Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Beech Lodge Care Facility
Name of provider:	Beech Lodge Care Facility Limited
Address of centre:	Bruree, Limerick
Type of inspection:	Unannounced
Date of inspection:	29 May 2019
Centre ID:	OSV-0000408
Fieldwork ID:	MON-0023487

About the designated centre

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

Situated in the village of Bruree, County Limerick, Beech Lodge Care Facility offers long term care, rehabilitative care, respite care and convalescent care for older adults. The age range catered from is 18 to 65+. Our care facility is a 66-bed facility which is made up of 48 single en-suite bedrooms and nine double en-suite bedrooms. There is 24-hour nursing care available from a team of highly trained staff. Our mission is to promote the dignity and independence of residents. We work with residents to achieve their goals. The designated centre consists of the following two units: elderly care unit: providing short & long-term care, respite/convalescence and palliative care, and the dementia unit: our secure 15-bed unit catering specifically for residents with dementia. This unit (also called the Daffodil Unit) is a 15-bed unit which includes a nurses' station, a kitchen and dining room. Residents can also access the physiotherapy room, activities area, music room and spacious garden. Here at Beech Lodge an individual programme of activities is tailored to each individual resident. Referrals for admission may come from acute or long-term facilities, community services or privately. Private admissions are arranged following a pre-admission assessment of needs including medical background, dietary requirements etc. This is to ensure we can meet your care needs. We aim to provide the best care possible and use a variety of care assessment tools to help us to do this. We also involve both the resident and their representative in this process. We provide a G.P. service to all residents. We aim to make dining a social experience. Individual diets, to suit medical needs, are incorporated into the menu planning process. Catering personnel are trained in the appropriate skills and are supported by the dietitian and the speech and language therapist (SALT). The facility has its own mini bus for the use of residents. There is a monthly residents' meeting to discuss issues ranging from activities, improvements in daily life, the environment and other issues. Activities include: newspapers, exercises , brain games, music, mass, art, baking, hairdresser, bingo, Sonas, and much more. We are interested in feedback to ensure that our service is continually reviewed in line with best practice. Visitors are welcome and local community events are accessible.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	64

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
29 May 2019	17:30hrs to 21:30hrs	Mary O'Mahony	Lead
30 May 2019	09:45hrs to 18:30hrs	Mary O'Mahony	Lead

Views of people who use the service

The majority of residents with whom the inspector spoke said they were happy in the centre. Residents praised the staff, and staff interactions on the day of inspection were seen to be patient and supportive.

Residents were satisfied with the choice of food and they said that the kitchen staff were aware of their dietary needs, likes and dislikes. They enjoyed the home baking available at each meal time. They spoke with inspectors about the easy access out to the garden areas, which were nicely planted and furnished. Laundry services were generally satisfactory. Their clothing was marked with their names and was returned to them safely on most occasions.

Residents were familiar with the new activities coordinator and the new person in charge. They described them as enthusiastic and caring. Residents enjoyed the activities on offer and said they were involved in music sessions, Sonas, reminiscence, individual knitting sessions, exercise sessions and various outings in the centre's own mini bus. Residents said that they received daily newspapers and had the use of TV, DVDs and radio. A number of residents said they attended the monthly residents' meeting which was well advertised in the centre. Residents said that their family members were welcome throughout the day. The medical care was good and they had access to hospital if necessary. The person in charge informed inspectors that advocacy services were involved with residents and their relatives to ensure that their concerns and rights were upheld. Despite this not all residents felt that concerns were addressed and any relevant concerns raised with the inspector were passed on to the person in charge.

Capacity and capability

This unannounced inspection of Beech Lodge took place in light of concerns in the office of the Chief Inspector for the safety and quality of life of residents, following receipt of unsolicited information from external sources.

The findings from this unannounced inspection of 29 and 30 May 2019 demonstrated that there had been a failure on behalf of the provider in many aspects of Regulation. The deficits in governance and management were evident in relation to a lack of demonstrable capability to monitor, identify and respond to allegations of abuse; failure to protect residents from abuse; failure to implement policies; failure to submit key notifications to the office of the Chief Inspector; failure to address inadequate staffing levels and not recording or properly

managing some serious complaints.

These findings of significant non compliance with the Regulations resulted in the issuing of an immediate and an urgent action plan in relation to safeguarding and protection of residents. Issuing of immediate and urgent action plans is a rare step only taken when the inspector has serious and immediate concerns in relation to the welfare and safety of residents. Timely and comprehensive responses were submitted by the provider in relation to these regulatory actions.

The inspector remained concerned that the registered provider had failed to set out a clearly defined management structure as set out under Regulation 3: Statement of Purpose. The new management team had yet to establish itself. As a result clinical governance required improvements: for example, the inspector found poor complaints management and a lack of adequate staff supervision which led to reports of alleged abusive interactions between staff and residents. This will be addressed in the Quality and Safety dimension of this report and under Regulation 8; Protection. The registered provider had not taken due diligence in the appointment of a person in charge that fully met regulatory requirements on commencement to the role under Regulation 14: Person in Charge.

Furthermore, a number of the records and documentation required by Schedule 2, 3 and 4 of the Regulations were not maintained in the centre as required under Regulation 21: Records.

- the inspector found that serious complaints in the centre were not recorded, addressed or managed appropriately in line with regulatory requirements; this was highlighted under Regulation 34: Complaints.
- serious and significant incidents were not all recorded and documented, as a consequence learning from incidents was not disseminated among staff to inform improvements in practice,
- the Chief inspector had not been notified of an alleged abuse or of the absconsion of a resident. These were described under Regulation 31: Notifications.

Documentation which was seen to be in compliance with the regulations included:

- the annual review of the quality and safety of care
- the directory of residents
- the residents' guide
- residents' contracts
- a sample of residents' records seen by the inspector such as care plans, assessments, medical notes and nursing records
- residents’ personal bank accounts were in place and financial management appeared robust
- staff meetings were held frequently

Policies on staff recruitment included a supervised probationary period. Assurance was given by the registered provider representative (RPR) that Garda Síochána (police) vetting clearance (GV) was in place for all staff. A sample of these

files was reviewed and records were seen to be in compliance with the relevant Regulations.

In summary, at the end of the inspection, the inspector still had serious concerns in relation to

- allegations of abuse had not been investigated or notified to the office of the Chief Inspector
- investigation follow up was not sufficiently robust
- staff disciplinary policy was not followed for a number of incidents
- performance improvement plans were not in place where necessary
- inadequate staffing levels at certain times of the day and night particularly in the dementia unit.

In conclusion, the findings of this inspection were that the provider had failed to take adequate steps to ensure regulatory compliance in relation to the governance and management of this centre: in particular in the failings regarding supervision of staff in promoting person-centred care and in safeguarding the safety and quality of life of residents.

At the end of the inspection the registered provider representative (RPR) was informed that due to the serious nature of the non-compliances the provider would be asked to attend a meeting at the office of the Chief Inspector, as a means of engagement under internal regulatory escalation processes.

Regulation 14: Persons in charge

The person in charge had been recently recruited for the role despite not having the required post registration management qualification.

This was in contravention of Regulation 14 which clearly sets out the experience and required qualifications for the role of person in charge of a designated centre.

Judgment: Not compliant

Regulation 15: Staffing

The inspector found that staffing levels were not adequate at various times during the day. This was particularly evident in the dementia unit in the morning. The inspector found that the night staff levels were inadequate also in this unit, where one nurse and one health care assistant cared for 15 residents with dementia. These staff were also responsible, at night, for a further group of residents in the adjoining

corridor. The nurse from the dementia unit also supported the staff nurse on the general units to administer medications to a number of the 51 other residents. This meant that there were periods of time when there was only one staff member on duty in the dementia unit, where residents had very specific care needs. The inspector observed practice at these times and formed the opinion that residents were not afforded adequate care when only one health care assistant, or periodically one nurse, was present in the dementia unit. The inspector found that the laundry staff member had been put on kitchen duties the previous day, due to a staff shortage which resulted in clothing not being returned for residents' use from the laundry unit and residents not having full choice of clothing available to them. Residents needs had not been supported by this staff reassignment and dignity was negatively impacted on by this oversight.

Minutes of a staff meeting in February and April 2019 demonstrated that senior management personnel were not happy with the staffing levels and did not want the centre to reach full capacity of 66 residents, with the reduced staffing levels at that time. In addition, staff had indicated that that care standards had deteriorated and that meal times were particularly problematic, as there were not sufficient staff available to afford proper assistance at meal times. It was acknowledged there had been a staff recruitment drive in April and May to address these issues.

Judgment: Not compliant

Regulation 16: Training and staff development

The majority of staff had been afforded mandatory training as set out in the Regulations as well and other appropriate training.

However, not all staff had attended training on the management of the behaviour and psychological symptoms of dementia (BPSD) and not all staff had attended other mandatory training, which was based on the centre's own policies, since they commenced working in the centre.

Staff said that the training they had received in caring for residents with BPSD, especially strategies to deal with disruptive and physical outbursts, did not meet their needs for this complex aspect of care.

The training in safeguarding and protection would be enhanced by additional training for delivering the course.

Judgment: Substantially compliant

Regulation 19: Directory of residents

This document contained all the regulatory requirements.

Judgment: Compliant

Regulation 21: Records

Staff files were complete and were seen to contain all the required regulatory documents.

Records required to be maintained under Schedule 3 and Schedule 4 of the Regulations were not maintained for example:

- complaints
- incidents
- restraint use
- notifications
- records of fire alarm testing

Judgment: Not compliant

Regulation 23: Governance and management

The provider had not made adequate arrangements to ensure that the service provided was safe, appropriate, consistent and effectively monitored. These failings were specified throughout the report.

The designated centre had not provided sufficient resources, such as adequate staffing, to ensure the effective delivery of care in accordance with the statement of purpose.

Allegations of abuse had not been investigated or notified to the office of the Chief Inspector; investigation follow up was not sufficiently robust; staff disciplinary policy was not followed for a number of incidents; performance improvement plans were not in place where necessary.

The inspector found that serious complaints in the centre were not recorded, addressed or managed appropriately in line with regulatory requirements; this was highlighted under Regulation 34: Complaints.

Serious and significant incidents were not all recorded and documented, as a consequence learning from incidents was not disseminated among staff to inform improvements in practice,

The Chief inspector had not been notified of an alleged abuse nor of the absconsion

of a resident. These were described under Regulation 31: Notifications.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Contacts were in place which outlined the care arrangements and associated costs.

Judgment: Compliant

Regulation 3: Statement of purpose

The undertaking in the statement of purpose to investigate complaints and to respect residents' privacy and dignity were not seen to be implemented. The document required updating to reflect the current management structure.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Serious events had not been notified to the office of the Chief Inspector as required under the Regulations.

For example: the absconsion of a resident, restraint use and allegations of abuse.

- One resident had been missing for an hour before being located in a family member's house. The family member had taken her home from the centre.
- A resident with dementia and associated behaviour challenges had been subjected to environmental restraint. Staff stated that there were not enough staff on the unit at the time of behaviour escalation.
- Residents with dementia had been hit by other residents, these incidents had not been recorded or submitted as notifications where required.
- A previous late notification of alleged abuse.

Judgment: Not compliant

Regulation 34: Complaints procedure

A number of serious complaints in the centre were not recorded, addressed or managed appropriately in line with regulatory requirements, for example:

- A number of complaints about the care of a resident and in particular the use of environmental restraint.
- A resident had complained of alleged abuse interactions which had not been adequately followed up.
- The satisfaction of all complainants had not been recorded.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Not all policies were adopted and implemented such as:

The policy on the prevention of elder abuse:

- Allegations were not recorded, notified or followed up. Safeguarding plans had not been developed for residents who were vulnerable.

The policy on behaviour that challenges:

- Staff training was not adequate. Staff were not seen to use techniques described in the policy to support residents with dementia to maintain well being.

The policy on restraint:

- Use of environmental restraint despite the policy stating that this was not an option to be used.

The complaints policy:

- Complaints were not recorded, followed up or addressed.

Judgment: Not compliant

Quality and safety

Findings on this inspection were that the quality and safety of care required a system of robust and consistent management which the inspector found was not established in the centre. There was lack of supervision and defined areas of responsibility between senior managers and nursing staff, which impacted negatively

on the roll out, development and maintenance of quality and safety systems.

Prior to the inspection a number of serious concerns had been raised with the office of the Chief Inspector. These indicated that not all relatives were happy in the knowledge that residents' health care and safeguarding needs were met to a high standard, as required by the Regulations. This was discussed with the RPR. On this inspection the inspector verified one such concern and found that it had not been addressed in relation to the management of staff involved, protection of the resident involved, notification of the event to the Chief inspector's office and updated staff training. Records had not been maintained in the care plans of the resident, in relation to serious occurrences.The inspector found that efforts had not been made to address, record or investigate the matters, which was in contravention of the Regulations on:

- Regulation 31 (Notifications):
- Regulation 34 (Complaints):
- Regulation 5 (Care Planning):
- Regulation 9 (Residents Rights) and
- Regulation 8 (Protection).

Details of these failings are described further under the aforementioned Regulations in this report.

The RPR and person in charge stated that safeguarding of residents was supported by training and policies on the prevention, detection and response to abuse. Nevertheless, the inspector found that a further allegation of an abusive interaction between staff and a resident had not been followed up with appropriate actions and ongoing support. Significant concerns relating to this aspect of resident care was detailed under Regulation 8: Protection, in this report as referred to above.

The inspector found that in the dementia/Daffodil unit residents were not always meaningfully occupied or supervised appropriately. Even though a Sonas session (activating communication through sensory experiences) was delivered to a small number of residents in the morning and a further group of residents engaged in a singing session, there were times during the inspection when staffing levels were completely inadequate in relation to the needs of the residents involved. Residents were seen to spend long periods of time walking around unattended and those who were sitting did not have regular staff attention. The inspector observed that, as a result of staff leaving the unit to attend to care needs or medication needs elsewhere in the centre, the remaining staff member was in an observation mode, as it was not possible to attend to individual needs in the bedrooms while alone on the unit. Staff stated that there was a need for more staff, including a dedicated activity person in the unit, to ensure that there was optimal care in place to support all aspects of residents' well being. Staff also informed the inspector that they felt that the training for BPSD did not adequately address individuals' needs. For example, during the inspection the inspector did not see care staff using rummage boxes, memory boxes, books or other distraction techniques to interact with residents who had dementia. This was also described under Regulation 9: Residents'

rights.

A number of areas of good practice were found in the general unit as follows:

News items and activity provision were recorded on notice boards which were updated daily. Residents were seen to be meaningfully occupied during the days of inspection with reading, knitting, card games, visitors and music at intervals during the inspection. Residents had comfortable, spacious accommodation with en-suite showers and toilets. Residents were seen to use the communal dining rooms and enjoy the sociable atmosphere of mealtimes. Premises were maintained to a high standard and the decor was bright and modern.

The inspector found that residents' health care needs were generally met to a good standard according to residents, relatives and documents reviewed. Care plans were individualised. General practitioners (GPs) attended the centre when requested. Allied health services were accessible particular physiotherapy which was provided on a daily basis in the dementia unit as well as the general unit. However, a resident who had experienced the behaviour and psychological symptoms of dementia resulting in increased agitation, weight loss and aggressive behaviour had not had a medical review for a period of time.

The risk register was maintained and was seen to have been updated. A number of unassessed risks were identified by the inspector which were detailed under Regulation 26: Risk management. Regular hand-washing and the use of personal, protective equipment (PPE) were observed by the inspector and staff were found to be aware of infection control best practice. Staff carried out regular fire drills and all residents had a "ski" evacuation sheet and a personal emergency evacuation plan in place. While many of the required fire safety checks were undertaken the inspector found that the weekly fire alarm sounding had not been part of these checks. The RPR undertook to carry out this weekly check.

At the end of the inspection the inspector:

- was not assured that all residents were safe in the centre and asked the RPR to review staff training and staff supervision in relation to safeguarding all residents and supporting residents who experienced the behaviour and psychological symptoms of dementia
- was not assured that similar restrictive practices, which were identified in the concern raised had not previously occurred, as this instance had not been documented or recorded.
- was not assured that all complaints in the centre had been documented and addressed, as the significant complaint in relation to this resident's alleged abuse had not been recorded.

Regulation 11: Visits

Visitors were welcome.

However, access around the centre and into the dementia unit was by staff fob only; therefore visitors could not freely visit their relative in the dementia unit without asking a staff member to help them gain access.

This applied to visitors who had been visiting for a number of years as well as new visitors.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Each person had adequate space to store their clothes, and personal possessions. Most of the rooms were seen to be personalised.

However, not all laundry was returned to residents in a timely and correct manner.

Judgment: Substantially compliant

Regulation 13: End of life

Staff had attended training in the care required at end of life. Residents' wishes were seen to be recorded.

Judgment: Compliant

Regulation 17: Premises

The premises was suitable for the needs of residents.

- It was well decorated, clean and bright.
- Signage around the centre was clear and easily read by residents.
- Notice boards were seen to contain interesting and relevant information including a schedule of activities.
- There were adequate shower rooms and sluice rooms available.
- Residents had access to en-suite shower and toilet facilities.
- There were large sitting rooms and dining rooms in the centre, as well as a physiotherapy gym, "dome" communal areas and a visitors' room.
- Gardens were well maintained and easily accessible.

Judgment: Compliant

Regulation 18: Food and nutrition

Food was plentiful and choice was available. The dining rooms were well laid out. The dietitian and the speech and language therapist (SALT) attended the centre to provide advice to staff on special dietary needs. The kitchen staff had received appropriate training.

Judgment: Compliant

Regulation 20: Information for residents

There were a number of notice boards available in the centre which were seen to contain relevant and informative documents.

The resident information booklet was comprehensive.

Community events were advertised and accessible.

Judgment: Compliant

Regulation 26: Risk management

Risk assessment failings included:

- a sluice room door was held open with a bin
- a bedroom door was held open with a chair
- arrangements were not in place for the identification, recording, investigation and learning from serious incidents or adverse events involving residents

Judgment: Substantially compliant

Regulation 27: Infection control

The centre was clean. Staff were aware of infection control processes. Training was provided to staff in correct hand washing technique.

Judgment: Compliant

Regulation 28: Fire precautions

The fire alarm was not tested on a weekly basis.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The inspector reviewed a sample of medication records.

The inspector found that there was no date of commencement documented for specific medicines which had been prescribed for one resident.

Medicines in one medication administration record seen by the inspector (MAR: the prescription held by the centre) had no date of prescribing inserted.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

In one care plan, seen by the inspector, a serious incident had not been recorded.

There was no information in the care plan which indicated that there had been a complaint about the incident.

Robust pre-admissions assessment were required to ensure that the needs of residents with dementia could be met in the centre.

The inspector formed the opinion from reviewing concerns received, speaking with staff and a review of a sample of the care plans of residents in the dementia unit that the pre-admission assessment required revision. This assessment was required by Regulation to ensure that the needs of residents with dementia could be adequately addressed by sufficient, highly trained staff who were competent to care for residents with BPSD.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to medical personnel.

Residents were seen to have access to consultants, the dietitian , speech and language services (SALT) and the services for psychiatry of old age.

There was a physiotherapist available in the centre on a weekly basis and was contracted to work 28 hours in the week. The physiotherapist was responsible for training in the prevention of elder abuse, manual handling assessments, auditing falls, restraints assessments and audit.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff did not have appropriate training in this aspect of care to enable them to acquire updated knowledge and skills, as well as best evidence based practice in caring for the residents involved.

Judgment: Not compliant

Regulation 8: Protection

The centre acted as a pension agent for 14 residents. The records seen by the inspector appeared to be in order and were maintained by the accountant in the centre. All pensions were paid into a client account in the name of relevant residents. Receipts were available for all transactions. Accounts were regularly reconciled.

Serious incidents of alleged abuse had not been investigated. One very serious abusive interaction had not been documented, addressed or investigated. A second incident of alleged abuse had not been investigated fully and adequate measures had not been taken to protect residents from further abuse. Care planning and a safeguarding plan had not been developed in relation to the allegation. Any measures which had been taken had not been documented. As a result a resident did not feel safe at all times in the centre.

- An immediate action was issued from the office of the Chief Inspector in relation to the removal of bolts from the doors of residents' bedrooms in the dementia unit.
- An urgent action plan was issued from the office of the Chief Inspector

following the inspection in relation to the investigation into a safeguarding and safety concern and to request assurance that all residents were safe in the centre.
- The provider was asked to ensure that the person in charge was the only person who had access to the 'master' key for residents' bedroom doors.

Judgment: Not compliant

Regulation 9: Residents' rights

The activity staff were enthusiastic and well liked by residents. They were familiar with the likes, dislikes and needs of residents. Individual attention was given to a number of residents who did not wish to attend group activities. An artist came to the centre every Tuesday and an art exhibition was being launched in the centre featuring art work created by residents. The activity coordinator was preparing for Nursing Homes Week which would involve a number of exciting activities for residents and their families.

Nevertheless, the inspector found that residents' rights were impacted on by the staff shortage. For example, residents in the dementia unit had not been protected from other residents whose behaviour was impacted on by BPSD as a consequence of their medical condition. The impact of the behaviour could have been alleviated if sufficient staff were available to provide individual care to residents at these times, to supervise and distract residents.

Furthermore, residents in the dementia unit were seen to spend periods of time unsupervised or walking up and down without companionship being available to them. One resident in the dementia unit was placed alone in an adjoining conservatory as staff said he was prone to vocalise loudly. The door to this room was closed when the inspector was present even though the resident was reclining quietly in a chair at that time. There was no plan of care in place for this person in relation to a schedule of staff visits or interventions, to ensure that he was not left unattended for long periods.

The privacy and dignity of all residents in the dementia unit was not protected: for example the inspector saw that inappropriate language such as ''nappy'' was used to describe adult incontinent wear. In addition, appropriate descriptions and resultant care interventions were not recorded from a person-centred approach, when a resident had experienced episodes of escalated behaviour. Moreover the inspector saw a resident walking around the hall in the dementia unit in his incontinence wear, looking for a toilet. The resident did not have pyjama pants on. There was only one staff member on the unit at this time and that staff member was supervising in the sitting area. These matters were addressed by the nurse, in a very kind manner, when she was alerted, by the inspector, to the man's predicament.

A residents' survey had been completed. The majority of residents were satisfied with the care they received. Nevertheless, not all residents were happy; some residents said that they would like more choice at mealtimes or laundry arrangements; other residents stated that they were not aware of the external bus trips and a further number stated that staff were very busy and that not all of them paid enough attention to their needs.

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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Beech Lodge Care Facility OSV-0000408

Inspection ID: MON-0023487

Date of inspection: 30/05/2019

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: - The PIC underwent the required management course within the first 4 weeks of her employment in the facility. On the day of inspection the new PIC was attending a section of the required management course. This course has been completed and the PIC therefore has the required post-registration qualification in place.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Following the Inspection, a comprehensive internal review was carried out on staffing levels by management. This review has led to the following actions: - An immediate review of Direct Care hours and roster as well as skill levels was completed for the unit to ensure residents social and care needs are at all times met to the best quality and safety standards. - Additional resources have been allocated for example: 1. Additional HCA hours (20.00 – 22.00) has been implemented in the unit since 30/6/19. 2. An additional person has been recruited full time for the Laundry. They commenced work on 24/6/19. 3. As part of our continued improvement plan we are recruiting an additional chef. 4. New CNM has commenced (24/06/2019) and three staff nurses have been promoted to senior level, thus filling the new management team of the care facility (See organogram included in the updated Statement of Purpose). - A recruitment process is in place for a social care practitioner to work from 10.00 to	

18.00 in the unit.

Residents' dependency levels, social and care needs are continually monitored and evaluated on an on-going basis and discussed at the clinical governance meetings.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
- Training is on-going for all staff. They have up-to-date knowledge and skills and respond to major incidences that are challenging within the Dementia Unit.
- All mandatory training will be up-to-date (except BPSD which is in train) by 31/07/2019.
- Our new Clinical Nurse Manager is currently training all staff in BPSD and using strategies to deal with disruptive and physical outbursts.
- The policy and procedure for safeguarding vulnerable people and risk of real abuse and associated records will be on the agenda for all future staff meetings.
- There is a new management plan for Challenging Behavior that outlines the use of interventions such as observation, psychosocial intervention or restraint-based intervention after risk assessment has been carried out by the multi-disciplinary team.
- All staff have received the in-house training in relation to the detection and prevention of, and responses to abuse, in line with legislative requirements.
-

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
- We have reviewed and will continue to review the policies around complaints, incident reporting, restraint use, notifications and records.
- Weekly fire alarm sound checks commenced 27/6/19 and records are being kept of all checks.
- We have purchased and implemented the New IT System which will give automatically provide notification reports and the facility to record and follow-up incidents and complaints. This system removes the possible risk of 'human error' factor by prompting follow-ups from original incidents.
- The New IT System also generates reports that will enable pattern recognition around incidents which will increase learning for all staff, and auditing, and will ensure the best quality of care for residents.
- The new management team (PIC, CNM) have prioritized auditing Complaints, Incidents,

Restraint Use and Notifications.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

- We have a full new management team in place PIC, CNM and 3 Senior Nurses as referred to in the organogram in the Statement of Purpose.

- We have now implemented a new registered provider audit to manage the Care Facility.
- We have (and will continue) to increase staffing where required to provide the best quality care for our residents. Roles are clearly defined for all staff.
- We have purchased and implemented the New IT System which will facilitate incident reporting, monitoring and management.
- All required notifications of incidents will be logged on the New IT System's database and will be sent on to HIQA.
- The New IT System will ensure any future required investigations are sufficiently robust and staff disciplinary policy is followed correctly. The New IT System will also facilitate a staff performance improvement plan audit being put in place.
- Staff Disciplinary policy has been reviewed and updated and implemented.
- Complaints are now recorded in detail and are being addressed and managed appropriately. Audits commenced on 26/6/19 and are being undertaken by the new management team (PIC, CNM). The new management team will give auditing the facility their greatest priority and auditing will be carried out on a monthly basis.
- The New IT System will be used by the management team to manage the incident reporting system and the record management system.
- All Incidents will be recorded, documented and actioned with learning outcomes and improvements in practice. This will be followed by staff meetings and training where appropriate to facilitate all learning outcomes and guide performance improvement plans.
- All staff shall receive training from an external trainer who has a Masters in Dementia Care and this will be completed by 31/07/2019.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

- Statement of Purpose Document has been reviewed and updated on 5/7/19. (Appendix 1 Statement of Purpose).

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
- The staff member on duty will report all incidents to the PIC/CNM in person or by phone, if they are not present in the Care Facility.
- The staff member on duty will complete an incident form immediately.
- All incidents will be screened at the time they are reported for any safeguarding concerns by the PIC/CNM.
- The PIC/CNM receiving the report will notify all relevant incidents within the required timeframes and deliver quality reports to HIQA.
- The manager on call is identified on the weekly roster to staff. This will allow for the timely review of an incident and will also provide the necessary supports and required interventions for staff.
- New risk management system is now being used to monitor all incidents.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
- The new PIC has been designated as the Complaints Officer for the Centre and is currently receiving guidance and mentoring from an external consultant with regards to responding to and managing complaints.
- Going forward all complaints will be responded to and managed in accordance with the complaints policy and logged and audited to ensure the satisfaction of the complainant and monitored by management using the new risk management system.
- All complaints will be reviewed by senior management at the Quality and Safety meetings. Complaints will also be used to provide feedback to all care staff and to inform changes and improvements to learning in the Care Facility.

Regulation 4: Written policies and	Not Compliant

procedures	
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: - A program of re-training and education has been put in place in the facility to focus all core care staff on the policies in question and the further education around other - Policies along with new developed detailed BPSD.	
Regulation 11: Visits	Substantially Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: - We operate an open visiting policy within our care facility. - There are two visitors' sitting rooms for any of our residents or their friends and family to use and all families have been introduced to this and the other facilities we have when their family member is admitted. - To ensure the safety and protection of residents, staff, equipment and confidential data, our current integrated coded and fob access control system is in place throughout our care facility to provide security, while maintaining the privacy and dignity of our residents. Visitors who have been admitted and recorded at reception are provided with an access code, and this code is updated weekly. - A risk Assessment with each resident who visits the unit is carried out to determine the requirement for the coded system in each case to ensure safety for all residents.	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: - Laundry is now managed by a new Laundress and all laundry is returned to residents in a timely manner. - A laundry audit is being carried out by the senior carer's across the entire facility. - The laundry is being monitored by the new management team.	
Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management: - Staff made aware of importance of keeping doors closed, unless requested by resident. Ongoing monitoring carried out by management. - Environmental auditing is continuous. - Staff training on identification and recording, investigation and learning from serious incidents from our staff and debriefing meetings. - The New IT System is in place to improve compliance and to support effective governance and management within the centre.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: - The fire alarm will be tested on a weekly basis and this will be documented in the fire book. - The fire book will be audited as per the audit schedule to ensure continued Compliance with regulation.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: - To ensure compliance with existing procedures Residents' G.Ps dating of discontinued of prescribed drugs is checked on a weekly basis by all nurses and monitored by the PIC/CNM - Audits of Medication prescriptions and administering continues on a monthly basis to monitor and ensure best practice.	
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 will be fully detailed to provide the best quality care for residents and to ensure that all incidents are properly recorded on care plans.
- Pre-admission assessment has been revised and audited to ensure full compliance.
- Short-term admissions are now assessed using a new pre- assessment tool which provides for greater detail in relation to the admission.

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 staff at the facility will attend training in Managing Behaviour That's Challenging, Safeguarding and BPSD weekly until all staff are trained and full compliance is achieved.
- New management team (PIC, CNM and Senior Staff Nurses) will focus on education on this and other policies over the coming weeks.
- Handover discussions around residents who present with responsive behaviour will take place regularly and their care plans will be updated accordingly based on Antecedent, Behaviour and Consequence monitoring. This will allow staff to pre-empt responsive behaviour, remove triggers and manage responsive behaviour in a person-centred fashion.

- These care plans will be audited as a part of the audit schedule to ensure compliance.
- Incidents related to this regulation will be audited and any learning outcomes will be used to improve and drive practice development in the centre.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Immediate Actions Taken

- The bolts were immediately removed from the doors in the unit. They were originally intended to stop residents from going into rooms that were not their own rooms and disturbing other residents' private property.
- An immediate and thorough investigation took place into the unrecorded incident and disciplinary measures followed, as well as learning outcomes being applied to ensure it could not reoccur.
- An independent advocate was brought in and residents were interviewed. The advocate comes in monthly to ensure best quality of care for our residents.

- An urgent action plan was forwarded to the Chief Inspector.
- Following the inspection Safeguarding training in the detection and prevention of and responses to abuse is being provided. This commenced with NHI regional training on the 24th June 2019 and is ongoing.
- Policies regarding the use of restraint, safeguarding, and challenging behavior are being reviewed and updated at present.
- Training commenced in the following areas in the Centre on Wednesday 3rd July:
o Behaviour and Psychological Symptoms of Dementia
o Principles Underpinning Dementia Care
o Communication & Dementia
o Responsive Behaviours
o Delirium/Pain/Acute symptoms & Dementia
o Abuse & neglect concerning culture of Dementia Care.
o Case Scenarios & workshop with Group Discussion.

This training was provided by an external trainer who has a Masters in Dementia Care. This training has been logged and monitored on the training matrix.

Long-term

- The new management team (PIC and CNM) will undertake to meet with residents individually to assess their satisfaction with the care they receive at the care facility. In particular, regarding their relationships with the staff here.
- All staff will have up-to-date knowledge and skills in the management, detection and prevention of and response to Abuse within the care facility.
- All staff will have up-to-date knowledge and skills in the management of Challenging Behavior.
- The Policy and Procedure for safeguarding of vulnerable people at risk of being abused will be on the agenda for all future staff meetings.
- There is a management plan for Challenging Behavior that outlines the use of interventions such as observation, psychosocial intervention or restraint based on an interdisciplinary assessment of risk.
- The new CNM has training in Dementia and Challenge Behaviour techniques (CPI), and she will spearhead the training in these areas for all care staff.
All progress will be measured through the audit process to monitor compliance and ensure continuous quality improvement based on audit results.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
- The staffing roster is now at full capacity.
- Audit of Staffing levels relative to Resident dependency levels will be monitored continually using the Bartel Assessment Tool.
- Presently recruiting for Social Care Practitioner who will be giving both group and

individual care.
- The New IT System will ensure, resident's rights, privacy and dignity
- Comprehensive residents survey re the quality of care and standards received showed 96.75% compliance on the 10/7/19.
- We have three choices at each mealtime for all residents. The residents have input into their choice of menu by giving their opinion at the monthly residents meeting.
- Our new bus takes residents on weekly trips to local areas, masses, shopping, day Trips etc which is discussed at residents monthly meeting.
- A Social care practitioner in the unit will ensure residents rights are guaranteed along with quality care in the Unit.
- Rummage boxes are being used in the unit and they and other distraction techniques will be used, as well as staff training on how to use the techniques available to staff.
- A new' Do Not Disturb' sign will be used during certain activities on door handles to enable privacy and dignity for all residents.

- All residents are afforded the opportunity to exercise their civil, political and religious rights.

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 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Substantially Compliant	Yellow	08/07/2019
Regulation 12(b)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that his or her linen and clothes are laundered regularly and returned to that resident.	Substantially Compliant	Yellow	24/06/2019

Regulation 14(1)	There shall be a person in charge of a designated centre.	Not Compliant	Orange	31/05/2019
Regulation 14(6)(b)	A person who is employed to be a person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have a post registration management qualification in health or a related field.	Not Compliant	Orange	31/05/2019
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	02/07/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/07/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	02/07/2019
Regulation 16(1)(c)	The person in charge shall ensure that staff are informed of the Act and any	Substantially Compliant	Yellow	31/07/2019

	regulations made under it.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/07/2019
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	05/07/2019
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	24/06/2019
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	Not Compliant	Orange	31/07/2019

	effectively monitored.			
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.	Substantially Compliant	Yellow	31/07/2019
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.	Substantially Compliant	Yellow	31/07/2019
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.	Substantially Compliant	Yellow	05/07/2019
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	26/06/2019
Regulation 29(5)	The person in charge shall ensure that all	Substantially Compliant	Yellow	25/06/2019

	medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	05/07/2019
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	31/05/2019
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.	Not Compliant	Orange	31/07/2019
Regulation 34(1)(d)	The registered provider shall provide an	Not Compliant	Orange	04/07/2019

	accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.			
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Not Compliant	Orange	04/07/2019
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	04/07/2019
Regulation	The registered	Not Compliant	Orange	04/07/2019

34(1)(h)	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.			
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	04/07/2019
Regulation 34(3)(b)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that the person nominated under paragraph (1)(c) maintains the records specified under in paragraph (1)(f).	Not Compliant	Orange	04/07/2019

Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	31/07/2019
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	02/07/2019
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	Orange	25/06/2019
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate	Not Compliant	Orange	31/07/2019

	to their role, to respond to and manage behaviour that is challenging.			
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	03/07/2019
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	31/07/2019
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Red	11/07/2019
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	31/07/2019
Regulation 8(3)	The person in charge shall	Not Compliant	Red	07/06/2019

	investigate any incident or allegation of abuse.			
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Substantially Compliant	Yellow	31/07/2019
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	05/08/2019
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	11/07/2019
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Not Compliant	Orange	31/05/2019