required. Inspectors acknowledge that some care plans were of a good standard. However, in the area of weight management and the management of responsive behaviour there were significant gaps that had a direct negative impact on the overall quality of care received by residents. The level of detail recorded needed improvement to ensure residents' needs were understood fully, and care was provided to meet that need.

Inspectors also reviewed residents' files to determine if appropriate access to a general practitioner and allied health care professionals was in place. Inspectors found that medical reviews were conducted routinely every four months as per regulatory requirements. However, a review of the frequency and timely access to allied health care professionals was required as evidenced in the progress notes specific to the management of residents weight loss. Inspectors found that advice received from allied health care professionals was not routinely updated in the care plans. Therefore it was not clear if the advice was communicated to all appropriate staff. One relative questioned inspectors as to why their relative had their drinks thickened. This instruction is sometimes given following a specialist assessment that identifies a resident is at risk when swallowing. The inspector reviewed the clinical notes. There was no clinical assessment identifying that the resident should have their fluids thickened. This was discussed with the nursing management who confirmed this was an error. The nursing management committed to address this error.

The management of restraint was reviewed by inspectors. Risk assessments and care records showed that bedrail use was reviewed regularly. There were arrangements in place to ensure that when bedrails were used they were checked regularly and checks were recorded on the electronic system. The number of residents using bedrails was very low. Inspectors observed that some residents were sitting on sensor alarms. The purpose of the alarm is to alert staff that a resident who is at high risk of falling is standing and potentially mobilising without supervision. Inspectors discussed the use of sensor alarms and highlighted concerns that sensor alarms have the potential to be restrictive and so management of this non invasive form of monitoring residents at risk of falls requires supervision. The

person in charge was in agreement to review the recording of the use of sensor alarms and add their use to a restrictive practice log.

The management of risk required improvement to ensure residents' wellbeing and safety. Risk management was the responsibility of all staff. The person in charge held a risk register in the main office. The system was that items are added or updated as risk was identified. Inspectors concluded that the risks identified on this inspection that were either not identified or updated on the risk register clearly evidenced that risk management procedures require improved oversight and more rigour to ensure safe outcomes for residents.

Regulation 26: Risk management

A review of all risk identified within the centre was required. Risk identified on this inspection had not been identified on the risk register. On day one of the inspection the inspectors asked the management team what was the biggest risk in the centre. The management team informed inspectors that staffing vacancies and the use of agency staff was the biggest risk. This risk was not documented in the risk register. Inspectors acknowledge that a recruitment campaign had occurred and that the centre management had recently signed a service level agreement with an external agency to cover the roster if the staffing numbers could not be maintained by current staff.

Additional risk identified on this inspection that was not included or updated appropriately on the live risk register included:

- The risk associated with high numbers of residents with significant unintended weight loss
- The risks associated with the management of resident absconsion was not updated following an event
- The risk of fire door wedges to keep fire doors wedged open. The risk is that in the event of a fire the doors will not close and so contain the spread of the fire.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had taken measures to protect the residents, staff and the premises against the risk of fire. Inspectors observed that suitable means of escape and emergency lighting was provided. Suitable fire fighting equipment was provided which was regularly tested, serviced and maintained. All staff

received annual fire training specific to this centre. Following the last inspection detailed simulated fire evacuation drills had been carried out.

Further review and supervision under fire preventative management was required to ensure that:

- Staff retained the information communicated during training sessions. This would ensure that staff know what action and immediate steps to take in the event of a fire in the centre.
- Personal Emergency Evacuation Plans (PEEP) were not reviewed and updated every quarter to reflect changes in residents mobility status. This poses a higher risk for residents when care needs are being met by agency staff.
- PEEPs were not available in all resident bedrooms.
- Not all staff spoken with knew what a PEEP form was.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

There was an electronic system of documentation in place to record resident's individual assessments and care plans. A review of this documentation found that the information presented was inconsistent in quality and in detail. Assessments tools were not used appropriately resulting in inaccurate information being used to develop care plans that, in turn, did not meet the needs of the residents. For example, to assess a residents risk of malnutrition the nursing staff used MUST (Malnutrition Universal Screening Tool). A review of the MUST assessments for residents found that they were incomplete and did not factor in the residents recent weight loss. For example, a resident who had lost 5kg in one month had been assessed as being Low Risk of malnutrition using MUST. The nutritional care plan developed for this resident did not reference the weight loss, or detail any plan in place to address the residents immediate nutritional needs. The care plan was generic and did not contain any detail in relation to the resident's preferences. The management of residents nutrition and weight is further discussed under Regulation 6, Health care.

Judgment: Not compliant

Regulation 6: Health care

Inspectors were concerned that the findings of a weight management audit conducted in October 2019 had not been appropriately analysed and no appropriate action plan had been put in place to address the issues identified. The audit identified 10 residents who had significant unintended recent weight loss. Although

some of the residents had been referred to a dietitian, the nutritional care plans of these residents had not been updated with the recommendations prescribed.

The centre had a high incidence of falls. A falls audit had been completed, however there was limited analysis of the information collected and no action plan developed. Inspectors acknowledge that the number of falls reported had reduced with the added supervision in the high dependency unit.

The centre had access to local general practitioner service (GP) and allied health care professionals such as palliative care, psychiatry of later life, speech and language therapy and dietitian.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The care of residents who may display behaviour that is challenging for the staff requires review. On the day of inspection there were six incidents of responsive behaviour recorded in the incident log that remained unresolved. No action had been documented to address these issues. A number of these incidents related to the repeated responsive behaviours of one resident that had not been appropriately addressed.

The care plans for residents with behavioural and psychological symptoms of dementia contained interventions that were not evidence based or in line with best practice. For example: one care plan stated "ensure that the resident is not asked questions when eating and drinking". No rationale for this instruction was identified.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 26: Risk management	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant

Compliance Plan for Coral Haven Residential Nursing Home OSV-0000331

Inspection ID: MON-0028262

Date of inspection: 10/01/2020

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:
- We are actively reducing the number of Agency staffing rostered.

- 3 New HCA's have been recruited in the last month.

- An ADON role is advertised and the hiring process initiated, this will support the organisational structure more efficiently.

- We have advertised for a Senior Staff Nurse and a Senior HCA role in house to improve staff supervision and clinical outcomes for residents.

- An activity Therapist role (Maternity Cover) is advertised, In the interim we have appointed 1 HCA to carry out activities predominantly in Fountain and Castleview in the afternoon and evening.

- The ground floor HCA will stay on ground floor all the time and not leave to assist in the 2nd floor.

- We are reviewing any kitchen duties at night and re assigning them. The HCAs will continue to visit the kitchen on occasions during the night to assist the resident that may require beverage etc, this is done in compliance with wearing the appropriate PPE's.

- recently introduced additional twilight shift to supplement cover on higher dependency floors between 4-10pm

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
- We will continue with our robust training schedule for 2020 working closely with the HR Manager for the Group who tracks the training for the home on the group training matrix.
- A new online training system is in place to support staff at induction and support our other training methods such as in-house training, Study days off site and webinars.

- Feedback sessions with staff to ensure learning outcomes on training they have attended has been understood.

- Recruit/appoint ADON, Senior Staff nurse & Senior HCA to provide better supervision and responsible for improving communication & interaction of nurse/care roles and also with residents/families

- Lead nurse allocated on each shift.

- CNM – supervision hours in evening to improve supervision.

- PIC & CNM will alternate late shifts to increase supervision of staff.

- Awareness sessions during handovers.

- Staff supervision audits of all care staff have commenced.

- Appraisals scheduled to start in February, Probationary reviews to continue

- Track training effectiveness through questionnaire.

- Increase frequency of Fire drills.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
- All residents have had their assessments reviewed and any interventions acted upon. This will be monitored in a form of an audit on assessment and care planning at least quarterly by the PIC and ADON.

- The risk register will be kept up to date by the PIC and ADON ensuring any new risks identified are documented in the Homes risk register.
- We will ensure that we come into compliance with the Governance and Management of the center – addressing complaints promptly and engaging with residents and families to resolve concerns/issues in an open and honest way that makes the resident and the families feel confident in the care that is being delivered.

- We are reviewing the audit management system to ensure action plans are formulated and actions plans are implemented and communicated to staff.

- Audits will be reviewed to identify trends and any learning outcomes.

- Weekly clinical meeting with PIC/ CNM to review clinical care but also to review unresolved complaints, concerns from residents/families, audits, risk management. Falls and clinical indicators within the home

- Staff meetings have been held for January 2020 all minutes have been documented and communicated with all staff. These staff meeting will be held quarterly or more often if required.

- All complaints have been reviewed with one under investigation remaining open.
- Implementing monthly review of complaints.

- Residents meeting will continue monthly with the advocate and all minutes will be circulated to the residents and families.

- Family Meetings will commence this year staring with the first one in February and will continue Quarterly.

- In addition to above, existing Governance and Management arrangement will continue to support PIC and home management team to ensure we are endeavoring to deliver a safe, quality service to all our residents including but not limited to;
- 1. Weekly review of key clinical/care, people, risk/facility and operational home metrics
- 2. Fortnightly skype video call with PIC and DG support team (including RPR) to work through PIC agenda and provide support
- 3. Monthly RPR & Group Clinical Dir/PIC meeting onsite in the home working through set agenda and also available to staff, residents and families as required
- 4. Bimonthly PIC gathering to address topical issues, sharing and learning & development
- 5. Roll out of twice annual internal audit process (addressing Regs & Standards) in December for 2020, assigning responsibility with full track and traceability
- 6. DG team (including RPR) will continue to support the home and its management as and when required by being available and onsite if necessary, in addition to scheduled times above.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
-The statement of purpose has been reviewed and updated to include how the Centre supports the resident to access services available through the medical card

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
- Review of the complaint Management system.

- All complaints have been reviewed and one complaint remains open – investigation continues.

- Trends have been identified and systems to improve complaint management in the home has started – with this topic on the agenda for the first family meeting.

- Complaints will be reviewed monthly by PIC, ADON, CNM to ensure action plans are implemented and complaints resolved.

- A complaint log will be maintained.

- Improve communication with families and conduct family meeting every 3 months – next family meeting is scheduled on 13/02/2020.

- Improve resident and family input in effective running of the home.

- Discussed with staff regarding inappropriate logging of incidents / complaints.

- Send acknowledgement after receipt of every complaint to complainant.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
- A review of risks identified in the Centre has been completed.
• staff vacancies
• Falls
• Weight loss
• Absconsion
• Wedges on doors replaced by electronic devices

- Risk Management Policy will be reviewed and updated

- Risk register will be kept up to date.
- Clinical assessments have been reviewed and any risks identified have been addressed or reviewed, including updating of care plans for each resident and communicated to staff at every handover.
- sensor equipment will be added to the restrictive practice log

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
- A new peep system is now in place – all peeps reviewed and updated to reflect the resident's level of cognition and physical ability.

- All staff have made aware of the peep system and this have been communicated at staff meetings and handover.

- Awareness briefing following any training and questionnaire to support knowledge gained.

- Conduct fire drills more frequently to bring more familiarity around fire alarm activation

- Fire drills are also simulated to reflect night time staffing however we will continue to assess our evacuation efficacy with simulated drills and based on the outcome of these drills incorporate any process improvements / key learnings to maximise the safety of both our residents and staff.

- Use of fire warden/fire marshall when staffing levels are lowest – We already have a periodic check in place whereby every resident is checked at least once an hour – this check will be extended to include all areas of the home as part of an additional 'Fire Watch' – we will create an hourly sign-off sheet to record these checks. The fire marshal will be clearly identified to all staff each evening.
• All staff are fully trained in fire precautions and all have assisted in a fire drill.
• We have and continue to review our dependency levels in the home.

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:
- All care plans and assessments have been reviewed ,updated and discussed with resident / family as per urgent compliance plan submitted on 17/01/2020.

- All care plans are more person centered, descriptive taking into consideration clinical assessment, the residents healthcare needs ,likes, dislikes ,choices and preferences.

- Nurses have been spoken to regarding completing the MUST risk assessment correctly at the Nursing meeting held on 28/01/2020 – MUST Training has been scheduled for February 2020.

- Using clinical assessment correctly ensuring the information is accurate this has been addressed.

- The management team will review and audit care plans and clinical assessments quarterly to ensure care plans remain person centered , relevant , updated and descriptive and that assessments have identified the risks and these risks have been addressed with any referrals being made to appropriate allied healthcare service.

- - Named nurse protocol in place – with the responsibility to review the respective care plans every 4 monthly or more often if required.

- Care plans will be updated on periodic basis or if any change to the resident treatment or changes to their health needs.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
- Any future Audits will be appropriately analyzed, have clear action plans and any issues identified will be addressed and implemented – trends will be identified.

- Care Plans will reflect any changes to the resident healthcare requirements.

- Communication with staff will take place regarding the changes in residents healthcare needs.

- Improved handover structure.

- All falls in the Centre have been analyzed and action plans developed to help reduce the incidence of falls within the home.

- All care plans have been prepared and updated to ensure residents are provided with appropriate medical and healthcare needs taking into consideration evidence-based practise.
- All referrals required have been made and this will continue.

- PIC & CNM will conduct clinical care meeting every week to review all residents Healthcare needs ensuring referrals are made and followed up in a timely manner.

- Recruit/appoint ADON, Senior Staff nurse & Senior HCA to support PIC and ensure effective supervision and communication between all professionals involved in residents care and treatment

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
- All resident who have behaviours that challenge now have a person centered behaviour support care plan.

- Any incident of Behaviour that challenge will be documented and reviewed by PIC, any actions to alleviate and manage behaviours that challenge will be implemented documented on resident care plan and communicated to staff.

- Staff training will be scheduled on Managing Behaviour that challenge.

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	Orange	31/03/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Red	17/01/2020
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	10/03/2020

Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	20/02/2020
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	20/02/2020
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Not Compliant	Orange	20/02/2020
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is	Substantially Compliant	Yellow	20/02/2020

	reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	10/02/2020
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	20/02/2020
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Orange	20/02/2020
Regulation 34(1)(h)	The registered provider shall provide an	Not Compliant	Orange	20/02/2020

	accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.			
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	20/02/2020
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Red	17/01/2020

Regulation 5(5)	A care plan, or a revised care plan, prepared under this Regulation shall be available to the resident concerned and may, with the consent of that resident or where the person-in-charge considers it appropriate, be made available to his or her family.	Substantially Compliant	Yellow	20/02/2020
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Red	17/01/2020
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional	Not Compliant	Orange	27/01/2020

	expertise, access to such treatment.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	10/03/2020