Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Donore Nursing Home
Name of provider:	Brecon (Care) Limited
Address of centre:	13 Sidmonton Road, Bray, Wicklow
Type of inspection:	Unannounced
Date of inspection:	12 November 2018
Centre ID:	OSV-0000032
Fieldwork ID:	MON-0024298

About the designated centre

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

Donore Nursing Home is a small centre conveniently located in a residential area between the seafront and Bray town centre with easy access to local amenities including shops, bank, church, local transport and the promenade. The centre has capacity for 24 residents and accommodation includes single, twin and multi occupancy bedrooms spread over three floors which are accessed by stairs and a stair lift. Residents have access to a secure garden to the rear of the centre and a smoking area is located close to the nurses office at the side of the building. Donore caters for older adults with enduring mental health needs, challenging behaviour and dementia. The centre aims to provide a comfortable, clean and safe environment for residents. The staff team is well-established with many staff working at the centre for over five years. Staff know the residents well and aim to provide a homely atmosphere where everyone is treated with compassion and care is person centred. Donore aims to provide a centre were people can live with contentment, laughter, socialize and experience a high quality of life by enhancing their optimum level of functioning, their worth, dignity and independence.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	19

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
12 November 2018	10:30hrs to 18:30hrs	Liz Foley	Lead
12 November 2018	10:30hrs to 18:30hrs	Ann Wallace	Support

Views of people who use the service

Inspectors spoke with nine residents during the inspection. Residents were generally happy with the care they received, their accommodation and choice of food. Residents felt safe in the centre and said staff were kind and respected their choices. Residents in multi-occupancy rooms reported that their privacy was protected and that they enjoyed the companionship of their room mates. However some residents said there were not enough activities and another said the activities did not interest them.

Capacity and capability

This was an unannounced inspection to monitor compliance and follow up on a triggered inspection which was completed in July 2018. Inspectors followed up on the compliance plan from the most recent inspection and found that the provider remained non-compliant with regulations 23 Governance and Management and regulation 8 Protection. The findings of this inspection are that the registered provider has not ensured there are appropriate systems in place to provide oversight of the service. Inspectors were not assured that there were sufficient staff available to meet the needs of residents and to deliver the service described in the centre's statement of purpose. This was a finding on the previous inspection. Recruitment efforts had limited success and recent staff resignations had compounded the impact of insufficient staff on the quality of life of residents. Staffing levels were unsustainable as the existing staff team were working extra hours in the centre to cover leave and vacancies. The centre did have a contract with an agency to cover short falls in staffing but inspectors were informed that the centre were using their own staff to cover leave at present. Recent changes to the management team had not been notified to the office of the Chief inspector. The provider had been actively recruiting for an assistant director of nursing, however the process had been delayed by an external agency. This appointment was at an advanced stage and it was hoped would be filled before December. A part time activities coordinator had been recruited.

While some improvements had been made in the monitoring of clinical key performance indicators, there was little evidence to support any monitoring of quality improvement in the day to day operations of the centre. For example there were no complaints recorded for 2018 despite inspectors being informed by a resident that they had complained about equipment. The centre was not following it's own policies and procedures in relation to safeguarding, care planning and reporting incidents. The management team failed to assure inspectors they had

adequate oversight of the service. Inspectors found:

- Inconsistent supervision of staff particularly on weekends
- Failure to communicate statutory notifications.
- The management of records was poor, The management team were unable to locate key pieces of information and were unsure of the extent of this issue.

The centre has had high levels of non compliance's on past inspections and have now engaged an external consultant to support them to meet their regulatory obligations going forward. This consultant was due to visit the centre on the day of this inspection but was cancelled by the provider. Eight regulations which underpin capacity and capability were monitored and seven were found to be non-compliant on this inspection.

Regulation 15: Staffing

Rosters were checked and matched the staff numbers on duty. A long term staff member had recently resigned and staffing levels were reduced as a result, the major impact of this was found to be on the availability of staff to support residents with meaningful activities, this is discussed under regulation 9 Resident's Rights. The previous inspection found staffing to be a challenge and it was unclear how many vacancies existed on the day of inspection. Resident's and staff told inspectors that currently there were not enough staff to take residents out as normal. Staffing levels did not reflect those described in the centre's statement of purpose. A part time activities person had been recruited to work eight hours per week but was on leave for over a month with no replacement. Recruitment of a full time assistant director of nursing was at an advanced stage and it was hoped they would commence before December 2018. The centre has a contract with an agency to cover short falls in staffing levels, however inspectors were informed that the centre were utilizing their own staff to cover vacancies and were not currently using agency staff. The centre's staff were working extra hours to cover vacancies and leave in order to provide continuity of care. According to the rosters viewed two staff were rostered to work an average of just over 62 hours and 63 hours respectively over a four week period from 26th October to 22nd November 2018.

There was a registered nurse on duty at all times in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

The training matrix was viewed by inspectors, there was 100% compliance with Fire safety and Safeguarding training. 90% of staff had received training in managing behaviours that challenge.

Staff were trained by the person in charge on the provision of meaningful activities and one Sonas practitioner had recently been recruited to attend the centre eight hours per week, however this person had been on leave for a month.

Supervision of staff at weekends was found to be inconsistent .

Judgment: Substantially compliant

Regulation 21: Records

Records set out in schedules 2, 3 and 4 of the regulations were available in the centre on the day of inspection. Schedule 2 documents viewed in respect of staff were found to be complete with the exception of one staff file that did not contain a full employment history and another staff file that did not contain a job description. Vetting disclosures as required under the 2013 Regulations and the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016 were in place for all staff. Schedule 3 documents viewed in respect of residents contained the required information. This was a significant improvement since the last inspection. Schedule 4 documents in respect of notifications did not contain all the required information.

It was acknowledged by the management team on the day of inspection that some documents were missing, it was not known where these documents were located. This had also been the finding on the previous inspection in July 2018.
The registered provider did not respond appropriately to the incidences of missing documents nor were they able to quantify what was actually missing and were not aware of their responsibility under General Data Protection Regulation to inform relevant bodies.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined management structure which was clear to staff and both residents and staff were aware of who to report concerns to. The provider and person in charge had not completed the compliance plan which they developed following the previous inspection in July 2018 and despite ongoing efforts to recruit new staff, staffing continued to be an issue. There was insufficient staff on duty to provide meaningful activities to some residents, this was due in part to further more recent resignations. The management team were unclear how many vacant posts

existed and only one staff member had been recruited part time to the centre since the previous inspection in July 2018, when staffing was also found to be insufficient. Systems were in place to monitor clinical aspects of care and included key performance areas such as falls, restraint, and pressure sores. There were areas of care and day to day operational management that were not being consistently or effectively monitored, therefore quality improvements were not reliably informed. There was insufficient management oversight of the following areas;

- care planning.
- notifications,
- complaints management,
- records management,
- governance and management communication,
- audit and quality improvement,
- supervision of staff out of hours and on weekends.

Judgment: Not compliant

Regulation 3: Statement of purpose

The current statement of purpose was reviewed in the centre on the day of inspection and did not contain all of the information set out in schedule 1 of the regulations. Some of the information did not reflect the current status of the centre for example, staffing levels described the centre as having a half a post specifically for activities when in fact there were eight hours per week allocated.

Judgment: Not compliant

Regulation 31: Notification of incidents

Two incidents set out in paragraphs 7(1) a-j of schedule 4, that require notification to the Chief Inspector within three working days had not been submitted. Quarter three notifications as set out in paragraphs 7(2) k-n of schedule 4 had not been submitted to the Chief Inspector in the time frame required. The centre did not have a copy of notifications they stated were sent to the Office of the Chief Inspector and were unsure of what had actually been sent.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints policy in place and procedures for making a complaint were displayed in the centre. There were no complaints recorded for 2018 however residents told inspectors that they had made complaints. The provider acknowledged that issues had been reported but did not see these as complaints as they had been dealt with at the time.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Some policies viewed by inspectors were found to be centre specific, signed and dated with planned review dates inserted. The centre was not following it's own policy on safeguarding, incident reporting and care planning. These were consistent with findings of previous inspections.

Judgment: Not compliant

Quality and safety

Residents choice and rights were respected in the centre. Residents acknowledged that they were encouraged and supported to exercise choice in relation to their daily lives, for example, residents could choose what time to get up at, what to wear, what to eat and for the most part how to spend their time. There was a forum where residents could contribute to or express concerns about the running of the centre and residents were supported to attend these meetings. An independent advocate was available to residents and their details were displayed in the centre. Staffing levels were impacting on some residents' choice of leaving the centre to go shopping or go for a walk as staff were currently unable to accompany them. Opportunities for meaningful activities were restricted due to staffing levels.

A comprehensive assessment of residents' needs were carried out and the information was used to develop a plan of care. Care plans were found to be inconsistent in format and it was unclear which care plan was to be used to guide care. Care plans did not have sufficient detail to guide staff on how to care for the residents ' needs. Interactions between staff and residents were observed to be person centered and respectful and staff were very knowledgeable of residents' needs. There was evidence of good access to the Multi-Disciplinary-Team(MDT) and the medical doctor, however the recommendations of the MDT were not consistently

recorded in the care plans to direct staff in how to care for the residents' complex needs. The risks associated with this was somewhat mitigated because the centre was small, staff knew the residents well and information relevant to care delivery was communicated verbally within the team.

Residents were observed to be content and interacted with staff throughout the day. The centre was comfortably furnished and supportive equipment was available to meet the assessed needs' of those residents' that required it. Some bedrooms were personalised and one resident happily invited inspectors to view their bedroom. Residents told inspectors they were well cared for and felt safe in the centre. There was a good choice of home cooked meals and snacks available to residents. Staff were observed discreetly assisting residents with meals and drinks throughout the day.

The majority of staff had training in responding to behaviors that were challenging and had very good knowledge of individual resident's triggers and de escalation techniques. The use of restraint was minimal in the centre and was risk assessed, however improvements were required in documenting alternatives to restraint trialled. Improvement was required to ensure that incidents of peer to peer abuse were consistently managed in line with the centre's policy.

Six regulations which underpin Quality and Safety were monitored and three were compliant.

Regulation 17: Premises

The centre was found to be clean and residents were comfortable. The stair lift had been most recently serviced on 27/07/2018. There were two multi occupancy bedrooms in the centre one with capacity for four residents and the other with capacity for three residents. There were two residents in each of these rooms on the day of inspection. Residents that resided in these rooms told inspectors their privacy was maintained and that they were happy living there. Mobile screens were used in these rooms and in the twin rooms to protect resident's privacy during personal care. Some bedrooms were personalised according to the residents wishes. There was access to outdoor space and a covered outdoor smoking area. Residents had space both inside and outside the centre to mobilize, there were two different seating areas and a small comfortable dining room.

The downstairs wheelchair accessible shower room is adjacent to the day room which is a distance away from the residents bedrooms and requires residents' to pass through both communal rooms to access this shower. There are no immediate plans to reconfigure this as according to the provider, it in not impacting on current residents' privacy. A smaller shower room is located near the bedrooms downstairs, however this shower is not wheelchair accessible.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A comprehensive needs assessment was carried out on each resident on their admission to the centre. This information was used to guide care planning and included individualised information on each resident's health and social status including their levels of ability. There was evidence of risk assessments for example, restraint and malnutrition risk assessments. However care plans did not contain enough information to guide staff on how to care for individuals' complex needs. Some residents files did not contain any information on residents' end of life care needs and one 'Do not resuscitate' order was located in a separate file and signed by the resident's next of kin. Improvement's were also required to ensure all care plans were reviewed at intervals not exceeding four months in consultation with the resident or where appropriate their family. Some individual care plans contained two different care plan formats and it was not clear which format was to be followed to guide staff. Some care plans were not dated. There was also good evidence of review by members of the multi disciplinary team (MDT) however the recommendations made by the MDT were not consistently recorded in the care plan to guide staff on changes to the residents needs.

Judgment: Not compliant

Regulation 6: Health care

Residents had good access to medical and MDT specialist support. The resident's were reviewed regularly by the General practitioner who knew the residents well and who worked closely with specialist medical and psychological services. Treatments recommended by the MDT and GP were administered by the centre staff.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The majority of staff had received training on how to manage behaviours that challenge. Responsive behaviours were well managed in the least restrictive manner in accordance with the national policy. Restraint use was at a minimum in the centre and was risk assessed, however it wasn't clear what alternatives to

restraint were trialled before the restraint was applied.

There was evidence of audits of restraint use.

Judgment: Substantially compliant

Regulation 8: Protection

All staff had received training on safeguarding and a policy was in place to guide staff on how to protect residents from abuse. Most of the staff who spoke with inspectors were confident in how to report suspected abuse.

One recent incident of peer to peer abuse was not responded to appropriately. The centre failed to follow its own policy on recognising and responding to incidences of abuse. The centre failed to inform the office of the Chief inspector and other appropriate agencies. While steps had been made to prevent a recurrence there was no evidence of an internal incident report or investigation.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors observed open and respectful interactions between residents and staff. There were facilities for occupation and recreation, however opportunities for some residents to participate was limited due to current staffing levels. Residents who normally went out for shopping or a walk were not going out as often as they usually did due to reduced staffing levels. There was one staff member recently recruited that was a qualified Sonas practitioner, however they were on leave for the past month. Residents were able to exercise choice and care was person centred. Staff were observed engaging residents in moments of person centred activities, for example, singing, knitting, art, chatting and hand massage. These moments were unstructured and part of routine care, and residents were observed to be engaged and enjoying the activity.

Residents were supported to undertake activities in private, those in shared rooms had their privacy and dignity protected by the use of screens. There was access to telephone, radio, TV, daily newspaper and WiFi. Residents had access to an independent advocate who had visited the centre most recently in October 2018. Residents were offered support to exercise their civil and political rights in the recent referendum. Residents were consulted about and participated in the running of the centre by attending residents meetings, however the minutes of the most recent meeting in March were not available for inspectors to view- staff on duty confirmed

that the meeting did take place.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not 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 17: Premises	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Donore Nursing Home OSV-0000032

Inspection ID: MON-0024298

Date of inspection: 12/11/2018

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: We have developed an activity book which will be used daily for each resident .This allows us to assess the resident's overall ability; the assessment will include assessment of their lifestyle and leisure preferences, their needs, strengths, weaknesses, ability to perform a range of tasks and their ability to interact positively with others. All staff will be aware of the unique physical and sensory challenges they may have. Learning the specific physical and sensory needs of the resident will help to better determine which activities are most suited for them e.g. the needs of cognitively intact residents will differ from those with cognitive impairment. Similarly immobile, bed bound or chair bound residents will have different activity needs. A new activity person stars on three day course on 7th of December 2018, January18, 2019,and march 1, 2019 in the Sonas centre . The new Health care assistant one had induction on 20th November 2018, the new Health care assistant 2 had induction on December 2018. If a resident refuses to be involved in an activity this will be respected and noted.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: We will ensure that the 10 percent of staff receive training in managing behaviours that challenge. Recent training on July 31 2018 of three new relief nurses on Safeguarding/ communications person centered care dementia and challenging behavior.	

The mandatory training will commence in March 2019 Since the last inspection the PIC has been on duty on both days of the weekend and will continue to do so until the deputy is in place.

Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: We will ensure records set out in schedules 2, 3 and 4 of the regulations are complete and in order .We have rewritten all our careplans .	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: We will now ensure all services are consistently and effectively monitored, therefore quality improvements were not reliably informed. We will ensure a quality management meeting is held weekly and will ensure it addresses all adverse events in the home making sure it captures all issuus relating to care planning,notifications,complaints management,records management,governance and management communication,audit and quality improvement,and supervision of staff out of hours and on weekends.	

Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: Statement of Purpose has been reviewed to ensure it reflects the current status of our home.	

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All Notifications need to be sent in a timely manner a new portal account has been opened for the Home. A second email account will be set up for the new nurse.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: We have activated a complaints log book. Ideally, each resident that has enough cognitive understanding of the complaints procedure we will furnish with a copy to them. Staff have been instructed to assist any Resident to make a complaint either verbally or in writing. We will ensure that all complaints or concerns and the results of any investigations are properly recorded and that such records shall be in addition to and distinct from a resident's individual Care Plan. The television company has installed new t v boxes and the residents are now used to the new remote controls.	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: We have ensured we follow our own policies and procedures by doing training sessions with our staff especially with safeguarding, incident reporting and care planning.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The smaller shower room walls are nearly .75m thick of stone and rubble and does not lend itself to be extended.

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:
Care plans will have sufficient detail to guide staff on how to care for our residents ' needs. Recommendations of the MDT will be recorded in the care plans to direct staff in how to care for the residents' complex needs.

Residents end of life care plans are updated and we will ensure all documentation relating to each resident is located together in the one place.We have ensured all care plans are reviewed at intervals not exceeding four months in consultation with the resident or where appropriate their family. We will ensure individual care plans are uniform and are consistant using one format.We will also ensure all care plans are dated.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
A restraint free environment is promoted at all times. Restraint is only used by appropriately trained staff as a measure of last resort, where there is an imminent risk of serious harm to the resident or other persons and where less restrictive strategies have been exhausted

We will ensure alternatives to restraint are trialled before the restraint is applied.
A low low bed was used and is now reflected in the residents care plan

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
We will ensure all incidents are responded to appropriately. We will ensure we inform the office of the Chief inspector and other appropriate agencies in a timely manner. We will ensure that an internal incident report or investigation takes place in future of all allegations of abuse.
We will ensure that all incidents of peer to peer abuse are consistently managed in line with our policy.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
We will ensure residents meetings are held every 3 months in line with our policy.

There was a record in the clinical notes by the advocate from his October 2018 visit.
We have an activity log book that is used daily by the carers and has been for some time and this will show continuous monitored daily activities.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/12/2018
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/03/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	17/11/2018
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a	Substantially Compliant	Yellow	31/12/2018

	particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
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	31/12/2018
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Yellow	31/12/2018
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	31/01/2019
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 effectively monitored.	Not Compliant	Yellow	31/12/2018
Regulation 03(1)	The registered provider shall	Not Compliant	Yellow	15/11/2018

	prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.			
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	Yellow	15/11/2018
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Not Compliant	Yellow	15/11/2018
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Yellow	31/12/2018
Regulation 34(1)(f)	The registered provider shall provide an accessible and	Not Compliant	Yellow	31/12/2018

	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.			
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Yellow	31/12/2018
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	Not Compliant	Yellow	31/12/2018

	resident's individual care plan.			
Regulation 34(3)(a)	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 all complaints are appropriately responded to.	Not Compliant	Yellow	31/01/2019
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	Yellow	31/01/2019
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	Yellow	31/12/2018
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after	Not Compliant	Yellow	31/12/2018

	that resident's admission to the designated centre concerned.			
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	31/12/2018
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.	Substantially Compliant	Yellow	27/11/2018
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Yellow	15/11/2018
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	Yellow	31/07/2018

Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Yellow	05/11/2018
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	31/12/2018
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Yellow	31/01/2019