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:	Sligo Nursing Home
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Ballytivnan, Sligo
Type of inspection:	Announced
Date of inspection:	25 September 2019
Centre ID:	OSV-0000363
Fieldwork ID:	MON-0022797

About the designated centre

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

Sligo Nursing Home is a purpose-built facility located a short walking distance of Sligo city. The centre can accommodate a maximum of 62 residents. Residents are accommodated in single and twin bedrooms. The centre is a mixed gender facility catering for dependent persons aged 18 years and over, providing long-term residential care, respite, convalescence, dementia and palliative care. Care is provided for people with a range of needs: low, medium, high and maximum dependency. Resident accommodation is over two floors with a lift facility. There are four corridors. Rosses Corridor and Garavogue corridor are on one level and Yeats corridor and Benbulben corridor are on the lower level. A variety of communal rooms are provided on both floors for residents' use, including sitting, dining and recreational facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	58

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
25 September 2019	09:00hrs to 17:00hrs	Una Fitzgerald	Lead
26 September 2019	09:30hrs to 14:00hrs	Una Fitzgerald	Lead

What residents told us and what inspectors observed

Feedback, both verbal on the day of inspection and through seven residents' questionnaires, was mainly positive about the care received by residents. Residents told the inspector that they felt they were well cared for by staff who knew their individual needs, likes and dislikes.

The inspector spoke with eight residents. Residents said that they enjoyed a good quality of life and that staff were kind and caring to them. Residents described how they spent their day and said they were encouraged to be independent, to make choices for themselves and to be as mobile and active as possible. One resident described how she was supported by the management team in applying to renew her driving licence to ensure that her independence with driving was maintained. Another resident told the inspector how she is supported to continue to manage her own medication administration.

Residents told the inspector that their bedrooms were their own space. The inspector noted that residents bedrooms were personalised. Multiple residents had been facilitated to bring in items form home. For example, paintings, large ornaments and pieces of furniture. In addition, resident's told the inspector that the design and layout of the room had been decided by them. For example, one resident had an alter of worship to their religion located near their armchair. Residents informed the inspector that their rooms were cleaned daily and that staff were very respectful of their personal belongings.

Residents and relatives informed the inspector that they were welcome in the centre at all times.

Capacity and capability

The centre was well organised. The person in charge and assistant director of nursing responsible for the direct delivery of care engaged with the inspector throughout the two days. This inspection was announced to inform the registration renewal of the centre. The application is due on the 20th October 2019. The information requested by the inspector was made available in a timely manner and presented in an easily understood format. The person in charge had effective systems in place that monitored the delivery of care. This was evidenced by:

- A comprehensive auditing schedule was in place. Where improvements were identified as required, action plans and changes were communicated to staff. For example, a recent audit identified that all residents who smoked must have a risk assessment and management plan in place. This action was

completed.

- The person in charge had good oversight of risk within the centre. For each risk identified it was clearly documented what the hazard was, the level of risk, the controls in place and the person responsible. This document was kept live and updated when needed.
- Staff told the inspector that they felt supported by the management team. The training matrix evidenced that all staff had received mandatory training required by the regulations. Additional training was also provided in multiple areas. For example, health and safety awareness. This enhanced the quality and safety of care for residents.
- The management team actively promoted a restraint free environment. The ethos and delivery of care was focused on eliminating the use of restrictive practices. The person in charge had taken the first steps in setting up a restrictive practice committee to ensure that the centre is operating in line with national standards.
- The nursing management team meet weekly to discuss all audits and operational matters within the centre. Statistical information is gathered to inform the management plan. The 2018 annual review was completed and was made available for review. In addition, priorities for 2019 were outlined in the quality improvement plan.

The inspector spoke with staff. The staff confirmed that the management team have a presence in the centre and were readily available for support. The centre had gone through a period of staffing instability. A recruitment campaign was put in place and as a result there were new staff appointed to address any gaps. Staff confirmed that the management team have a system in place that ensures that any sick leave is covered. The inspector reviewed the rotas and found that staffing numbers on duty had been maintained to ensure that direct delivery of care had not been compromised.

Staff informed the inspector that they would not hesitate to bring any issue concerning a resident to the attention of the person in charge and had full confidence in management to take action if required. The inspector reviewed the complaints log. There was evidence that when a complaint is logged appropriate steps are taken as per the centre's policy. The documentation in place evidenced that the management engaged with the complainant to ensure that all reasonable measures were taken to ensure a satisfactory outcome.

The inspector spoke with resident relatives. A common theme from the conversations had with relatives was that they were concerned that the volume of drinks given to residents who required assistance in the evening time was not sufficient to ensure that residents remained sufficiently hydrated. Relatives spoken with confirmed that they had not brought a compliant to the management team. The inspector reviewed multiple resident fluid charts and found detailed entries for residents who were on intake/output charts. This was discussed at the feedback meeting. The person in charge committed to address the concerns of fluid intake and complete a review to ensure that all residents who require assistance and are identified at risk will be commenced on a fluid monitoring chart if required.

The inspector did a walkabout of the premises with the person in charge. The centre is registered as per Condition 7 to accommodate 62 residents. The inspector found that the number and availability of showers on the lower level was not sufficient. This is addressed in the quality and safety section of the report.

Regulation 14: Persons in charge

The centre was managed by a suitably qualified and experienced nurse. She had a strong presence within the centre and was known to the residents. The person in charge conducts weekly walkabouts of the centre observing resident and staff engagements. She held authority, accountability and responsibility for the provision of the service. During the inspection she clearly demonstrated that she had indept knowledge of the regulations and standards of the care and welfare of residents in the centre.

Judgment: Compliant

Regulation 15: Staffing

Sufficient numbers of staff with appropriate skills were available to meet the assessed individual and collective needs of residents in the centre. A planned and actual staff rota was available. The roster reflected the staff on-duty on the day of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

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. The inspector found that training in other areas such as infection prevention and control, managing behaviour that is challenging, cardio pulmonary resuscitation (CPR), and medication management was also in place. Staff were supported and facilitated to attend training.

All new staff complete an induction programme to ascertain competency in their assigned role.

In addition, the nurse management team had completed annual staff appraisals.

Judgment: Compliant

Regulation 21: Records

The inspector reviewed staff files and found compliance with Schedule 2 regulation requirements.

Judgment: Compliant

Regulation 22: Insurance

The provider had an active insurance policy for the centre property and public liability insurance.

Judgment: Compliant

Regulation 23: Governance and management

Their roles and responsibilities of the management team were outlined. Progress had been made since the last inspection on the systems in place to ensure that the service delivered is safe, appropriate, consistent and effectively monitored.

An annual review of the service had been completed in consultation with the residents.

Judgment: Compliant

Regulation 24: Contract for the provision of services

Contracts for the provision of care were available for each resident. The contracts outlined the terms and conditions of residency, services to be provided and the fees to be charged. Signatory agreement by residents or their family members on their behalf with this arrangement was in place.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was last reviewed September 2019. Further detail was added during the inspection to ensure that the Statement of purpose is accurate and contains all of the information set out in Schedule 1. The updated SOP will be forwarded into the office of the Chief Inspector . The registration renewal application is due into the Office of the Chief Inspector on the 20/10/2019.

Judgment: Compliant

Regulation 30: Volunteers

The roles and responsibilities of all volunteers is set out in writing. A Garda Síochána (police) vetting disclosure was in place for all volunteers.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents were notified to the Office of the Chief Inspector as set out in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

A policy and procedure was in place in the centre to inform management of complaints received. A summary of the complaints procedure was prominently displayed for information for residents and their relatives in the main reception foyer. Details included the nominated complaints officer in the centre, the appeals process and ombudsman contact details.

A record of complaints raised by residents and relatives was maintained in the centre. The records included details of the investigations carried out in relation to the complaints and of the prompt actions taken to resolve the complaint. Details of communication with the complainant and their level of satisfaction with the measures put in place to resolve the issues were also included.

The inspector found two incidents of concern that had been brought to the attention

of the care team that were not logged as a compliant. This was discussed with the management team who were in agreement that further education was required to ensure that all staff were aware that an expression of dissatisfaction with any aspect of the service can constitute a compliant and should be managed in line with the complaints policy.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The policies listed in Schedule 5 required by the regulations were available within the centre, and had been reviewed within the last three years. These documents were accessible to staff.

Judgment: Compliant

Quality and safety

The centre is purpose built. Resident accommodation is over two floors with a lift facility. Corridors are wide and have a spacious feel. Residents move freely around the centre. There is a sitting room and dining room on both floors. The centre is well maintained and was noted to be clean. Residents confirmed that their bedrooms are cleaned daily. The inspector did a walkabout of the premises with the person in charge. The centre has four corridors where bedrooms are accommodated that are named after local areas of interest. The Benbulben corridor, Yeats country corridor, Rosses corridor and Garavogue corridor. The double bedrooms on the Benbulbin corridor are small in size. The statement of purpose outlines that residents with high dependency needs are not accommodated in the these bedrooms. The inspector found that the number of shower and bath facilities available for residents on the lower ground floor were not sufficient. When operating at full capacity there are 23 residents sharing two bathrooms (one with a shower, one with a bath and shower). The residents in the shared bedrooms on the Benbulben corridor have to travel past the communal sitting and dining room along the corridor to access the nearest shower/bath. At the feedback meeting the provider representative committed to review the availability of shower and bathrooms facilities and will address the actions to be taken within the compliance plan response.

Resident's had their needs assessed and addressed by person-centered care plans that reflected their individual preferences and care choices. The documentation and electronic care planning system in place for the residents was easily understood. On admission, residents had been assessed by a registered nurse to identify their individual needs and choices. The assessment process used validated tools to assess

each resident's dependency level, risk of malnutrition, falls risk and skin integrity. Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. The person in charge completed care plan reviews with the nursing team on a weekly basis. The system ensured that the development and review of all resident care plans were completed and kept person centred. For example, the inspector reviewed the care plan of a resident who had commenced an antibiotic the previous evening. The care plan was updated to reflect the changes. The staff had been informed at the handover of the change in the residents condition.

The person in charge worked in partnership with the assistant director of nursing. The inspector found that they held responsibility and accountability for the delivery of clinical care. From a review of the audits and conversations had the inspector summarised that quality improvement initiatives were having a positive outcome on the daily lived experience of residents. For example, the person in charge completed in dept monthly analyses of resident falls within the centre. Learning and areas of improvement are communicated to staff.

Residents' healthcare needs were met through timely access to treatment and therapies. Residents have access to a general practitioner (GP) and allied healthcare professionals. There was good evidence within the files that advice from allied healthcare professionals was acted on in a timely manner. For example, a resident admitted with a wound had detailed comprehensive notes in place. The photographs and documentation in place evidenced that healing had occurred. This had a positive outcome for the resident.

The inspector found that the clinical team were actively promoting a restraint-free environment. The inspector found that all staff delivering the care on the days of inspection were clear in their understanding of the risks of restrictive practices and their potential impact on residents. The person in charge had a restraint record for both floors. The inspector reviewed documentation on the management of bedrails. Staff actively sought ways to reduce restrictive practices by trialling alternatives. For example, low low beds. On review of the documentation the inspector found that each resident had had a risk assessment of need completed. The inspector reviewed the care plans and found clear documentation in place by the nursing team. Each bedrail in use had a restraint release review chart record in place.

Residents' links with the community were maintained where possible, and this was supported by access to local media, internet and telephone services. An activity schedule was displayed prominently within the centre. Multiple residents informed the inspector that they were happy with the activities in place. Residents felt that their overall quality of life in the centre was enhanced by their participation in the activity programme provided. Outings to the beach and a boating trip had taken place since the last inspection. The inspector acknowledges progress made since the last inspection. However, the inspector was concerned about the participation in activities for residents with dementia. The centre has two activities co-ordinators employed who work Monday to Friday. The inspector was informed that the responsibility for activities at the weekends is the responsibility of all care staff. The inspector found poor evidence that this role and expectation is fully understood by

the healthcare team. Activities and the recording of meaningful activities for all residents is completed by the activities team and so there was no evidence within resident files of what activities if any they had attended at weekends.

Regulation 13: End of life

There was no resident receiving end of life care during the inspection. Staff provided end of life care to residents with the support of their GP and community palliative care services. The inspector reviewed the file of a resident that had been in the center for an extended period of time. The care plan identified the expressed preferences regarding their preferred setting for the delivery of care at their end of life. In addition, the end of life care plan in place evidenced that the resident had discussed the steps that were to be taken immediately following their death.

There was a system in place to identify the resuscitation status of each resident. This decision was recorded in the medical file. Staff spoken with were clear on how to access this information in a timely manner to ensure the most appropriate outcome for the resident. The management team ensured that there was a member of the team with current CPR (cardio pulmonary resuscitation) training on duty 24 hours.

Judgment: Compliant

Regulation 17: Premises

The centre is a two storey purpose built facility. The centre is registered to accommodate 62 residents in single and double bedrooms. The centre is divided into four corridors. Benbulbin and Yeats country corridors are located on the lower ground floor. Rosses and Garavogue corridors are located on the ground floor. Each unit is staffed separately and has a nursing station, sitting room and dining room.

On the Benbulbin corridor there are are eight double bedrooms. Each bedroom has a toilet and handwash basin ensuite. The inspector found that the number of shower and bath facilities available for residents on the lower ground floor were not sufficient. When operating at full capacity there are 23 residents sharing two bathrooms (one with a shower, one with a bath and shower). In addition, one of the bathrooms is behind a door that is marked as for staff use only. The residents in the shared bedrooms on the Benbulben corridor have to travel past the communal sitting and dining room along the corridor to access the nearest shower/bath.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

The inspector tracked the file of a resident who had been admitted to an acute setting from the centre. The electronic system in place generates a transfer letter that contains relevant information about the resident to the acute hospital. Additional information relevant to the rationale for transfer was also communicated. For example, the list of current medications.

Judgment: Compliant

Regulation 26: Risk management

There was a health and safety statement available for review.

The risk register was managed by the person in charge. Once a risk was identified it was entered onto the register and all additional measures in place to minimise the risk was then identified.

Judgment: Compliant

Regulation 27: Infection control

The centre was found to be clean. The procedures in place for managing the prevention and control of infection were in line with National Standards. The inspectors spoke with the staff responsible for the cleaning of the centre. Staff were knowledgeable on the cloth color coded system in place. Staff were observed to wash hands in between resident contact. There was hand hygiene soap dispensers strategically placed throughout the centre corridors for resident, relative and staff use.

Judgment: Compliant

Regulation 28: Fire precautions

Daily checks on exits were carried out throughout the premises. Fire drills were completed. The fire alarm was checked weekly. The inspector released multiple fire

compartment doors and observed that the doors seals did not meet. The inspector was able to see through the gap between the fire doors. This meant that in the event of a fire the smoke would not be contained in the compartment. This was addressed by the operations manager immediately and was corrected by the end of day one of the inspection.

All staff had completed annual fire training. Staff spoken with talked through what action to take in the event of the fire alarm being activated. Each resident had a completed emergency evacuation plan in place to guide staff. Following on from the last inspection the management team had reviewed the detail recorded in simulated fire evacuation drills. The evacuation times were included in the drills.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were written operational policies informing the ordering, prescribing, storing and administration of medicines to residents. Practices in relation to prescribing and administration of medications met with regulatory requirements.

The pharmacist who supplied residents' medicines was facilitated to meet their obligations to residents and made themselves available to answer any queries individual residents had regarding their medicines.

Medicines controlled by misuse of drugs legislation were stored securely and balances were checked twice daily by staff.

The nursing management team completed in house medication audits on a monthly basis. There was four medication administration errors reported in 2019. This errors had not had a negative impact on the residents. Lessons learned were identified was communicated to all staff. For example, as a result of one error the nurse managers complete a weekly check to ensure that any allergies are identified in the nursing and medication prescription sheets.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Each resident's needs were comprehensively assessed within 48hours of their admission and at regular intervals thereafter. Staff used a variety of accredited assessment tools to complete a comprehensive assessment of each resident's needs, including risk of falling, malnutrition, pressure related skin damage and mobility assessments. These assessments informed care plans to meet each resident's needs. The interventions needed to meet each resident's needs were

clearly described in person-centred terms to reflect their individual care preferences. Care plans were stored in an electronic system and all staff spoken with could navigate the system with ease and retrieve the information in a timely manner. For example, all staff were able to inform th inspector of the resuscitation status of all residents.

Where possible, residents were consulted with regarding their care plan development and subsequent reviews. The families of residents unable to be involved in this process were consulted on behalf of individual residents. Records were maintained of this consultation process.

Judgment: Compliant

Regulation 6: Health care

Residents were provided with timely access to medical and allied health professional services as necessary. A physiotherapist employed by the provider completed an initial assessment of each resident's mobility needs and risk of falling on admission.

There was good evidence that advice received was followed which had a positive impact on the resident. For example: advice received from the tissue viability nurse specialist on a pressure wound was followed. As a result, there was clear evidence from the documentation and photographs that healing had occurred.

Physiotherapy, occupational therapy, speech and language therapy, tissue viability, optical and dietitian services were available to residents as necessary. Community palliative care services were also available to residents as appropriate.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The inspector reviewed the files of residents who exhibited responsive behaviours and found that the care plans in place were detailed and person centered. The staff were familiar with the residents and were knowledgeable on the triggers that may cause any distress. In addition the staff knew how to deescalate any behaviours in a manner that was not restrictive.

The management team was seen to be actively promoting a restraint-free environment. There was a total of three residents who had bedrails in use on the days of inspection. The inspector reviewed the resident files and found that appropriate assessment of need and been completed. The resident files were compliant with regulation requirements. In addition, the person in charge has plans in place for the development of a restrictive practice committee who will have

responsibility to review all restrictive practices within the centre.

Judgment: Compliant

Regulation 8: Protection

There were system in place to support the identification, reporting and investigation of allegations or suspicions of abuse. Records evidenced that all staff had received upto date training in the prevention, detection and response to abuse.

The inspector followed up on an external allegation of financial abuse that had been reported into the Office of the Chief Inspector. The centre had followed their internal policy and had completed an investigation. An advocate and safeguarding officer had been involved. The Gardai were not informed as per the residents instruction. The inspector met with the resident. The resident confirmed that full support was provided. The inspector judged that all appropriate and reasonable measures had been taken to protect the resident.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were aware of their rights, including, civil, political and religious rights. Advocacy services were available to assist residents where required. Staff were observed knocking on doors and awaiting for a reply before entering.

Following on from the last inspection the activities schedule was reviewed. There are now two staff sharing one post co-ordinatiing the activities. The feedback in the resident surveys and on the days of inspection specific to activities was neutral. The inspector spent time sitting and observing staff and resident engagement. The activity co-ordinations do not work at weekends. The responsibility to provide meaningful activities as per resident wishes rests with the nurse and health care assistants on duty. There was an activities programme displayed for residents. The inspector spoke with staff and judged that further development with care staff is required so that they fully understand their role and responsibilities regarding normal socialisation and engagement with residents.

As found on the last inspection the space and layout in the twin rooms on the Benbulben corridor were not sufficient to accommodate residents who had high dependency needs. The clinical management team have acknowledged the restrictions of the space and so only admit residents with low dependency needs into the double occupancy rooms. The Statement of Purpose had been amended to outline that all residents will be appropriately assessed prior to admission into the

double rooms.

The privacy and dignity of the residents on the lower ground level was compromised by the limitations of showering and bath facilities available. There are two shared communal bathrooms. One bathroom has a shower only while the other shared bathroom has a shower and bath. The location of bathrooms meant that residents had to travel a long distance through the hallway, passing the communal sitting and dining rooms to access the showers.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Sligo Nursing Home OSV-0000363

Inspection ID: MON-0022797

Date of inspection: 26/09/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The PIC is committed to responding positively to any issues, concerns or complaints raised by residents, families or others. We will provide further education to staff regarding the need to recognise and respond to expressions of dissatisfaction and understanding when to escalate complaints which may require a more thorough investigation by the PIC. Such education will include how to capture and record complaint information and how such information can provide a learning and service improvement opportunity.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Registered Provider has undertaken a review of the sanitary facilities available in lower ground floor. An additional assisted shower room will be located adjacent to the Benbulben wing.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The PIC will ensure the activity programme includes meaningful and purposeful activities	

that takes account of individual resident's interests, preferences and abilities, based on consultation with residents. There will be activities scheduled seven days per week and all staff will be involved in social engagement with residents. We will keep a record of individual resident's participation and preferences regarding activities in the resident's clinical record.
An additional assisted shower room will be located adjacent to the Benbulben wing. This will ensure that residents are treated with dignity and respect, including maintaining privacy when transferring residents into shower/bath facilities.

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/03/2020
Regulation 34(1)(h)	The registered provider shall provide an 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.	Substantially Compliant	Yellow	30/11/2019
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in	Not Compliant	Orange	31/12/2019

	activities in accordance with their interests and capacities.			
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.	Not Compliant	Orange	31/03/2020