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:	College View Nursing Home
Name of provider:	Aspen Green Limited
Address of centre:	Clones Road, Cavan, Cavan
Type of inspection:	Unannounced
Date of inspection:	25 October 2022
Centre ID:	OSV-0000128
Fieldwork ID:	MON-0037477

About the designated centre

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

College View Nursing home is a purpose built nursing home located in landscaped gardens on an elevated site within the Cavan town opposite St Patrick's College on the Clones Road. The centre is registered to accommodate a maximum of 69 residents, both males and females, over the age of 18 years on a long term and short stay, respite and convalescence basis. The centre provides care for a wide range of age related conditions such as general nursing care for elderly residents, Old Age Psychiatry, dementia specific care, respite care, post operative care and palliative care. The town can be accessed by wide footpaths which have been extended to meet the drive into the nursing home. There are extensive gardens over an acre which include raised flower beds, extensive lawns and secluded sun and patio areas for those residents who like to sit outside.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	68

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
Tuesday 25 October 2022	10:30hrs to 18:15hrs	Catherine Rose Connolly Gargan	Lead
Tuesday 25 October 2022	10:30hrs to 18:15hrs	Rachel Seoighthe	Support

What residents told us and what inspectors observed

Overall, inspectors observed that while a number of residents in the centre enjoyed a good quality of life and their rights were respected, this was not found for other residents including residents accommodated in the dementia unit. Residents' quality of life in the dementia unit was impacted by restricted access to the outdoors, limited opportunities to engage in meaningful social activities and a physical premises environment that had limited comfort particularly in the combined sitting and dining area which was the only communal area available on this unit. The inspectors also observed that a number of interactions between staff and residents were focused on providing care interventions and tasks and were not person-centred.

Inspectors were met by the assistant director of nursing who guided them through the infection prevention and control measures in place. Following an introductory meeting, inspectors walked around the centre with the management team. This gave inspectors opportunity to meet with residents and their visitors, to observe the lived experience of residents in their home environment and to observe staff practices and interactions. During this time, residents accommodated outside of the dementia unit were observed engaging in activities in the sitting rooms on their units or spending time in their bedrooms. In contrast seven of the 12 residents accommodated on the specialist dementia unit were observed sitting in the communal room, six of whom were sleeping and one resident was colouring a picture. Music was playing in the background and one carer was in attendance whilst the remaining care staff were assisting other residents in the unit with getting up for the day.

Throughout the day the inspectors observed that staff did not identify that two residents were experiencing responsive behaviours (How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). For example, one resident who declined to speak with an inspector or with staff was visibly withdrawn, refusing to eat and remained in their bedroom. Another resident removed their wound dressings leaving their discharging wound exposed. Staff appeared to accept that the behaviours these residents were exhibiting were 'usual behaviours' for these residents and did not offer appropriate interventions or report the behaviours to senior staff. As a result, these residents were not adequately supported and their care needs were not being met.

On the day of the inspection an activity coordinator was supported by care staff to facilitate a planned schedule of social activities in the three communal rooms in the centre. The inspectors observed that the social activities in the two of the communal sitting rooms were carried out in line with the planned schedule. The activities were lively and residents were clearly enjoying them. However the scheduled activities were not provided for residents in the specialist dementia unit. Throughout the day of inspection, the inspectors observed that a small number of residents coloured

pictures, but otherwise the social activities available on the day of inspection consisted of listening to music CDs. Residents on this unit had a range of complex needs and it was clear that they did not have access to meaningful activities in line with their preferences and ability to participate.

Residents' accommodation was arranged on ground floor level on two sides of a spacious reception area with plentiful seating. Residents' bedrooms varied in size and layout. While, the majority of residents' bedrooms seen by the inspectors had sufficient space to meet their needs, the inspectors observed that the layout of two twin bedrooms had both residents' wardrobes in one of the resident's bed space. The inspectors observed that the screen curtains were closed around one resident's bed in one of the twin rooms and the other resident could not access their clothes without entering the other resident's bed space. In addition due to the configuration of the privacy curtains, when closed, one resident could not access the en suite facility without disturbing the other resident.

Inspectors observed that access to a dementia specific unit was controlled with a coded lock. The dementia specific unit referred to as 'a special care unit' provided accommodation for 12 residents in 10 single bedrooms and one twin bedroom. The inspectors observed that the dementia unit was confined and lacked personalisation which contrasted with the bright spacious corridors and communal areas on the other two units. While, some traditional memorabilia that was familiar to residents was seen in the communal room, the corridor lacked these personal touches. A small number of residents' rooms on this unit were personalised with photographs and items of value to them, however a number of bedrooms were not personalised to promote their comfort and personality on their private space.

Resident's bedroom doors in the dementia specific unit were painted in a variety of colours and toilet seats and grab rails were in a contrasting colour to promote residents' independence and to assist them with way-finding. The inspector's observed that a bird cage with two birds was in place off the main corridor. However, the inspectors observed that residents access was hindered by storage of a hoist adjacent to this bird cage. There was only one communal room available to residents in the dementia specific unit. This room was used both as a sitting and as the dining room. It was also the only communal space available for activities to take place on the unit. There was no quiet area outside of their bedrooms for those residents accommodated on the unit who preferred or needed a low stimulus environment. Furthermore residents on this unit did not have anywhere outside of their bedrooms to meet with their visitors unless they travelled to one of the other units. The inspectors also observed that the doors to the outdoor garden were secured with a key coded lock and residents could not access the outdoor garden without the assistance of staff to open the door for them.

On the other units, the inspector observed that many of the residents spent their day in the communal sitting rooms or walking around the centre. Residents' visitors were made welcome and were seen by the inspectors coming and going throughout the day of the inspection.

Inspectors observed that several staff interactions with residents, especially in the

dementia unit and when assisting residents with eating their meals were focused on care tasks and there was limited or no social conversation with residents.

Residents told inspectors that they felt able to talk to a member of staff if they were worried about anything or were not satisfied with any aspect of the service. Residents said they believed they would be listened to and any issues they raised would be addressed to their satisfaction

The next two sections of the report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance with the regulations are set out under each section

Capacity and capability

This was an unannounced risk inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 as amended. This inspection found that significant focus and effort was now required from the provider to ensure that the management and oversight systems in place are effective in bringing the designated centre into regulatory compliance and to ensure that residents have a good quality of life and receive appropriate care and support in line with their needs.

Inspectors also reviewed the provider's progress with completing the actions in the compliance plan from the last inspection in June 2022. This inspection found that the provider had taken actions to address fire safety in the centre and to upgrade the call-bell system. However, compliance with a number of the other regulations had disimproved since the last inspection in June 2022. Inspectors also followed up on unsolicited information of concern that had been received since the last inspection. The concerns related to alleged deficits in the quality of care, residents' rights, staffing and governance and management of the service. The inspectors' findings substantiated the information received and these findings are discussed under the relevant regulations.

The registered provider of College View Nursing Home is Aspen Green Limited and further to a change of directors on the company board, the company Chief Executive Office (CEO) represents the provider. The person in charge has been in the role since June 2021 and works full-time in the centre. An assistant director of nursing supported the person in charge and provided deputising arrangements for when the person in charge was not available. Staff working in the centre who spoke with the inspector were aware of their individual roles and responsibilities.

There were comprehensive systems in place to monitor the quality and safety of the service and records showed that the auditing systems had effectively identified improvements and risks, however many of the areas identified as needing improvements had not been progressed or closed out to completion and the inspectors found that a numbers of the risks already identified by the provider had

not been effectively mitigated. This was negatively impacting on overall clinical effectiveness and on some residents' quality of life. These findings are discussed under the relevant regulations.

This inspection found that since the June 2022 inspection the provider had increased the staffing resources in the centre, however the oversight and the daily allocation of nursing staff was not effective and did not ensure residents' needs were met. Inspectors found that staff were not appropriately supervised and had not completed mandatory training to ensure that they had the necessary knowledge, skills and competencies to carry out their roles and responsibilities to the required standards. The inspectors' findings are discussed further under Regulations 15, Staffing and 16, Training and staff development.

The inspectors' observations of staff practices and discussions with some staff did not give inspectors' satisfactory assurances that they were familiar with residents' needs and were competent with carrying out their respective roles. Inspectors also found that a number of interactions by staff with residents were focused on completing care tasks. These observations were brought to the attention of the provider.

Arrangements for recording accidents and incidents involving residents in the centre were in place and were notified to the Health Information and Quality Authority as required by the regulations. The person in charge was continuing to work with staff to reduce the incidence of resident falls in the centre.

Staff working in the centre had completed satisfactory Garda Vetting procedures. The provider was not a pension agent for any residents' social welfare pensions.

Regulation 15: Staffing

The allocation of staff nurses in the centre did not ensure that there was adequate numbers of staff with appropriate skills to ensure that residents' care needs and preferences were met. The staff nurse assigned to the specialist dementia unit also had responsibility for care of residents in another unit. The other unit was located in a different but adjacent part of the building which meant that the nurse could not observe or hear what was happening on the specialist dementia unit whilst she was working on the other unit. Inspectors observed that as a result of this arrangement the nurse spent significant periods of time away from the specialist dementia unit on the second day of the inspection which meant that no nurse was available to supervise staff and residents on the unit for prolonged periods of time.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors found that staff training did not ensure all staff had the requisite skills and knowledge to provide appropriate care and support for the residents. This was evidenced by:

- A review of the staff training records found that some staff had not completed mandatory training in safeguarding vulnerable adults.
- Some staff spoken with by inspectors were not knowledgeable about the reporting arrangements in the centre regarding allegations or concerns of abuse.

The findings of this inspection confirmed that staff had training needs in the following;

- Evidence based wound care.
- Assessment and care planning.
- Dementia care.
- Supporting residents with responsive behaviours.

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of all residents. This was evidenced by:

- Poor supervision of fire safety practices as evidenced by fire doors wedged open repeatedly throughout the inspection.
- Poor supervision of care which meant that some residents' care plans were not being implemented which posed a risk to residents' health and well-being.

Judgment: Not compliant

Regulation 23: Governance and management

The management and oversight of the available resources were not effective in maintaining compliance with the Health Act 2007 (Care and Welfare of resident in Designated Centres for Older People) Regulations 2013 and ensuring that residents' care and services were delivered in line with the centre's statement of purpose. This is evidenced by;

- The high number of non-compliances found on this inspection and failure to complete the actions detailed in the compliance plan from the last inspection in June 2022
- The management and oversight of the daily nursing resources did not ensure that residents had access to the nursing care and supervision that they needed.
- Assessment of residents' dependency needs, which was also used to inform staffing resources provided was based on a functional assessment only and did not include assessment of each resident's cognitive and physical well-

being. This posed a risk that residents' needs would not be adequately met.

The management systems in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored were not effective This was impacting on clinical effectiveness and on the residents' quality of life. This was evidenced by;

- There were disparities between the high levels of compliance reported in a number of the centre's own audits and the inspectors' findings in these areas of service during the inspection.
- Evidence was not available that action plans developed to address improvements identified in the centre's own audit systems were progressed to completion

Inspectors also found that several risks were not identified and managed to ensure residents' safety and well-being. For example:

- Risks to residents found on this inspection in relation to the safe administration of medications had not been identified or managed through the provider's own medication audit processes.
- The provider had not obtained final sign-off by a person competent in fire safety to ensure that all fire safety improvement works that had been recently completed were done to the required standard and were in compliance with relevant legislation.
- The risk associated with the absence of nursing staff from the specialist dementia unit for long periods each day had not been identified and addressed by the provider.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of accidents and incidents involving residents, that occurred in the centre was maintained. Notifications and quarterly reports were submitted within the specified time frames and as required by the regulations.

Judgment: Compliant

Quality and safety

Overall, this inspection found that significant actions are now required to ensure that residents' clinical care and support needs were delivered to a good standard and that risks posed to their health and well-being were effectively mitigated. In addition

the layout of two bedrooms,one in the dementia unit and one elsewhere in the centre did not ensure that residents could carry out personal activities in private. Furthermore the provision of only one communal room on the specialist dementia unit combined with restricted access for residents on the unit to the outdoor garden was negatively impacting on the residents' choice and opportunities for meaningful activities and recreation. Focus by the provider and the centre's management team is required to bring the centre into compliance with regulations and to ensure that all residents living in the designated centre have a good quality of life.

The premises was laid out over two floors and was separated into four units areas with storage and office facilities on the first floor and resident accommodation on the ground floor. There was a secure specialist dementia unit with 12 beds where residents with complex cognitive needs were accommodated. As discussed earlier in the report the current facilities and layout of the specialist dementia unit did not provide a suitable environment for residents who were living with dementia and who needed a spacious calm environment in which they could could both mobilise safely and relax in comfort. In addition, the layout of two twin bedrooms, one of which was in the dementia unit did not ensure that the four residents accommodated in these two rooms were able to carry out personal activities in private.

The provider had progressed upgrading of the centre's fire alarm system since the last inspection and this action improved the measures in place to protect residents from risk of fire. However the inspectors found that that fire compartmentation and containment of fire and smoke was not effective as a number of fire doors were wedged open and would not close in the event of a fire emergency. In addition, not all staff had been facilitated to attend fire safety training.

Notwithstanding the infection prevention and control improvements made since the last inspection, further improvements were required to ensure residents were protected from the risk of infection. These findings are discussed further under Regulation 27

The inspectors' found on this inspection that residents clinical and support needs were not effectively met. For example not all residents had a comprehensive assessment completed to identify their clinical, support and social care needs. Furthermore, improvements were required to ensure that care plans were person centred and that care interventions were informed by residents individual preferences and wishes. This inspection also found that some residents needs were not informed by a care plan and where care plans were in place, inspectors found a number of instances where these care plans were not being appropriately implemented by staff.

Residents had access to their general practitioners (GPs), specialist medical and nursing services including psychiatry of older age, community palliative care and allied health professionals,however referrals to these services were not always timely which resulted in poor outcomes for some residents' health, well-being and quality of life.

Although residents received the correct medications, inspectors' observation of

nursing practices showed that administration of residents' medicines was not in line with professional standards and required improvement. This finding is discussed under Regulation 6, Health care.

While the incidence of residents developing pressure related skin wounds in the centre over the past 12 months was low, care of residents wounds was not in line with evidence-based wound care procedures and with the guidance of a tissue viability specialist expertise.

Most residents outside of the dementia unit had opportunities to engage in varied meaningful activities that met their interests and capabilities. Residents' in the dementia unit and residents elsewhere in the centre with mental health and cognitive needs were not adequately supported by staff to participate in a social activity programme that met their interests and capabilities. This finding is discussed under Regulation 9: Residents' rights.

Residents had access to religious services and were supported to practice their religious faiths in the centre. Residents' meetings were regularly convened and there was evidence that issues of concern raised by residents were generally progressed. Residents had access to local and national newspapers, televisions and radios.

While measures were in place to protect residents from risk of abuse some staff had not been facilitated to attend mandatory safeguarding training in line with the centre's own training requirements. The inspectors also found that some staff did not have the appropriate knowledge and skills in relation to their responsibility to report any safeguarding concerns they might come across in their work.

Whilst there was a positive approach to care of residents predisposed to experiencing episodes of responsive behaviours, the documentation of their care needs and the interventions required to support them required improvement.

Regulation 11: Visits

Visits by residents' families and friends were encouraged and practical precautions were in place to manage any associated risks to ensure residents were protected from risk of infection. Residents could meet their visitors in private in an area outside of their bedroom if they wished to do so.

Judgment: Compliant

Regulation 17: Premises

The registered provider failed to ensure that the premises was appropriate to the

number and needs of the residents. This was evidenced by;

- The layout and design of the dementia unit did not provide residents with adequate dining, sitting and recreational facilities. The dementia unit accommodated 12 residents and the only communal room available to them in the unit measures 38.70 square meters. This communal room functioned as the residents' dining, sitting and recreational room and did not provide adequate space for residents to comfortably rest, dine and participate in social activities. This was a finding from the last inspection in June 2022.

The registered provider failed to ensure that the premises conformed to the matters set out in Schedule 6 of the regulations. This was evidenced by:

- There was insufficient storage space for residents' assistive equipment in the dementia unit which meant that a hoist was stored along the corridor. This hindered residents' access to the handrail and to a birdcage in the dementia unit and posed a risk of falling and injury to vulnerable residents.
- Storage of residents assistive equipment was observed in a communal shower/toilet in another part of the centre.
- The floor surface in the hairdressing room was damaged and therefore could not be effectively cleaned. This was an action on the centre's maintenance programme and was a finding from the last inspection ,with a planned completion date of 31 December 2022.
- A pull-cord system in operation to switch on lighting in the communal toilets and showers was not adequate and in the absence of a risk assessment completed for each resident, did not optimise residents' independence or safety from risk of falling.
- The call bell system in use on the day of inspection was not fit for purpose. This was a finding from the last inspection. The inspectors were told by the new provider representative that installation of a new call bell system had been completed and would be operational on the day following the inspection.
- Paint was damaged and missing from the surfaces of some residents' bedroom doors and therefore did not support effective cleaning. An area of the floor covering was missing in one resident's bedroom and the floor covering was lifting in an area of one dining room.
- Grabrails were not in place on one side of several toilets used by residents. This posed a risk of falling to vulnerable residents and did not promote residents' independence.

Judgment: Not compliant

Regulation 27: Infection control

The provider did not ensure that infection prevention and control procedures were consistent with the national standards for infection prevention and control in

community services published by the Authority. This was evidenced by:

- Floor surfaces in a communal dining room and a communal sitting room were visibly unclean.
- There was poor oversight of the cleaning procedure and the quality of environmental hygiene. For example, inspectors observed that a table surface which was stained after resident use was not cleaned between meals. This posed a risk of cross contamination.
- While there was a tagging system in place to show which equipment was decontaminated after use between residents, inspectors were not assured that this system was effective. Inspectors observed that tags were not removed from equipment between use by residents. The dates on tags viewed by inspectors indicated that not all equipment was decontaminated at regular intervals.
- Although, there was a sink designated for hand hygiene by staff in the clinical room, this was a domestic style sink and did not meet clinical hand hygiene sink specifications. The inspectors were told that replacement was scheduled in the days following the inspection.
- Hand hygiene sinks were not available outside of those provided in residents' bedrooms and communal bathrooms/toilets which meant that the sinks in residents' bedrooms were serving a dual purpose, as facilities for residents' personal hygiene needs and as hand hygiene facilities for staff. This posed a risk of cross contamination and did not support effective hand hygiene procedures.
- Infection prevention and precautions and practices in place did not reflect national guidance on care of residents colonised with Extended-Spectrum Betalactamase (ESBL). ESBL are bacteria that mostly live harmlessly in the gut (colonisation). Rarely people that are colonised can develop an infection. If a resident is a carrier or is colonized with ESBL they can spread the bacteria).

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed a number of residents assessment and care plan documentation and found that significant actions by the provider and person in charge were necessary to ensure residents needs were appropriately assessed and that care plans were developed and implemented to address any needs identified. This was evidenced by the following findings;

- Comprehensive assessments were not completed for a number of residents. This meant that not all these residents' needs were identified and as such a number of these residents did not have a care plan in place to address all of their needs. For example;
    - One resident who reported that they were experiencing pain had not

had an assessment of their pain completed since 29 January 2022.
    - Some residents did not have their social activity needs assessed and did not have a social care plan in place to inform their access to activities to meet their interests and capacities.
    - One resident known to be colonised with an MDRO (Multi-drug resistant organism) did not have their infection prevention and control needs assessed and they did not have a care plan in place that set out all of their care needs and interventions required. As a result this resident was not accommodated in a single bedroom with appropriate toileting hygiene procedures in place to prevent cross infection.
    - One resident with a discharging wound did not have their wound care needs assessed and did not have an up to date wound care plan in place to inform nursing staff what dressings and interventions were required. In addition information in relation to wound progress was not available.
- Where care plans were developed, the inspectors found that some residents' care plans were not being implemented by staff. For example;
    - One resident who was assessed as having a high risk of falls and needed supervision by staff was observed by inspectors to be unsupervised on several occasions during the inspection.
    - One resident who was assessed as being at high risk of unintentional weight loss and malnutrition and required supervision and encouragement with their meals. Inspectors observed that the resident was not supervised by a member of staff during their lunch or tea-time meals on the day of inspection.
    - Two residents' care plans stated that they should drink 1500-2000mls over each 24 hour period to ensure their health and well-being. However, these residents' fluid intake records evidenced that their fluid intake requirements were not met. Although staff were aware, of that the residents' fluid intake was not in line with their care plan goal, there was no evidence that this was reported to nursing staff and that any remedial actions were being taken by staff.
    - One resident with care plan to prevent constipation had not had a bowel movement for eight days. Treatment given on two occasions was not effective and there was no evidence of further actions taken by staff to address this resident's needs. Furthermore there was no evidence that this had been reported to the resident's general practitioner (GP).
    - A resident with unintentional weight loss did not have weekly weight monitoring completed in accordance with their care plan.

Judgment: Not compliant

Regulation 6: Health care

Nursing practices in relation to the management of residents' wounds and safe

administration of medicines in the centre did not ensure that residents received a high standard of evidence based nursing care to meet their needs. This is evidenced by the findings set out below;

- Nurses were not referring to a prescription signed by a doctor to inform their administration of residents' medicines. Residents' medicine prescription that were signed by the doctor were retained in an office and nursing staff referred to records of residents' medicines prepared by the pharmacist. This finding is repeated from the last inspection in June 2022.

The inspectors found that residents were not being referred for medical review by their GP in a timely manner. For example;

- Residents who were not able or were not compliant in taking their recommended fluid intake were not referred to their GP for review.
- A resident who had expressed they were in pain did not have a medication review to reassess their requirement for increased/alternative analgesia,
- There was delay in referring one resident with an exudating wound that was not healing for a specialist tissue viability nursing assessment.
- A resident who was not eating and at significant risk of poor health outcomes was referred back to the dietician for a review on 07 July 2022 and at the time of the inspection the resident was still waiting to be seen. There was no evidence that staff had followed up with dietetics to ensure that the resident was seen and reviewed.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Inspectors found that one resident's responsive behaviours were not being managed appropriately and this was posing a risk to their health and well being. The resident spent long periods in their bedroom and was also refusing their meals on a regular basis. As a result the resident was becoming increasingly isolated and was losing weight.

Further to review of the staff training records, inspectors found that the majority of staff had not been facilitated to attend training on managing responsive behaviours. Inspectors observed that staff did not demonstrate appropriate skills and knowledge to support some residents who displayed high levels of responsive behaviours.

The doors from the specialist dementia unit to the enclosed garden were secured by a key-code which meant that most residents accommodated on this unit were restricted from accessing their outside space without a member of staff to open the key coded exit door. In addition the exit door from the dementia unit to the other units and communal spaces in the designated centre was similarly locked with a key code system. The key codes were available by the doors for those residents who

could read and understand how to use the information however, no residents were observed to be independently using the key pads to leave the unit on either days of the inspection. Inspectors found that residents did not have an appropriate risk assessment to indicate why these restraints were needed and what if any alternatives had been trialled for each resident. As a result inspectors were not assured that the locked exit doors were being managed in the least restrictive manner.

Judgment: Not compliant

Regulation 8: Protection

The provider had not taken all reasonable measures to ensure residents were protected from risk of abuse. For example;

- Four staff had not been facilitated to attend safeguarding training.
- A number of staff spoken with by inspectors were not knowledgeable regarding the arrangements in place to report concerns or allegations of abuse.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents who were accommodated in the specialist dementia unit did not have access to suitable facilities for recreation and occupation. Although, an activity schedule was displayed in the unit, this schedule was not provided for the residents and they spent ling periods of the day with little to do and no access to meaningful activities in line with their preferences and capacity to participate.

Residents with higher levels of social and cognitive needs who did not attend the communal rooms on the other three units and spent their days in their bedrooms were not adequately supported to participate in meaningful social activities to meet their interests and capacities.

Residents' rights were negatively impacted by the layout of two twin bedrooms viewed by inspectors. For example;

- In one room when the bed screen curtains were closed around the second bed nearest to the window, the resident in the first bed bed nearest to the door was devoid of natural light and could not see out of the window without encroaching on the other resident's bed space.
- In another room the configuration of the privacy curtains did not divide the space available to both residents equally. This meant that the reduced bed

space available to one resident did not provide enough room for two staff to work with the resident when they were providing personal care for this resident without potentially compromising this resident's privacy and dignity.

Residents rights to exercise their choice was impacted by the following;

- As there was only one communal room available on the dementia unit which was busy and crowded, those residents who wished to access a quiet space within the dementia other than their bedroom were not able to do so. In addition the door to the gardens were locked which meant that residents on this unit were not able to choose to go outside without a member of staff being available to open the door for them. These were repeated findings from the last inspection in June 2022. This was also a finding from the last inspection.
- Residents in twin bedrooms shared one television. This did not support both residents' choice of programme viewing or listening.

Judgment: Not compliant

Regulation 28: Fire precautions

Action was required by the provider to ensure adequate precautions were in place to protect residents and others from the risk of fire and compliance with Regulation 28. This was evidenced by;

- Inspectors found that doors to some communal rooms were wedged open. This meant that the self closure devices were ineffective and the doors would not close in the event of a fire in the centre.
- Electrical extension leads were in use in a number of areas and posed a risk of fire.
- The smoking room in the centre was in use by a small number of residents and there was no fire blanket available in this room.

Four staff had not completed up-to-date mandatory fire safety training. The inspectors were told that training for these staff was scheduled in November 2022.

Judgment: Substantially compliant

Regulation 12: Personal possessions

One resident in a twin bedroom in the dementia unit could not maintain control of their personal clothing and possessions because their wardrobe was located within the other resident's bed space. In addition their bedside locker was located along the wall opposite their bed which meant that they could not access their belongings

when they were in bed. Some residents in twin bedrooms did not have a suitable shelf surface for them to display their personal photographs in their bedrooms if they chose to do so.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 12: Personal possessions	Substantially compliant

Compliance Plan for College View Nursing Home OSV-0000128

Inspection ID: MON-0037477

Date of inspection: 25/11/2022

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: - A review has been completed in the centre following the inspection. This was completed over the first two weeks in November by Senior Management. The review showed that there is adequate staffing in the centre however, an adjustment to allocations was completed to ensure adequate staffing and skill mix throughout the centre. This is reviewed on a daily basis by the Senior Management team. The allocations and changes made are now reflected in the staff rosters. - The centre has a continuous recruitment process in place for all roles. - A protocol is in place when unplanned staff illness occurs which follows a contingency plan for staffing. - The plan for decommissioning the Special Care Unit is in place for completion by March 31st 2023. In the meantime, the reallocation of staff and skill mix will remain in place from the review of staffing but will be further reviewed following the decommissioning.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: - All staff currently working in the centre have completed Safeguarding training and this was completed by December 16th 2022. - In addition to online training in Safeguarding being provided to all staff, informal refresher education is also being provided to all staff through the delivery of brief, informal education sessions delivered by the management team. This is being completed by December 31st 2022. - An audit on staff understanding of safeguarding will be undertaken by January 31st	

2023. This will identify any potential gaps in education in relation to safeguarding and managing incidents. Gaps will be identified and one to one education sessions will be completed by the Senior Management Team as required.
- A full review will be undertaken of the training matrix to identify any training needs for staff such as wound care, care planning etc. A schedule of training will be developed in line with these findings and delivered on an ongoing basis to all staff. This will be completed by January 31st 2023. Training in wound care, assessment and care planning, safeguarding and dementia training will be completed by March 31st 2023. Ongoing audit processes within the home will assist in the identification of any potential gaps in training required by staff and regular feedback from all audits will be provided to all staff at staff meetings.
- A full review of the governance structure within the home has been completed within the centre. The organisational structure will be updated to include the Senior Household Coordinator whose role is to assist with the supervision of care staff in the centre in collaboration with the Director of Nursing, The Assistant Director of Nursing, Staff Nurses and Senior HCAs (Team Leads on Daily Basis).
- Staff nurse and non clinical staff meetings will be held to explain the updated structure and clarify roles and responsibilities of all staff within the centre. These will be completed by January 31st 2023.

- A review will be undertaken of the formal performance management processes within the home, to ensure that feedback and support is provided to staff in both informal and formal capacity. This will be completed by February 28th 2023.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
- A full review will be undertaken of each individual management role within the centre to ensure absolute clarity in the roles and responsibilities they each have in the delivery of effective governance and management in the centre. This will be completed by March 31st 2023.
- A fortnightly Senior Management Team meeting will be held to identify progress in non -compliances identified in internal audit and external inspections. Each area of non - compliance will identify a person responsible and timeframes and ongoing monitoring to ensure improvements identified are progressed to completion. These commenced in January 2023.
- As previously discussed under Regulation 15 Staffing review of staffing and allocations are conducted on a daily basis and changes made reflected in the staff rosters.
- The evidence based Modified Barthel tool is being utilised in the centre to assess dependency levels in addition to other assessments such as the comprehensive assessment, 'A Key To Me', mobility assessment, skin assessments, continence assessments, and cognitive assessments that incorporate assessment of the residents

cognitive and physical needs. These assessments directly inform the needs of the residents and the required resources. As previously stated this is reviewed on a regular basis.
- Training for all staff who complete audits within the centre will be provided and ongoing support in place to ensure consistent and effective monitoring of the service. This will be completed by March 31st 2023.
- A full review will be undertaken of the risk register and risk management practices within the centre. This will be completed by March 31st 2023. Any required actions identified through this process will be monitored and continuously assessed and control measures implemented.
- On the day of inspection fire safety improvement works were ongoing in the centre and these have subsequently been signed off by a competent fire safety expert. These were made available to us on the 27th of October 2022.
- As outlined in response to Regulation 15- Staffing, a review was undertaken of staffing and staff allocation within the centre and necessary amendments made to the allocation of staff across all units. This is monitored on a daily basis by the Senior Management Team.
- A review was undertaken of the processes in place in the home in relation to administration of medications within the home. This is to ensure that all prescribed medications are checked against the signed prescriptions at the point of administration. All staff have been educated on this change in process and audits will be completed to ensure ongoing compliance with this process. This was completed in December 2022.

- All of these actions under this regulation will be discussed as outlined above at fortnightly Senior Management Team meetings to ensure that action is being taken to bring this regulation into compliance.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
- A review of the dining practices within the home was completed in November 2022. Additional sittings were implemented in all dining areas of the home to ensure that every resident can sit and enjoy their meal in communal dining areas if that is their choice.
- To come into compliance with Regulation 17 the Special Care Unit will be decommissioned following consultation with all families of residents in this unit. There will no longer be a designated, dementia specific unit in the centre. All residents in this unit will be integrated as part of the overall facility, with access no longer restricted and they will be encouraged to move freely throughout the facility. This will be completed by March 31st 2023.
- Communal space throughout the facility has been reviewed to ensure that following the decommissioning of the Special Care Unit that all residents will be afforded equal opportunity to access the adequate communal space of the facility in line with their own preferences. This was completed in December 2022.
- A full review will be undertaken of storage facilities within the centre and risk assessed

to ascertain any additional areas suitable for storage. In the absence of this, control measures will be put in place to ensure that equipment is not left in areas where it will be blocking resident access to handrails. This will be completed by March 31st 2023.
- A review has been undertaken of storage facilities in the centre and storage solutions identified in the Special Care Unit to ensure adequate storage space is in place for resident assistive equipment. This will be completed by February 28th 2023.
- The hoist has identified storage space within each unit. This was completed January 2023.
- The floor surface in the hairdressing room has been replaced. This was completed by November 7th 2022.
- A full review is being undertaken of the light pull cords in place in communal bathrooms, the replacement of 6 with motion sensors is scheduled for completion by January 14th 2023. The total number of 14 light pull cords will be completed by January 31st 2023. Any resident who uses the communal toilets or showers have had a risk assessment completed to ensure they can safely use the pull cord system in place at present. These were in place on the day of inspection. Support and education will be provided to these residents to ensure they can safely use this system while awaiting review.
- A new call bell system has been installed and is operational within the centre. This was completed in November 2022.
- A review was undertaken of any required painting and decoration within the centre and an ongoing plan of works developed with the maintenance team to ensure required works throughout the home are addressed going forward in a timely and effective manner. The painting and decorating needs in the Special Care Unit are underway and are to be completed by February 28th 2023.
- A review will be undertaken of all bathrooms to define the requirements for each bathroom. A works plan will be put in place to ensure that grabrails are in every bathroom in the centre which does not currently have one and this will be completed by March 31st 2023.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
- The quality of cleaning and oversight of cleaning procedures within the home was immediately addressed with the hygiene team on the day of inspection. This will be supported going forward by increasing audits conducted on cleaning processes and the documentation of same within the centre. All hygiene staff within the centre have completed certified Clean Pass training. Oversight of cleaning processes will be supported on a daily basis by the Senior Management team through regular supervision and feedback. This will be completed by January 31st 2023.
- To support the effective use of a tagging system for cleaning in the centre, informal education and communication to all staff about the correct use of the process will be supported by the Senior Management Team. Regular spot checks will also be conducted

to ensure adherence to the process. This will be completed by January 31st 2023.
- Replacement of sink in clinical room and insertion of additional handwash sink into it-review is in process and a plan to replace the sink will be completed by June 30th 2023.
- A full review will be undertaken of clinical sink facilities in the centre to assess the locations of additional handwash sinks being placed in the centre. The sinks will be in place in the centre by June 30th 2023.
- A review was undertaken of practices in place for the management of any resident with ESBL in the centre to ensure that it is in line with current guidance. This was completed by November 2022.

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:
- A full review will be undertaken of the care planning and assessment process in the centre to ensure that it is completed for each individual resident with increased frequency of audit to ensure adherence to the process as outlined in regulation, to ensure that every resident has person centred and specific care plans in place in line with their personal choices. This will be completed by March 31st 2023.
- Care plan training will be delivered for all staff to ensure they understand the process of assessment and care plan development in line with regulation. This will be delivered in person, with support of online training if necessary. This will be completed by March 31st 2023.
- A review of any resident experiencing pain has been completed to ensure that appropriate assessments and care plans are in place for them to support their treatment needs. This was completed by December 1st 2022. Any changes to care plans are communicated on an ongoing basis to all staff to ensure their understanding of same.
- A review was undertaken on the documentation of activities by staff to ensure that it is standardised for all residents and captured appropriately. Audits will be undertaken of all PAL assessments and 'A Key to Me' assessments for all residents within the centre to ensure they are updated regularly and in line with the individual needs of each resident. This will be completed by March 31st 2023.
- Any resident with an MDRO has had their IPC needs assessed and appropriate care plans are in place in line with their needs. This was completed in December 2022. Any changes to care plans are communicated on an ongoing basis to all staff to ensure their understanding of same.
- Every resident who requires a wound care plan has been reviewed and their needs identified and documented clearly in their care plan. This was completed in December 2022. Any changes to care plans are communicated on an ongoing basis to all staff to ensure their understanding of same.
- A full review will be undertaken of the current care plan development process in the centre to ensure that all care plans are in line with resident choice, their care needs are identified and person centred. This will include a review of the documentation,

assessment processes, communication with all team members, involvement of resident and their families in the process, escalation process for all concerns and the ongoing audit and review of this process. This will be supported by education for all staff by the Senior Management Team. Increased review and audit will be implemented to support this change. This will be complete by June 31st 2023.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
- A review was undertaken of the processes in place in the home in relation to administration of medications within the home. This is to ensure that all prescribed medications are checked against the signed prescriptions at the point of administration. All staff have been educated on this change in process and audits will be completed to ensure ongoing compliance with this process. This was completed in December 2022.
- GPs review residents weekly within the home or sooner if indicated. A full review will be undertaken of all referral processes within the home to ensure that all residents are referred for medical review in a timely manner and in line with their changing needs. This will be completed by March 31st 2023.
- Additional audits to be completed to ensure referrals happen appropriately and in an effective and timely manner in the centre for all residents and that the feedback from consultations will be documented and communicated to the resident, staff and family members where appropriate. This will be completed by March 31st 2023.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
- Education for all staff to support them in managing behaviours that challenge will be provided to staff through both formal and informal education sessions e.g online education, toolbox talks and the engagement with Psychiatry of Old Age services to attend scheduled training by them in 2023. This is ongoing but will be completed by June 30th 2023. This will be supported through supervision of all staff by the Senior Management Team as well as ongoing audits to ensure staff demonstrate appropriate skills and knowledge.
- The resident who was experiencing responsive behaviours has ongoing review by the Psychiatry of Old Age Team and Behavioural psychiatrist as well as other members of the multidisciplinary team such as OT and dietician. An MDT meeting was held with them on 13/12/22. SAGE advocacy services were also provided to the resident. Any

recommendations made by the MDT are in place for this resident and ongoing review and engagement with them in her plan of care is underway. This resident is for further review by Psychiatry of Old age in January 2023.
- Risk assessments have been completed in the centre to facilitate the door to the garden in the Special Care Unit to remain open, ensuring residents can access this space freely in line with their preferences. This was completed January 2023 and has been clearly communicated to all staff. Ongoing monitoring of this practice will be undertaken by the Senior Management Team to ensure restraint is not used inappropriately. Furthermore, planned decommissioning of the Special Care Unit as outlined in responses above will ensure that all residents have freedom of access to communal spaces throughout the facility.
- A risk assessment has been put into place and education provided for all residents who have capacity to utilise the keypad doors and ensure they can independently do so, allowing them to move freely through the facility. This was completed in January 2023.
- Any instance of restraint will be reported to the Inspector through quarterly notifications, with ongoing review by the Management Team to ensure that it's use is monitored on an ongoing basis.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
- All staff in the centre have completed Safeguarding training by December 16th 2022.
- Informal refresher training in relation to safeguarding is being provided by the management on an ongoing basis for all staff in the centre. December 31st 2022. These sessions will be delivered by the team ensuring that staff are afforded the opportunity to ask questions or voice any uncertainties they may have in relation to safeguarding.
- An audit on staff understanding of safeguarding will be undertaken by January 31st 2023. This will be completed through face-to-face sessions with staff. This will identify any potential gaps in education in relation to safeguarding and managing incidents. Gaps will be identified, and one to one education sessions will be completed by the Senior Management Team as required.
- Safeguarding will be a set agenda item at all staff meetings to ensure the open and transparent communication of safeguarding concerns. This was completed November 2022.
- Safeguarding and advocacy service information is provided to residents at all resident committee meetings. This will continue within the centre.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
- The Special Care Unit will be decommissioned following consultation with all families of residents in this unit. There will no longer be a designated, dementia specific unit in the centre. All residents in this unit will be integrated as part of the overall facility, with access no longer restricted and they will be encouraged to move freely throughout the facility. This will be completed by March 31st 2023.
- Each resident with social and cognitive needs will be reassessed to ensure that they can participate in activities in a meaningful way. This will completed through PAL assessment and 'A Key to Me' assessment. This will be completed by February 28th 2023.
- Communal space throughout the facility has been reviewed to ensure that following the decommissioning of the Special Care Unit that all residents will be afforded equal opportunity to access the adequate communal space of the facility in line with their own preferences. This was completed in December 2022
- A review is being undertaken of all double rooms in the centre to ensure optimised space for the privacy and dignity of all residents. Any required action to ensure the optimisation of privacy and dignity for all residents from this review will be completed by March 31st 2023.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
- All wedges across the centre were removed on the day of inspection to ensure that this process ceased within the centre. Daily checks on this is completed by the management team to ensure adherence, and ongoing communication to all staff about the importance of ceasing this practice is ongoing. This was completed December 2022.
- The use of extension leads is currently risk assessed within the centre to minimise any potential risk of use. Additional plug points will be inserted in areas in line with a risk assessment to ensure there is adequate plug points to control the use of extension leads. This will be completed by June 30th 2023.
- A fire blanket was put in place in the smoking area on the day of inspection.
- All staff have completed fire safety training within the centre as of November 10th 2022.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
- A review is being undertaken of all double rooms in the centre to ensure optimised space for the privacy and dignity of all residents. Any required actions that need to be

taken to address the optimisation of space will be completed by March 31st 2023.
- Additional storage solutions will be identified in shared rooms to ensure residents have adequate space for personal belongings. This will be completed by February 28th 2023.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	31/03/2023
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes	Substantially Compliant	Yellow	28/02/2023

	and other personal possessions.			
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/03/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/03/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/03/2023
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	31/03/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Not Compliant	Orange	31/03/2023

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/03/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/06/2023
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.	Substantially Compliant	Yellow	30/06/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the	Substantially Compliant	Yellow	30/11/2022

	designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/03/2023
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	31/03/2023
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social	Not Compliant	Orange	31/03/2023

	care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
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 that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/03/2023
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.	Substantially Compliant	Yellow	31/03/2023
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a	Not Compliant	Orange	31/03/2023

	high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	31/03/2023
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	30/06/2023
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is	Not Compliant	Orange	31/03/2023

	not restrictive.			
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	31/03/2023
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	31/12/2022
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	31/03/2023
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	Orange	31/03/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with	Substantially Compliant	Yellow	31/03/2023

	the rights of other residents.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/03/2023