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:	Sacred Heart Hospital
Name of provider:	Health Service Executive
Address of centre:	Golf Link Road, Roscommon
Type of inspection:	Unannounced
Date of inspection:	16 January 2020
Centre ID:	OSV-0000654
Fieldwork ID:	MON-0024833

About the designated centre

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

The Sacred Heart Hospital provides residential, respite and rehabilitation services to ninety five adults. The centre is organised into four units. St Catherine's unit has 37 places beds which include 24 places devoted to long term care and 12 places for residents who require respite care or rehabilitation. It also has one palliative care suite. Our Lady's unit provides care for 17 residents who require long term care. St Michael's and St Josephs provide 20 and 17 places respectively for long term care. All units are self contained and have a main sitting and dining area and other smaller seating areas. There are a number of communal bathrooms and toilets on each unit. St Catherine's has four single en-suite rooms. There are several enclosed gardens that are accessible from each unit and that have been cultivated to provide interest for residents. The centre is located close to Roscommon town and local amenities. There are allied health professionals on site and a physiotherapy suite and an occupational therapy room are accessible to residents. An activities therapy team organise and provide the daily activities programme. The centre supports residents to maintain links with the local community and residents can attend day care services located elsewhere on the site where they can meet and maintain links with neighbours and friends form the community.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	84

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 16 January 2020	11:00hrs to 19:00hrs	Geraldine Jolley	Lead
Friday 17 January 2020	08:00hrs to 17:30hrs	Geraldine Jolley	Lead

What residents told us and what inspectors observed

Residents and visitors the inspector talked with said they valued the service as they found the centre a good place to live and the staff kind and helpful. The inspector talked to ten residents and to three visitors. Residents told the inspector that they felt safe and secure in the centre. They said they were well cared for and several commented on the good relationships they had developed with staff that made a positive impact on their day today lives. Residents described for example the ways that staff helped them with their personal care, organising their clothing and making them comfortable when they retired at night. Some residents said they felt staff were working very hard and were very busy.

Residents said they could talk with staff about any concerns or worries that they had and said matters they raised were sorted out promptly however some residents described a concern about the phone service and said that family and friends had difficulty contacting the centre at times as there had been problems with the telephone system.

Residents told the inspector that there had been great improvements in the space that they had around their beds. They said they liked having an armchair near their beds. All residents interviewed said the centre was warm and comfortable. Residents described the food as tasty and wholesome. They said there was good choice provided at mealtimes.

Residents described the activities they attended regularly and many said that there was good entertainment and varied activities however some said that activities could be unpredictable as staff were sometimes not available to do activities and absences also meant that regular carers were not available. Residents also said that staff were often very busy and some said that it took some time to answer call bells. Residents could attend activities in the day care service on site and a small number availed of this opportunity. Others said they went out with friends and family which kept them in touch with neighbours and their local community. Residents were supported to attend activities in other units and to attend daily Mass in the chapel. There were activities organised for the late evening in some units.

The inspector observed that staff had good relationships with residents and ensured they greeted them and talked to them whenever they met.

Capacity and capability

The centre had a clear governance and management structure in place. The provider representative and person participating in management visited the centre

regularly and undertook reviews and audits of aspects of the service as well as meeting with the person in charge. This had resulted in improvements for residents and better support for the person in charge. For example more spacious wardrobes for residents' clothing had been provided.

Staff described good team working arrangements and were clear about what was expected of them in their roles. While there were adequate numbers of care and nursing staff allocated to each unit and care was found to be appropriate in line with the aims and objectives outlined in the statement of purpose there were significant staff shortfalls that impacted on residents' day to day lives in the centre. There were improvements required to staff deployment and recruitment to ensure that there was continuity of care as staff expressed frustration when there were unexpected staff absences that had to be covered. There were ten vacant posts that were filled by agency staff. There was also a significantly reduced presence of staff at the reception area which meant that most days the centre did not have a focal point where visitors and professionals could request information or locate the unit or service they required. Residents said that staff shortfalls meant that they could not rely on having regular carers and nurses to provide personal care.

The person in charge was a registered nurse and had been in this role several years. She worked full time in the centre and was supported by an assistant director of nursing and a team of clinical nurse managers who took responsibility for day-to-day management of the centre in her absence. Both the person in charge and the assistant directors of nursing were known to residents and their families. The person participating in management was available during the inspection and was knowledgeable about ongoing issues relevant to the centre. There were clear systems of communication and a reporting structure between the provider representative and the person in charge.

Staff had access to a range of policies and procedures to support the delivery of safe and appropriate care and services to residents. Staff were informed about key policies and changes during staff meetings and refresher training sessions. Staff who spoke with the inspector could describe critical procedures such as the fire safety procedure and the safeguarding of vulnerable adults policy.

Residents and visitors who spoke with the inspector described staff as being approachable, caring and committed to ensuring residents had a good quality of life in the centre. They said that staff knew the residents well, that care was person centred and that individual choices were observed. The inspector talked with staff and residents during the two days of inspection. Residents in the rehabilitation unit said they had exercise programmes to follow and were seen regularly by the physiotherapists and occupational therapists who reviewed their progress and prepared them to be as independent as possible. Some residents required lengthy periods of rehabilitation and they said that their personal care and accommodation met their needs. The inspector noted that where residents had made significant improvements and were being supported to link with local community activities and organisations that their care required review to ensure that they were offered opportunities to live independently taking into account their support needs.

Residents said that their choices and preferences were respected and said staff observed how they liked their daily routines and personal care to be addressed. Residents said they would raise a concern with any member of staff and knew who the senior nurses were if they wished to raise a more serious matter. Families and residents told the inspector that when they had raised a complaint that this had been dealt with and they were generally satisfied with the outcome except for the issues that had arose with the telephone during 2019 when the automated system installed made it difficult to get through to units or get a response. This had been resolved but had taken several months to rectify.

There was a quality management system in place which included audits of risk areas such as falls, restraints, wounds, medicine errors and dependency levels. There were reviews of quality of life indicators and the inspector saw that improvements to personal storage arrangements had been made and residents were pleased with the improved storage solutions. Some audit systems required review as the information only indicated the level of compliance and did convey where deficits were or remedial action to be taken to achieve improvements.

There were two conditions applied to the centre's registration at the time of the last registration renewal. Additional shower/toilet facilities were required in St. Joseph's and Our Lady's units. This work was completed in 2019 and this condition was removed. The remaining condition requires that the centre is upgraded and the new 50 place centre completed by 31 December 2021 in line with the letter submitted to the office of the Chief Inspector on 11 June 2018. This work had not commenced and the action plan in this report outlines a requirement to update the Chief Inspector on how this will be achieved.

Unsolicited information supplied to the office of the Chief Inspector during 2019 conveyed concerns about the telephone answering system, the food served at weekends and the smoking arrangements. These areas were investigated by the provider at the request of the inspector. The response indicated that the telephone system had been upgraded and choices of food for evening meals at weekends particularly where residents required specialist diets had been expanded. The inspector found that smoking arrangements were not appropriate and required review. This is discussed under regulation 17 in this report.

Regulation 14: Persons in charge

The person in charge is appropriately qualified and experienced as required by regulation 14-Persons in charge. She has a qualification in health service management. She has a full time role and has responsibility for the management of the designated centre and the day care service.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of nursing and care staff on duty during the inspection was appropriate to meet the needs of the residents taking into account the size and the layout of the centre however there were significant challenges to maintaining the staff allocations due to varied absences. There is always a minimum of one registered nurse on duty in each unit. There is a clinical nurse manager in charge of each of the four units during the day and a clinical nurse manager is also on duty at night time.

The inspector was told that when there were unexpected staff absences in units that staff from other units were requested to cover the shortfalls which hindered continuity of care at times. There were 10 whole time equivalent staff vacancies that had persisted some time and these were filled by agency staff and part-time staff working additional hours. A review of the rotas for a two week period-the 12 and 19 January 2020 conveyed that there were six unplanned illness days to cover in addition to a range of planned/known absences. There were nine planned absences due to holidays, parental leave, maternity leave and study leave from St. Catherine's unit, three from St. Joseph's, five from St. Michael's and three from Our Lady's units. The combination of absences and the vacancy factor contributed to disruption of staff roles and continuity of care. For example the two staff on catering duty in dining room of St. Catherine's unit on the second day of the inspection were normally engaged in care roles.

There was a receptionist available two days a week which meant the entrance was largely unsupervised and there was no one to guide people visiting the centre to where they needed to be which created a risk if people were trying to locate a service or the unit where a resident lived. Residents said that staff were often very busy and some said that it took some time to answer call bells. The inspector concluded that staff allocations and deployment required ongoing review to ensure continuity of care and to reduce the risk created to the security of the building by the absence of staff in the main reception area.

Judgment: Not compliant

Regulation 16: Training and staff development

All staff were up to date with mandatory training in fire safety, moving and handling and safeguarding. Staff interviewed conveyed a good understanding of their roles and responsibilities and were well informed about dementia care and the varied ways dementia could impact on daily life and also the impact of moving from home to residential care. The proportion of staff trained in dementia care and in the management of responsive behaviours had increased significantly since the last inspection. Over 80 % of nurses and carers had completed this training and the person in charge said that training was ongoing to ensure all staff had up to date

knowledge in these areas.

Judgment: Compliant

Regulation 19: Directory of residents

The centre's directory of residents required review to include the details of all residents admitted to the centre as the record did not include the details of residents admitted for short term care .

Judgment: Not compliant

Regulation 21: Records

The records set out in schedules 2,3 and 4 were available.

An action plan in the last report that required that information provided on transfer into and out of the centre is retained in the resident's file had been completed. Records of residents' property and finances were maintained and updated.

While there were policies and procedures for the maintenance and storage of records the inspector found that a number of records required organisation and filing to ensure current relevant information was readily accessible.

Judgment: Substantially compliant

Regulation 23: Governance and management

The designated centre has a clearly defined management structure that identifies the lines of authority and accountability. Staff were familiar with the reporting structures in place and their responsibility for delivering safe good quality care to residents.

The provider representative and persons participating in management visited the centre regularly and undertook reviews of aspects of the service and levels of compliance with regulations. The inspector saw that a review completed in January 2020 had identified areas where compliance had been achieved and where work was required. The ongoing staff shortfall was being addressed by attempts to have posts approved to fill the vacancy factor.

There was a quality assurance system in place to monitor how care was delivered

and to ensure the services were safe and appropriate. This included an annual review of the quality and safety of the service which was developed in consultation with residents and their families. The format of some audits required review as they did not provide any meaningful analysis or explanation of the findings. For example a level of compliance was described however this did not indicate if there was improvement from the previous audit and did not describe where deficits were noted or an action plan to remedy them.

Fire safety work had been identified as necessary in St. Joseph's and Our Lady's unit and this would necessitate that the units were unoccupied. Work was scheduled to start in April and was scheduled to take one month in each unit. The work included the replacement of walls between the hallways and residents' bedrooms that currently have large glass panels with more solid fire proof walls. However, residents continued to be admitted to the centre and there was no plan as to how residents in these units would be accommodated during the time the work was underway. The impact of the consequent loss of light was not fully evident. The inspector concluded that the lack of a clear plan for this significant change that included disruption to residents' accommodation while the work was completed did not ensure the governance and management was robust and did not adequately ensure the safety and well-being of residents.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

An action plan in the last report in relation to the information to be made available in contracts had been addressed. Each resident had a contract for care which included the terms of residency and the room to be occupied. The fees for additional services were outlined.

Judgment: Compliant

Regulation 3: Statement of purpose

The centre had a statement of purpose that had been updated in December 2019. The required information was described.

Judgment: Compliant

Regulation 30: Volunteers

There were over 30 volunteers contributing to services in the centre. All had an outline of their role and responsibilities when in the centre. Some were involved in pastoral care duties and others helped staff with the social care programme. They were supervised and supported in their work by nursing and activities staff. An action plan in the last report had been addressed. The inspector saw that all volunteers now had a vetting disclosure in accordance with the national Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Judgment: Compliant

Regulation 31: Notification of incidents

All incidents that required notification to the office of the Chief Inspector had been provided and additional information was supplied when requested.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints procedure in place and residents interviewed could describe how they would make a complaint. Residents said when they raised issues they were usually addressed in a timely way and resolved with the exception of the telephone issue that took several months to resolve. There was one ongoing complaint about the lack of wifi and options to address this were being explored by the person in charge.

Residents and their families were made aware of the complaints procedure. A copy was displayed prominently on each unit. The person in charge was the nominated complaints person. Complaints were recorded on each unit. Details of the nature of the complaint, the investigation and the actions taken to resolve the complaint were available in the record. However information on the complainants satisfaction with the outcome was not always recorded. The record also contained compliments about the service some of which were recorded on the same page as complaints and the inspector formed the view that the format of the record should be reviewed so that a clear complaint record was maintained.

The complaints procedure included details of the appeals process if the complainant was not satisfied with how their complaint was managed by the centre.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The policies and procedures listed in Schedule 5 of the regulations were in place and were accessible to staff who needed to access them for advice and guidance. While policies and procedures were reviewed regularly the fire procedure included in the fire register was dated 2018 although an updated version was available.

Judgment: Substantially compliant

Quality and safety

The inspector found that there were good arrangements in place that ensured residents had good quality health care that promoted their well being and independence. There were deficits in the premises and in risk management that required attention to ensure the provision of a quality safe service that complied with legislation.

Residents' had detailed assessments of their health and social care needs on admission to the centre. The assessments included relevant health conditions, nutrition problems, risk of falls and the impact of dementia. Nursing staff developed care plans in collaboration with the resident and their family and care plans viewed were found to describe the care interventions and services required to meet residents' identified needs and to promote their independence and well-being. Staff interviewed were familiar with residents daily routines and preferences. Residents told the inspector that staff observed their wishes and choices in relation to where they decided to spend the day, what activities they attended and when they got up and went to bed. Staff interactions with residents were observed to be friendly, cheerful and helpful. There was good emphasis on person centred care. The inspector saw that individual arrangements were made in accordance with residents' choices. For example meals were taken to residents if they decided to remain in their rooms and they were taken to activities in other units if they wished to attend.

Care plans and risk factors were reviewed every four months or more often if the resident's needs changed. Residents and family members were invited to be part of the reviews and their contributions and views were recorded and used to plan how care was delivered. The inspector reviewed a sample of care plans in each unit. They were found to be a of a good standard and provided adequate guidance to staff in their day to day work with residents. There were improvements needed to the regular reviews of care as it could not be determined what progress or change had taken place from one review to another. Specific problems such as wound care were outlined well and the regular updates provided a clear picture of the effectiveness of interventions. Some residents who had completed periods of rehabilitation required a review of their care to ensure all available options for more

independent living that could be suitable for them were explored.

Residents' health needs were met by nursing and care staff supported by medical and specialist health care services. Physiotherapy and occupational therapy services were available on site. There was a good focus on multi-disciplinary teamwork in all areas. Residents told the inspector that physiotherapy input had ensured they maintained their mobility and their ability to dress themselves for example. Residents admitted for rehabilitation described the progress they had made and how they were preparing for discharge. Specialist services that included dietetics, speech and language therapy, psychiatry of old age and chiropody were available and there were no delays when referrals were made. Residents had good access to medical staff. A General Practioner (GP) visited the centre daily during the week and an out-of-hours service was available.

The centre provided evidenced based care to residents who were approaching end of life. Several nurses had training in this area. There was additional advice and guidance provided by the local palliative care service. Residents were consulted about their wishes at end of life and where the resident had provided information this had been included in their end of life care plan. There was a palliative care suite with a single room and self-catering accommodation available where residents and their families could spend time together privately.

Residents told the inspector that the food was very good and that they enjoyed a variety of meals. They said that there were good menu choices each day. The inspector observed breakfast time in St. Catherine's unit and lunch time in Our Lady's unit. There were sufficient staff available at meal times to assist residents and ensure they had adequate food and fluids. Drinks and snacks were served throughout the day. Unrequested information supplied to the office of the Chief Inspector conveyed concern about meals at weekends. This had been reviewed by the provider and the choice offered to residents who were on specialist diets was found to be limited and had been improved.

The centre's activity programme was coordinated by health care staff who had training in this area and were allocated regularly to facilitate the social care programme. The programme included group activities in communal areas and one-to-one activities for residents who needed a higher level of support or who did not participate in group activity. The inspector saw that some activity was organised in the evenings and observed an Imagination Gym session that took place after evening tea. The inspector saw that activities were scheduled regularly however the dependence on care staff to deliver the programme was subject to disruption at times as carers could be redeployed to other duties if there were staff shortages.

Resident's told the inspector that they felt safe and protected in the centre. All staff had attended safeguarding training and were aware of their responsibility to keep residents safe and to report anything of concern. All staff employed had Garda vetting in place and confirmation that staff working on an agency arrangement had vetting disclosures was sought as part of the service level agreement.

The centre was generally clean and there were adequate hand washing facilities in

each unit. Staff were observed to follow good infection control practices however not all staff had attended infection control training according to the training record.

There were comprehensive fire safety procedures in place and all staff working in the centre had attended fire safety training and fire drills. Staff were aware of what to do to keep residents safe in the event of a fire and how to evacuate residents from compartment to compartment. There were regular checks of fire safety equipment and means of escape. Fire drills had taken place during night time hours and records of fire drills confirmed that learning from the exercises was discussed with staff.

The staff were working towards a restraint-free environment. There were regular reviews of restraints such as bedrails to ensure they were necessary and records showed that where restraints were used this was done in accordance with national best practice guidance. There was multidisciplinary input into decisions about the use of restraint.

The centre had policies and procedures in place to protect residents' finances and records viewed showed that all transactions were recorded. The system was regularly audited.

Residents told the inspector that they were comfortable and they said that having more space around their beds and better storage had been a positive outcome for them. Residents' bedrooms were laid out in a spacious and comfortable manner and privacy curtains were available in rooms occupied by more than one person. Residents' had their own wardrobes, chests of drawers and lockers to store clothing and belongings. The action plan in the last report that described inadequate storage had been addressed.

There were communal toilets and bathrooms on each unit. Toilets and bathrooms had grab-rails and call-bells in place to promote residents' independence and safety. A condition applied to the registration had been addressed and removed.
Two shower rooms had been provided on St Joseph's and Our Lady's units. These were were wheelchair accessible and had been completed to a high standard.

There was a lack of storage space in the units which meant that large items of equipment such as hoists, shower chairs and commodes were stored in hallways, bathrooms and sluices.

Each of the units had a comfortable area and a dining room. These areas were well decorated and comfortably furnished. There were small seating areas in each unit if a resident wanted to meet with their visitors in private. There was a designated smoking room on site however, the visitor's room in Our Lady's unit was also allocated for smoking. It was not ventilated and smoke intruded into the surrounding area. The smoking policies of the service were not observed. A large chapel was attached to the centre and residents and members of the local community attended mass there on weekdays. The centre had several garden areas and outside spaces that adjoined bedrooms and communal areas. These were provided with seating and had been cultivated with trees and shrubs to provide

interest for residents.

Regulation 10: Communication difficulties

Residents who were assessed as having specific communication difficulties had a care plan to guide and inform staff on the most appropriate ways to help them communicate to their maximum ability. Residents with dementia had an assessment that conveyed their levels of orientation and memory capacity which was taken into account by staff in the daily interactions with residents. Residents in the rehabilitation unit told the inspector that the assistance they had during their illness had improved their communication capacity and their quality of life.

Judgment: Compliant

Regulation 11: Visits

The centre had an open visiting policy and residents were able to see visitors throughout the day at times that suited them. There was a sitting area on three units where residents could see visitors in private however in Our Lady's unit private space for visits was not available and residents had to use other areas in the centre if they wished to have privacy during visits.

Judgment: Substantially compliant

Regulation 12: Personal possessions

There were policies and procedures in place to ensure that individual residents had access to and could retain control over their personal property, possessions and finances.

The action plan in the last report that required that storage space for residents was improved had been addressed. Residents now had adequate wardrobe and other storage areas to keep their belongings. This was regularly reviewed the inspector was told to ensure residents were satisfied with the arrangements.

Judgment: Compliant

Regulation 13: End of life

There were appropriate arrangements in place to deliver evidenced based end of life care.

Judgment: Compliant

Regulation 17: Premises

The following premises matters were observed to require attention:

- St. Michael's unit: There was very poor light at the nurse's station and in the office
- There was no racking in one sluice area
- Some wheelchairs and specialist chairs were very noisy when moved
- Our Lady's Unit: The use of the visitors' room as a smoking area created a hazard as it was not ventilated adequately and smoke intruded into the communal areas

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were provided with a varied menu and snacks and drinks were available throughout the day. The inspector saw that water jugs were refreshed regularly. The quality of food was good and residents said they were offered a choice at meal times.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place and a risk register described risk areas and how these were to be addressed to ensure risk was controlled. In general the risks identified had a good risk control plan to manage the hazard however the inspector found that the overall identification of risk required improvement as some risks were not controlled effectively. For example:

- The risk assessment for smoking in Our Lady's unit was not being adhered to nor were the controls to be observed. Flammable materials such as papers and books were in close proximity to where residents smoked

- Large items of equipment such as hoists and trolleys were stored in hallways for example in St. Michaels's unit and in St. Catherine's unit where they sometimes intruded into the hallways and presented a trip hazard
- Radiators in St. Joseph's unit hallway were excessively hot and presented a burns risk
- The fire safety work in Our Lady's and St. Joseph's units will require some bedroom areas to be vacated however there was no risk assessment completed to advise staff or residents from these areas about the relocation required or how this was to be achieved taking into account the work was scheduled for April and residents continued to be admitted to the centre. A plan that outlines the works required and the actions to be taken in relation to the relocation of residents while the works are underway should be supplied to the office of the Chief Inspector as part of the response to this report.

Judgment: Not compliant

Regulation 27: Infection control

Overall infection control measures were appropriate. There were Infection Control policies and procedures in place. Staff demonstrated good hand washing and infection control practices in their day to day work. Some staff had not attended refresher training on this topic.

Damage to paintwork in some area compromised the effective cleaning of surfaces however the risk was reduced due to the ongoing maintenance work underway. Painting of the dining room in St. Michael's was underway during the inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were detailed fire procedures in place and fire action instructions were displayed throughout the centre. The fire safety policy had been updated. All fire equipment and means of escape were checked regularly. The fire alarm was tested regularly and fire alarm panels were strategically located . Equipment was serviced on a contract basis. All staff received annual fire safety training updates. Regular fire drills had been completed in 2019.

A fire safety review completed during 2019 had highlighted that the doors and walls between hallways and cubicles in St. Joseph's and Our Lady's units did not offer protection in the event of fire and needed to be replaced. This work was

scheduled to commence in April 2020.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medicines were stored safely and were regularly reviewed by doctors. Medicine errors were recorded and fully investigated. The centre had a nurse prescriber on the team. Nurses were observed to administer medicines safely and to record the response to antibiotic treatment and other short term medicines.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Residents had been comprehensively assessed at admission and care plans detailed health, personal and social care needs. The inspector noted that care plans for dementia care and wound care were well developed. Staff were provided with good guidance on how to address problems associated with dementia and there was good background detail to guide staff and ensure care was person centred.

Care plans were reviewed every four months but the reviews did not always indicate who was involved or the progress or change in the residents' health and well being from one review to another. Some residents had made significant progress for example had progressed from requiring percutaneous nutrition to being able to eat solid food but the reviews of care did not describe this development. Other residents had achieved a higher level of independence and increased mobility but this was also not evident in reviews.

An action plan in the last report described where care plans required improvement to the way responsive behaviours were managed. This had been addressed. The inspector saw that responsive behaviours and triggers for behaviours were described well and that records of responsive behaviour incidents were comprehensive and outlined interventions that had good outcomes for residents.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a wide range of health services and specialist services were

available when required. The multidisciplinary team work approach was noted to have good outcomes for residents many of whom described improvements in their health and well being.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The centre was gradually reducing the number of bed rails and other restraints in use. Where restraints were used the national policy and good practice standards were observed.

Residents who displayed responsive behaviours were supported by staff and appropriate techniques were employed to deescalate the behaviour. The inspector saw that staff had in some cases made significant changes to care plans and to the ways residents were supported to ensure good outcomes for residents.

The majority of staff had received training in managing responsive behaviours and this was ongoing to ensure all staff acquired knowledge in this area.

Judgment: Compliant

Regulation 8: Protection

All staff had received training on the detection, prevention management of incidents or allegations of abuse. Staff were aware of their role and responsibility to protect residents and to report any matter that caused them concern. Safeguarding incidents that were notified to the office of the Chief Inspector were found to have been managed well and were referred to the local safeguarding team for advice and guidance.

The person in charge had investigated any allegation or incident of abuse in line with the centre's policies and procedures.

Judgment: Compliant

Regulation 9: Residents' rights

The rights, culture and diversity of each resident were respected. Staff promoted privacy and dignity and ensured that personal care was delivered in private.

Residents had access to an independent advocate.

The centre had a varied activities programme in place. Residents could choose which activities to take part in and where they declined to attend an activity this was respected by staff. Residents said they enjoyed baking, music sessions, discussions and reading local and national papers.

The improved provision of toilet and shower areas had ensured that residents had appropriate access to hygiene facilities. Residents were registered to vote and could vote in the centre or go out to their local polling station with family of they wished to vote in their local areas.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not 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	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Sacred Heart Hospital OSV-0000654

Inspection ID: MON-0024833

Date of inspection: 17/01/2020

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In regard to the absence of staff in the main reception area, the PIC has applied for a receptionist to cover the shortfall in this area, this has been signed off by the PPIM in time for the February PMCG (Payroll Management Control Group). Approval sought to get Agency to cover in the meantime was approved and we are sourcing an Agency replacement currently. The PPIM will work with the DON to review the rosters in the context of planned absences to minimise the disruption to continuity of care Completed 31st March, 2020	
Regulation 19: Directory of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Centre's directory of residents did not include the details of residents admitted for short term care. This has been addressed and there is a second Directory of Residents specifically for short stay residents and this was commenced immediately after the inspection and backdated to the 1st January 2020.Both Directories for the long term care and short stay residents comply with the requirements laid out in the Health Act Regulations. All staff are aware that both Directory are to be made available to the HIQA Inspectors for review going forward. Action Completed 21st January, 2020.	

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
"While there were policies and procedures for the maintenance and storage of records the inspector found that a number of records required organisation and filing to ensure current relevant information was readily accessible." The Fire Registrar was reviewed with old records for previous years filed away while current records are now kept easily accessible for review upon inspection. Completed 22nd January2020.

Staff Files are currently being reviewed to ensure that Documents required under Regulation 21 Schedule 2, Health Act 2007, are to the front and easily accessible for review on Inspection. Work in Progress Completion Date 30th April, 2020

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
We are currently reviewing the format of our Audits to ensure that we acknowledge improvements from previous audits and act on any deficits noted as recommended in the report with support from QPS . Audits will be in line with this format from 31st March, 2020

HSE Estates procured a Design Team to complete detailed surveys to identify Fire Safety concerns identified in an updated fire risk assessment. The Design Team completed these Surveys on the 20th January and 10th February 2020. These surveys will inform the development of the detailed design for procurement of a specialist works contractor to address the Fire Safety concerns identified in the fire risk assessment and subsequent detailed surveys and inspections.

The Fire Works relate to Our Lady's and Josephs Wards.The non-compliant (fire) glazed screening along the north facing corridors into the bedrooms are directly opposite full glazed facades to the south facing direction (permitting maximum natural daylighting into the bedrooms), which offsets any significant reduction of natural daylight into these bedrooms. Furthermore, there is high level glazing panels above the door threshold level over the full width of each bedroom. These are to be retained and will allow additional daylight inward.

The detailed design will consider the finishes and décor to these new fire compliant partitions to ensure they are bright thereby reflecting light while being in keeping with

the décor of the bedrooms. The doors into these bedrooms will also be fire compliant and with requirements to allow staff viewing, while ensuring resident privacy. These new fire compliant partitions will also provide better comfort and sound proofing to the noise generated in the corridors (trollies, catering, deliveries, visitors etc), positively impacting on the comfort and well-being to residents particularly at rest periods.

Fire doors within the Wards are identified in the updated fire risk assessment and have also been inspected by the Design Team to identify all required works to ensure compliance and that fire compartmentation is maintained and improved. These works will be completed during the replacement of the glazed screens to the bedrooms.

Given the disruptive nature of the works pertaining to the removal of the existing glazed screening and replacement works as above, careful consideration and a detailed designers risk assessment is an ongoing part of the detail and project. The risks posed to the residents, staff, visitors and others will also receive significant operational consideration. The works will also be within the corridor, which is the primary means of access for all persons in these Wards, thereby presenting risks during the construction works in each unit. The duration of the works and disruption will invariably be much greater if the current day-to-day operations continue. Therefore, in consideration of all Health and Safety concerns for residents, staff, visitors and works contractor personnel, and the comfort and well-being of residents, the works are proposed to be completed in a phased basis with periods where one or both units may be closed/vacant. Any vacation of beds within the wards is expected to be achieved by closing to admissions and possibly some temporary relocation. Dates for the works will be confirmed following the procurement and return of works contractors tenders and a full plan. A plan will also be developed outlining the specific arrangements for each bed and each resident. The aim is to carry out disruptive works during the summer months. The schedule of works and closure will require sign off from the Services and Estates. The plan will be communicated to all stakeholders and following feedback any required adjustments made. All temporary relocations will be discussed with residents to achieve an agreed arrangement.

A copy of the full plan will be made available to HIQA when complete

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
"The format of the record should be reviewed so that a clear complaint record is maintained."
We are reviewing the format of the Complaints/Compliments Book to address the issues raised of segregation of complaints from compliments. The new booklets will be in place by the end of March, 2020.There are two dates planned for training in regard to the revised HSE Complaints Policy, 24th March & 23rd April for all staff in the SHHR. Once

staff have attended this training we will be using the new HSE reporting format which is in line with your recommendations. The training will reiterate the requirement to ensure the outcome of all complaints is recorded To be completed by: 30th May, 2020

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: "While policies and procedures were reviewed regularly the fire procedure included in the Fire Register was dated 2018 although a updated version was available. "The Fire Registrar was reviewed and all out of date documents were safely filed away, leaving only current documentation. The Fire Policy/Procedure was changed to the current updated Policy/Procedure November, 2019.Completed: 21st January, 2020

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits: "In our Lady's unit private space for visit was not available and residents had to use other areas in the center if they wished to have privacy during visits." This is currently being addressed. The small private sitting room is being painted, re-floored and the furniture changed. This will be available for all Our Lady's residents for private visits. Completion expected by the 9th March, 2020.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: 1. St. Michael's unit: There was very poor light at the nurses' station and in the office – this had been addressed previously by Maintenance and the wattage was increased to maximum for that fitting but Maintenance are now exploring the replacement of the light fitting in that area. 2. There was no racking in one sluice area – while this is true it was in the process of being addressed and approval was given for replacement and same was ordered –

delivery lead time is four to six weeks. Planned completion 28th February, 2020.
3. The wheelchairs and specialist chairs were very noisy when moved - annual maintenance contract was in progress at the time of inspection to detect and rectify such matters. Following review of the service report some wheelchairs are being decommissioned and will be replaced. Some wheelchairs were replaced already on 21st February, 2020 while the remainder will be replaced by the 31st March, 2020.
4. Our Lady's Unit - The use of the visitors room as a smoking area. This practice has ceased after discussion with residents. The room has been cleaned and painted while the flooring is being changed and new furniture is being purchased. The room will revert to a private sitting room for all Our Lady's residents who wish to avail of same for private visits. A Memo has issued to all staff in Our Lady's advising them to inform any resident or other person smoking outside the designated smoking room to cease immediately. Planned completion 31st March, 2020
5. A design team has been established to progress the 50 bed new build

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
1. The control measures in the risk assessment on smoking in Our Lady's unit was not being adhered to. The small visitors room is no longer a smoking area, the practice having ceased after discussion with residents. The room has been cleaned and painted, the flooring is being changed and new furniture is being purchased. The room will revert to a private sitting room for all Our Lady's residents who wish to avail of same for private visits.
Planned completion 31st March, 2020
2. Large items of equipment such as hoists and trolleys were stored in hallways. Large equipment may be placed in hallways temporarily while in use for example in the case of a Mobi Hoist used to assist a resident out of bed, after which they are stored off the hallway. Trolleys/skips for laundry are stored in hallways during care activity for ease of access only. Trolleys and hoists are not stored permanently in hallways – this came up in a previous inspection and was corrected. There is a designated area for the permanent storage of such equipment away from the hallways. A notice to this effect has been circulated to all wards.
3. Radiators in St. Joseph's hallway were excessively hot and presented a burns risk. Radiator temperatures are controlled by the Building Management System which is regulated by the external temperature. Maintenance are to take and record radiator temperatures. These temperatures will then be reviewed and any required further identified
4. HSE Estates procured a Design Team to complete detailed surveys to identify Fire Safety concerns identified in an updated fire risk assessment. The Design Team completed these Surveys on the 20th January and 10th February 2020. These surveys will inform the development of the detailed design for procurement of a specialist works contractor to address the Fire Safety concerns identified in the fire risk assessment and

subsequent detailed surveys and inspections.

The Fire Works relate to Our Lady's and Josephs Wards.The non-compliant (fire) glazed screening along the north facing corridors into the bedrooms are directly opposite full glazed facades to the south facing direction (permitting maximum natural daylighting into the bedrooms), which offsets any significant reduction of natural daylight into these bedrooms. Furthermore, there is high level glazing panels above the door threshold level over the full width of each bedroom. These are to be retained and will allow additional daylight inward.

The detailed design will consider the finishes and décor to these new fire compliant partitions to ensure they are bright thereby reflecting light while being in keeping with the décor of the bedrooms. The doors into these bedrooms will also be fire compliant and with requirements to allow staff viewing, while ensuring resident privacy. These new fire compliant partitions will also provide better comfort and sound proofing to the noise generated in the corridors (trollies, catering, deliveries, visitors etc), positively impacting on the comfort and well-being to residents particularly at rest periods.

Fire doors within the Wards are identified in the updated fire risk assessment and have also been inspected by the Design Team to identify all required works to ensure compliance and that fire compartmentation is maintained and improved. These works will be completed during the replacement of the glazed screens to the bedrooms.

Given the disruptive nature of the works pertaining to the removal of the existing glazed screening and replacement works as above, careful consideration and a detailed designers risk assessment is an ongoing part of the detail and project. The risks posed to the residents, staff, visitors and others will also receive significant operational consideration. The works will also be within the corridor, which is the primary means of access for all persons in these Wards, thereby presenting risks during the construction works in each unit. The duration of the works and disruption will invariably be much greater if the current day-to-day operations continue. Therefore, in consideration of all Health and Safety concerns for residents, staff, visitors and works contractor personnel, and the comfort and well-being of residents, the works are proposed to be completed in a phased basis with periods where one or both units may be closed/vacant. Any vacation of beds within the wards is expected to be achieved by closing to admissions and possibly some temporary relocation. Dates for the works will be confirmed following the procurement and return of works contractors tenders and a full plan. A plan will also be developed outlining the specific arrangements for each bed and each resident. The aim is to carry out disruptive works during the summer months. The schedule of works and closure will require sign off from the Services and Estates. The plan will be communicated to all stakeholders and following feedback any required adjustments made. All temporary relocations will be discussed with residents to achieve an agreed arrangement.

A copy of the full plan will be made available to HIQA when complete

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Nursing staff who have not completed training on infection control, have been advised of the requirement to complete the online training via hseland by the end of June.
Completion :30th June, 2020

"Damage to paintwork" compromised the effective cleaning of surfaces – On-going maintenance of the premises was underway during the inspection and is a continuous process in the SHHR, with areas prioritised according to need. Maintenance have been informed to put painting of paintwork to the upper end of the list

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
HSE Estates procured a Design Team to complete detailed surveys to identify Fire Safety concerns identified in an updated fire risk assessment. The Design Team completed these Surveys on the 20th January and 10th February 2020. These surveys will inform the development of the detailed design for procurement of a specialist works contractor to address the Fire Safety concerns identified in the fire risk assessment and subsequent detailed surveys and inspections.

The Fire Works relate to Our Lady's and Josephs Wards.The non-compliant (fire) glazed screening along the north facing corridors into the bedrooms are directly opposite full glazed facades to the south facing direction (permitting maximum natural daylighting into the bedrooms), which offsets any significant reduction of natural daylight into these bedrooms. Furthermore, there is high level glazing panels above the door threshold level over the full width of each bedroom. These are to be retained and will allow additional daylight inward.

The detailed design will consider the finishes and décor to these new fire compliant partitions to ensure they are bright thereby reflecting light while being in keeping with the décor of the bedrooms. The doors into these bedrooms will also be fire compliant and with requirements to allow staff viewing, while ensuring resident privacy. These new fire compliant partitions will also provide better comfort and sound proofing to the noise generated in the corridors (trollies, catering, deliveries, visitors etc), positively impacting on the comfort and well-being to residents particularly at rest periods.

Fire doors within the Wards are identified in the updated fire risk assessment and have also been inspected by the Design Team to identify all required works to ensure compliance and that fire compartmentation is maintained and improved. These works will

be completed during the replacement of the glazed screens to the bedrooms.

Given the disruptive nature of the works pertaining to the removal of the existing glazed screening and replacement works as above, careful consideration and a detailed designers risk assessment is an ongoing part of the detail and project. The risks posed to the residents, staff, visitors and others will also receive significant operational consideration. The works will also be within the corridor, which is the primary means of access for all persons in these Wards, thereby presenting risks during the construction works in each unit. The duration of the works and disruption will invariably be much greater if the current day-to-day operations continue. Therefore, in consideration of all Health and Safety concerns for residents, staff, visitors and works contractor personnel, and the comfort and well-being of residents, the works are proposed to be completed in a phased basis with periods where one or both units may be closed/vacant. Any vacation of beds within the wards is expected to be achieved by closing to admissions and possibly some temporary relocation. Dates for the works will be confirmed following the procurement and return of works contractors tenders and a full plan. A plan will also be developed outlining the specific arrangements for each bed and each resident. The aim is to carry out disruptive works during the summer months. The schedule of works and closure will require sign off from the Services and Estates. The plan will be communicated to all stakeholders and following feedback any required adjustments made. All temporary relocations will be discussed with residents to achieve an agreed arrangement.

A copy of the full plan will be made available to HIQA when complete

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Care plans were reviewed every four months, but the reviews did not always indicate who was involved or the progress or change in the resident's health and wellbeing from one review to another.
CNM2s are aware that a more detailed evaluation is required going forward, detailing residents involvement in the review and input from Multi-disciplinary team. A Care Plan support group of nurses, for nurses, is planned for June, 2020 to assist new staff with documenting care plans and evaluations. CNME care plan training is available for all nurses upon request.

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)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	09/03/2020
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	Not Compliant	Yellow	31/03/2020

	in accordance with Regulation 5, and the size and layout of the designated centre concerned.			
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	
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	Yellow	31/03/2020
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Yellow	21/01/2020
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	30/04/2020
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to	Not Compliant		

	ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Yellow	30/04/2020
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of	Substantially Compliant		30/06/2020

	healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Yellow	
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	
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	Not Compliant	Yellow	31/05/2020

	resident was satisfied.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	21/01/2020
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Yellow	30/06/2020