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:	St. Theresa's Nursing Home
Name of provider:	Camillus Healthcare Limited
Address of centre:	Dublin Road, Thurles, Tipperary
Type of inspection:	Unannounced
Date of inspection:	12 November 2020
Centre ID:	OSV-0000434
Fieldwork ID:	MON-0030886

About the designated centre

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

St. Theresa's Nursing home was established in 1980 and is located on the outskirts of the town of Thurles in close proximity to shops, restaurants and other facilities. It is a two-storey premises with bedroom accommodation on both floors and communal accommodation on the ground floor only. Accommodation on the first floor comprises five single rooms and five twin bedrooms. Two single bedrooms on the first floor have full en suite facilities with toilet, shower and wash hand basin and all of the other bedrooms have wash hand basins in the room. Access to the first floor is by stairs and chair lift. Accommodation on the ground floor comprises 12 single and four twin rooms with two bathrooms and one toilet. Sanitary facilities comprise three assisted bathrooms on the ground floor, each of which have an assisted shower, a toilet and a wash hand basin and a separate toilet with hand basin.There is a dining room adjacent to the kitchen on the ground floor. Communal space consists of two sitting rooms and a separate room that can be used by visitors. There is also a nurses' office on the ground floor that is located in close proximity to the communal living rooms. There is an outdoor area with suitable patio type furniture. The provider is a company called Camillus Healthcare Limited. The centre provides care and support for both female and male residents aged 18 years and over. Residents 50 years and over with dementia and or a physical disability can also be accommodated. Care is provided for residents over age of 50 years requiring convalescent, respite and palliative care. Pre-admission assessments are completed to assess each resident's potential needs. Based on information supplied by the resident, family, and / or the acute hospital, staff in centre aim to ensure that all the necessary equipment, knowledge and competency are available to meet residents' needs. The centre currently employs over 30 staff and there is 24-hour care and support provided by registered nursing and healthcare assistant staff with the support of housekeeping, catering, administration, laundry and maintenance staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	27

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 12 November 2020	10:00hrs to 18:30hrs	Helena Grigova	Lead
Thursday 12 November 2020	10:00hrs to 18:30hrs	Mary O'Donnell	Support

What residents told us and what inspectors observed

Inspectors met all the residents and spoke with residents who were willing and able to converse. The feedback from residents was positive. This was a nice place to live, the food was good and staff were friendly and kind. Residents acknowledged that COVID-19 had impacted on their quality of life but they felt lucky that the centre had not experienced an outbreak.

Inspectors saw that the centre is located on the Dublin road close to Thurles and in close proximity to a hotel where residents used to enjoy going before the pandemic. Inspectors arrived unannounced and saw that residents had taken their breakfast. Residents were satisfied that breakfast was served until 10:15 hours and they could breakfast in their rooms or in the dining room. Some residents were in the day room, others were in bed or just getting up and other residents were watching television in their room. The inspectors noted each bedroom had a wall clock and a wall mounted television set. Many of the bedrooms were personalised with pictures, ornaments and family photographs. Resident's bedroom accommodation was provided on both floors. The person in charge and staff assured the inspectors that only mobile residents were accommodated in a number of bedrooms upstairs that had additional steps up to them and all residents on the first floor were assessed to ensure that they could safely use the stair lift. Residents' had personal emergency evacuation plans and mobility, moving and handling assessments which were kept downstairs in the nurses' office. These were no copies available to staff in the resident's room to ensure that they were fully informed to provide safe care. This would have implications if agency staff or relief staff were employed in the event of a COVID-19 outbreak.

Inspectors saw that there was a set activity schedule for each day on a clip board in the nurses' office. Activities included stretching exercises, arts and crafts and board games. Information on residents' backgrounds, lifestyles and hobbies was not evident in the residents' files and it was not evident that residents' interests and capabilities informed the activity schedule. Health care attendants were delegated responsibility for activities each day. They said they did not assess resident's ability to engage in an exercise programme or other activities. Nor did they document each resident's level of engagement in the activities they provided.

One lady said she remained in her room because she enjoyed watching television and she felt safer there. Some residents enjoyed reading and they said that staff had kept them supplied with books during the lock-down. Two residents who enjoyed crochet and knitting said they were fortunate to have hobbies to keep them occupied. One male resident entertained the residents and staff with a tune on his mouth organ, He said playing music was the thing he enjoyed most. Some residents said they were grateful for mobile phones, Skype and technology which helped them to stay in contact with their families. Residents reported that their views were listened to and since residents meetings were no longer held they often shared their views with the person in charge and they felt they were listened to and that issues

or suggestions made by the residents were acted on.

Residents were complimentary about the food and said they were offered choice at all meals. Inspectors saw that the lunch and desert served during the inspection was both appetising and in good portions. Most residents had dinner in the dining room or in the communal rooms so that they could maintain a social distance. There was very little conversation between residents at lunchtime but staff sat with residents who required assistance and tried their best to encourage conversation and social interaction. A few residents choose to have their meals in their rooms. Inspectors noted the meals were served hot and they saw staff offering resident's deserts and drinks and checking if they had what they required. Residents spoken with confirmed that food portions were plentiful and drinks and snacks were available between meals and at night time.

Inspectors observed that staff knew residents well and engaged with them in a personal, meaningful way by asking about their well being, their families and meals. Residents told inspectors that they had good relationships with staff and found them very helpful. All the residents who spoke with inspectors were very complimentary about the staff. Residents were disappointed that visiting restrictions were in place. One resident said she gave up on window visits because they were not the same. Her family live outside the county so they cannot call to see her. She speaks with them daily on the phone, but she lamented that there was so little happening, they sometimes had very little to talk about.

Inspectors saw that residents were supported by staff to access telephones, IT communications and newspapers and enjoyed religious services on the television.

Capacity and capability

The centre is owned and operated by Camillus Healthcare Limited who is the registered provider. The company is made up of two directors one director is the provider representative (RPR) and she is involved in strategic management of the centre. As person in charge she is also responsible for the day to day running of the centre and works from Monday to Friday and is on call at the weekends. She is supported in her role by an acting nurse manager (CNM), a team of nurses, health care staff, housekeeping and catering staff. The CNM works night duty and deputises in the absence of the person in charge. The person in charge also works as a nurse providing direct care to residents. She is responsible for the induction and supervision of staff as well as aspects of staff training.

Inspectors acknowledged that residents and staff living and working in centre have been through a challenging time and they have been successful to date in keeping the centre COVID-19 free. Regular swab tests had confirmed all staff to be negative for COVID-19 and a number of the required precautions were in place to prevent infection. However, the inspectors identified that improvements were required in a number of infection control practices and in the centres preparedness for an

outbreak of COVID-19. Following the inspection a self-referral was made to the HSE infection control team for a review of the centre following the inspection as recommended by the inspectors to ensure compliance with the national guidelines including the Health Protection Surveillance Centre (HPSC) Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities.

This was an unannounced risk inspection to monitor compliance with the care and welfare of residents in designated centres for older people, regulations 2013. Inspectors followed up on a piece of unsolicited information which raised concerns regarding inadequate staffing, lack of activities and training for catering staff. Inspectors found evidence that the staff who worked in catering had food handling training completed. Staffing was found to be inadequate and the person in charge were unable to provide information about what training health care staff had to support them to provide suitable activities for residents.

Although residents were complimentary about the care and service provided in the designated centre, inspectors found that there was not a robust management structure with good governance and effective oversight to ensure that service was provided for residents in line with designated centre's statement of purpose. The registered provider representative/person in charge (PIC) was present on the inspection and was the only nurse on duty until 14:00 hours. A Clinical Nurse Manager (CNM 2) who deputised for the person in charge had recently stepped down and another nurse was appointed in her place as Acting CNM (ACNM) to deputise for the person in charge. However, the staff roster for three weeks showed that the person in charge worked five shifts a week for six hours a day. She was the only nurse on duty on seven of the fifteen shifts that she worked. The clinical nurse manager worked three night shifts per week and had limited availability to support the person in charge. Inspectors found that the current management structure did not support strong governance and did not ensure that the service is consistently and effectively monitored.

The staffing resource was inadequate. The person in charge confirmed that two staff were on sick leave and staff recruitment was ongoing. Two nurses were recently recruited. One of whom was working as a healthcare assistant (HCA) while awaiting her registration with the Nursing and Midwifery Board of Ireland (NMBI). The second nurse was expected to begin employment in December. A staff member who previously worked full time as a healthcare assistant confirmed that she moved to laundry work two years ago. She was currently covering some HCA shifts in addition to her laundry duties.

Inspectors found that staff had good access to online training, however records showed that not all staff completed a range of mandatory and additional training. Inspectors were not assured that staff were sufficiently knowledgeable to undertake wound care assessments and or to complete nutritional assessments for residents who were unable to sit in the chair scales. Supervision to ensure that staff training was implemented in practice was also weak. Inspectors found evidence that good manual handling practices were not consistently adhered to.

Inspectors concluded that significant improvement was required to ensure that those in charge are monitoring the service and have the necessary oversight to ensure that residents are receiving a safe and appropriate service. Following the inspection the provider was issued with an urgent compliance plan to address concerns relation to regulations 23 Governance and Management, regulation 15 Staffing, regulation 27 Infection prevention & control and regulation 28 Fire precautions.

Regulation 15: Staffing

Inspectors found that the centre was not sufficiently staffed to cope with an outbreak of COVID-19. The centre was not set up to respond to, contain or manage a COVID-19 outbreak. The staffing model required one nurse on duty to provide nursing care to the residents as well as supervise health care and cleaning staff. Staff were assigned to teams in the morning but they worked with all the residents during the day. Staff also held multiple roles for example a staff member provided direct to residents and then worked in the laundry in the afternoon. Health care staff on night duty also did cleaning duties in communal areas. These practices could impact on the containment of infection if there was an outbreak in the centre.

Inspectors reviewed three weeks rosters and noted that the person in charge was the only nurse on duty on 7 of the 15 shifts she worked. A situation where the person in charge provides direct care to residents poses an additional risk in relation to the management of the centre, if the person in charge became ill or had to self isolate. The provider was issued with an urgent action plan to review the staffing levels and the staffing model in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Training in infection prevention and control, including hand hygiene and the donning and doffing of PPE was provided through HSE online training. A record was maintained of staff attendance at these mandatory training sessions. Inspectors observed good practice in relation to hand hygiene and staff using PPE.

Staff had access to a suite of on-line training. Mandatory training including safeguarding training, fire training and moving and handling training were provided on-line to staff. Computerised records to confirm that all staff had completed on line training were not available on the day of inspection, however it was submitted to the chief inspectors office post the inspection. On-line training was not followed up to ensure that staff had the necessary knowledge or to discuss how the training could be applied when working with residents in the centre. Inspectors saw

documentary evidence that all staff who worked in catering had completed food safety training.

The current staffing arrangement did not support adequate supervision of staff to ensure that training was implemented in practice. Inspectors noted that staff did not have appropriate knowledge in relation wound care, manual handling and responsive behaviours. The person in charge said she provided the household staff with the necessary training in order to clean the centre. However, there was no records of the training maintained and supervision of cleaning practices in the centre required strengthening.

There was evidence that newly recruited staff shadowed an experienced staff member. However, they did not have a formal induction with evidence of sign off on key aspects of care and procedures in the centre.

Judgment: Not compliant

Regulation 21: Records

The three staff files examined held the required documentation as set out in the regulations. An GardaSíochána (police) vetting disclosures were available in the three staff files reviewed. The person in charge gave assurances that all staff had completed satisfactory vetting in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and their staff files contained the necessary disclosure documentation. Documentation confirmed that all nursing staff had up-to-date professional registration with the Nursing and Midwifery Board of Ireland (NMBI). A newly recruited nurse was working as a health care assistant while awaiting completion of her registration with NMBI.

A record of fire drills and tests of fire equipment was maintained. Records were maintained detailing fire safety checking procedures completed and service records for emergency lighting were available. The records of fire drills described the scenario practiced and and staff in attendance. These records required improvement to include details of any problems encountered and new learning. Servicing records for the fire alarm detection system and fire extinguishers were submitted following the inspection.

Daily records of each resident's condition and any treatments given was maintained by night and day nursing staff. However, individual assessments were not completed nor care plans for a resident with a wound or residents with responsive behaviours. This is detailed under regulations 5 and 7.

A register of any restrictive procedures used in the centre was in place. However, it did not have the required information as set out in schedule 3. For example, there was no record of the reasons for its use, the duration of use or other interventions used to manage behaviour. External doors were operated with a key pad and this

was not documented as a restrictive practice.

A copy of the transfer letter when residents were transferred to hospital was not available.

Judgment: Not compliant

Regulation 23: Governance and management

Governance and management in the centre was weak because the provider company had two directors and one director had responsibility for the operational management and clinical governance of the centre. She was the provider representative and the person in charge and on the morning of inspection, she was the only nurse on duty providing care to 26 residents until 14:00hrs. The person in charge was supported by an administrator who was working from home. Consequently electronic records such as training records and equipment servicing records were not accessible to the person in charge on the day of inspection and were submitted afterwards. There was a strong reliance on verbal communication between the manager and the staff team, hence records of management or team meetings were not maintained. There was no documentary evidence of the issues discussed, organisational priorities or that agreed actions were followed up and completed.

The systems in place to monitor the safety and quality of the service required significant improvement. Key information was not routinely gathered for monitoring or trending purposes. For example inspectors followed up on notifications of injuries from falls which were submitted to the Chief Inspector. However, there was no data or information on falls gathered and analysed to monitor the incidence of falls or to identify areas from improvement. A schedule of annual audits had been completed in 2019 but only two audits were completed in 2020. Seven audits were examined and none of them identified any areas for improvement.

The provider had not identified and taken appropriate action to address the risks associated with the following issues:

Infection Control:

- Inspectors were not assured that there was a robust plan in place to manage an outbreak of COVID -19 in the centre. Infection control practices in the centre were not fully in compliance with the Health Protection Surveillance Centre (HPSC) Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities. The guidance document was not available in the centre. There were significant risks identified with infection control practices in the centre. These are discussed under Regulation 27: Infection Control

Staffing:

- The risk of having only one nurse on duty over two floors and staff who worked across all areas. This is outlined under Regulation 15: Staffing

Risk Management:

- There were some risks identified during the inspection. This is outlined under Regulation 26: Risk Management

Fire Safety:

- Although regular fire drills were taking place in the centre,similated drills did not provide assurances that residents in each compartment could be safely evacuated using night time staffing levels. Drill reports seen were not sufficiently detailed to identify learnings and further actions required.
- Residents' personal evacuation plans did not state the number of staff required to support a resident.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose held most of the required information but it required review to include all the information set out in schedule1.

- The statement of purpose did not include the total staffing complement; household, laundry, administration and maintenance staff were not included.
- The statement of purpose did not include arrangements for the management of the centre where the person in charge is absent.
- The floor plans did not include the laundry. The two storey block with staff facilities was not included.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents, which were specified in the regulations for the sector, had been notified to the Chief Inspector in the required time frame.

Judgment: Compliant

Regulation 34: Complaints procedure

A complaints policy was on display and available to inform management of complaints in the centre. Information on the complaints procedure and how to access support was communicated to residents and relatives on admission.

The person in charge had responsibility for managing complaints in the centre and to ensure that complaints were responded to appropriately and records kept as required. The records confirmed that complaints were dealt with, appropriately recorded, investigated and the outcome was discussed with complainants. The satisfaction of complainants with the outcome of investigations was recorded and an appeals procedure was in place.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had policies in place on matters set out in Schedule 5. Policies were signed to indicate that they were reviewed every three years.

Judgment: Compliant

Quality and safety

Overall, residents were supported and encouraged to have a good quality of life which was respectful of their wishes and choices. There was evidence of good consultation with residents. COVID-19 had impacted on residents' access to allied healthcare services and opportunities for social engagement. Inspectors found that immediate improvements were required in the management of infection control.

The inspectors saw that residents appeared to be very well cared for and residents gave positive feedback living in the centre and the care the received. Staff supported residents to maintain their independence where possible and residents' medical needs were generally met. Residents had access to local general practitioner (GP) services. However, access to a range of allied health professionals was restricted throughout the pandemic. In some cases timely referrals were not made to psychiatry of older life or to community allied health services, and this impacted on residents. A nurse in the centre with a chiropody qualification provided chiropody services. The last time a resident was seen by a physiotherapist was January 2020 and dietetic and speech and language referrals had not been made since March 2020. Residents' progress notes reviewed by inspectors were specific to the

management of residents with weight loss, risk of chocking and residents with impaired mobility. One resident with obvious seating needs did not have appropriate seating and sat in a chair which had outside fabric and foam heavily torn on one side.

The resident assessment process was seen to involve the use of a variety of validated tools and care plans were found to be person centred but not consistently detailed to direct care. There was a reliance on verbal communication in relation to residents and their changing needs. Residents had a comprehensive assessment of their needs on admission and care plans were put in place but as residents' needs changed a nursing assessments were not consistently done or care plans developed to inform safe consistent care.

A policy to inform the management of restraint required review to reflect current practice. Environmental restraints were not included in the policy. Restraint use was low and generally reflected procedural guidelines in line with the national restraint policy.

There were systems in place to monitor symptoms of residents and staff for COVID-19 and there were protocols for testing of suspected cases. Care plans to support the changing needs associated with COVID-19 were in place and advanced care plans were in place which reflected residents wishes. Staff were being tested on a regular basis and all staff were cooperative in attendance for testing. To date no staff or resident had tested positive. A number of infection control practices were of a reasonable standard in that all staff adhered to the uniform policy, they wore appropriate PPE and practiced good hand hygiene. Suitable arrangements were in place for the self-isolation of residents for 14 days following admission and on return to the centre. Frequently touched surfaces were cleaned regularly over 24 hours. However, as previously outlined, improvements were required in a number of infection control practices, including cleaning schedules and the standard of cleaning in some communal areas. An increase in the number of staff was necessary and the staffing model required review. The contingency plan and preparedness for the management of an outbreak of COVID-19 required review and action.

Staff were found to be very knowledgeable about resident’s likes, hobbies and interests but information was not documented in social assessments and care plans to ensure that social activities met resident’s needs and interests. The design of the premises was homely and in a good state of decorative repair. Inspectors noted that some items were stored inappropriately and some minor maintenance was required. Eight of the nine twin rooms would not meet the requirements when SI:No. 293 came into effect in Jan 2022. Residents did not have access to a secure outdoor area and key codes were used on external doors.

There were systems in place to safeguard residents from abuse. All staff had a valid Garda vetting disclosure in place prior to their commencement of work in the centre. The centre's risk register required review to include all identifiable risks in the centre and controls in place to mitigate a number of potential risks to residents such as the open access to stairs.

Inspectors found that residents were consulted about how the centre was run and were enabled to make choices about their day-to-day life in the centre. There were adequate arrangements in place for consultation with relatives and families. Resident meetings no longer took place but the person in charge met with each resident on Friday to share information and elicit their feedback. Residents knew the person in charge well and told inspectors they would be confident that any issues they raised would be taken seriously.

Regulation 11: Visits

The provider had arrangements in place for residents to receive visitors, and suitable communal and private space was available for residents to meet with visitors.

The provider developed a visiting protocol to minimise any risk of COVID-19 to residents, staff and visitors and the centre had reopened for visitors on a phased basis in line with the national guidance during the summer. Visits were organised by appointment over a seven day period. Visiting controls included symptom checking and a visitor health risk assessment before the visit, a sanitising tunnel, hand hygiene, maintaining social distancing, and cleaning of the room following every visit. Level five restrictions were in place at the time of inspection and window visits and compassionate visits were facilitated.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were satisfied with arrangements in place for laundering and storage of their clothing and personal possessions. There were arrangements in place to label items of clothing with the resident's name. The sample of clothing checked had a label with the resident's name on it.

Inspectors observed that each resident had a locked unit for secure storage in their rooms.

Judgment: Compliant

Regulation 17: Premises

The design of the centre was homely and the premises was generally well decorated and maintained. The centre was warm and there was a schedule of planned

maintenance in place. The accomodation was set out over two floors with an extension to the ground floor. The majority of rooms were single bedrooms and there were nine twin rooms. Eight twin rooms did not have sufficient space to accommodate two residents and will not comply with SSI No 293, which is due to come into effect on 1 January 2022. There were sufficient numbers of bathrooms and toilets.

Three of the twin rooms on the first floor had only one resident. Inspectors saw that many of the residents had a commode in their room and most of the twin rooms had one arm chair. Two single rooms had large accessible ensuites. One of these rooms was reserved as an isolation room.

Storage space was an issue, as the linen trolley and two commodes which were not in use was stored in the bathroom.

Although the centre was generally well maintained there were a number of issues identified with the premises that are actioned under Regulation:26 risk management and Regulation 27: Infection control.

Judgment: Substantially compliant

Regulation 26: Risk management

The risk management policy had the required information to meet regulatory requirements. However, the original policy was dated and required a full revision and update. For example the section relating to accidents was drafted 11 years ago.

The risk register included details of hazards, risk assessments and measures to mitigate risks. However, the risk register was reviewed annually and was not used as a live document to review risks and ensure that the controls in place to manage risks were effective.

Risks and hazards identified on inspection that required attention:

- Storage of equipment in the bathrooms.
- Plastic bags with clinical waste left on the ground beside the skip.

Accident and incident logs were maintained in the centre and inspectors reviewed a sample of incident reports. Inspectors found that near misses were not recorded and accidents and incidents were not appropriately analysed to improve safety. For example in 2020 four residents required medical treatment or hospitalisation following a fall. Residents were not comprehensively reviewed following a fall to minimise the risk of another fall. Residents who had an un-witnessed fall did not have neurological assessments completed and two residents who sustained a head injury had neurological observations completed but they were not done with the required frequency for the period recommended in line with best practice.

Judgment: Not compliant

Regulation 27: Infection control

The infection prevention and control policy was revised to include reference to COVID-19. The person in charge was the nominated lead for infection prevention and control in the centre. There were enhanced arrangements regarding infection control set out in the contingency plans developed by the provider. The person in charge told inspectors she ensured that staff read and understood the policy and she provided staff with regular updates to appraise them of any changes in the national guidance. Although the guidance document was not available to staff on the day of inspection, the person in charge and staff demonstrated some awareness of key statutory guidance specific to COVID-19. Staff had access to HSELanD training including hand hygiene and the donning and doffing of personal protective equipment (PPE). Records confirmed that the bed pan washer was serviced in September.

Cleaning schedules were in place for frequently touched surfaces. A programme to decontaminate frequently touched surfaces was carried out by day and night staff. The room allocated for isolation was clean and had a large accessible ensuite. Household staff used a colour coded flat mop system and the cleaning trolley was clean and well stocked. Staff described the terminal cleaning process carried out when a resident recently left precautionary isolation. Staff told inspectors that each bedroom was cleaned daily and deep cleaned once a month. Although the bedrooms appeared clean, there was no documentary evidence that regular cleaning and deep cleaning was completed. The person in charge was responsible for household staff and infection prevention and control training relevant to their roles — including the use of equipment and solutions for cleaning. However, there was no records of topics covered or dates for when the training was provided. The provider had a system in place to ensure that there was signage and adequate supplies of masks, PPE, disinfectant, hand hygiene products, tissues and cleaning products.

A contract for waste disposal was in place and additional pedal bins had been procured. The provider had recently purchased a device to sanitise staff and any visitors to the centre. The temperature of persons entering the centre were checked. All residents had their temperatures taken twice daily and they were monitored for symptoms of COVID-19. The uniform policy was updated and all staff wore a freshly laundered uniform and changed into and out of their uniforms at the beginning and end of each shift. Records of staff temperature checks were available and staff were aware of the need to report any symptoms to the person in charge. A COVID-19 audit was carried out to ensure that the residents were socially distanced, that staff wore face masks appropriately and that sanitising stations were operational and appropriately stocked. Early on inspectors found that there were no paper towels in one bathroom, the pedal bin was not working in another and the soap dispenser in a ground floor toilet was empty. Inspectors noted that these issues were addressed during the day. A COVID-19 audit was carried out by day and night

staff.

Some areas of infection prevention and control required strengthening. For example:

- Equipment such as fixtures on the chair lifts and foot plate on the hoist were not clean and two residents shared a hoist sling.
- Bathrooms on both floors were visibly dirty with organic matter on the floors.
- Assistive equipment in the bathrooms and some radiators were rusted and could not be effectively cleaned
- The storage rack on the sluice room did not have a drip tray
- Sanitising stations were accessible in all compartments. Additional stations would be required to contain an outbreak.
- The shelf where PPE was stored was too low to allow the floor to be cleaned
- Many of the residents on the first floor had commodes in their rooms. Inspectors were not assured that commode pots or urinals were appropriately disinfected. Although staff told inspectors that they put the equipment in the bed pan washer. The lid of a commode pot in one room was not clean and there was a urinal stored in the bathroom on the first floor.
- Two commodes and a high support wheelchair were ripped this prevented effective cleaning
- The cleaners room on the first floor was not plumbed and staff described how they used the adjoining bathroom to fill and empty water containers.
- Clean linen was not covered and the linen trolley was stored in the bathroom.
- Inspectors noted that there was equipment stored in the clinical room and the clinical waste bins were difficult to access. Clinical waste bags were left on the ground outside beside the waste collection unit outside

Inspectors did not visit the laundry facilities but the person in charge undertook to self- refer to the HSE to request an on site inspection to identify areas for improvement in relation to infection prevention and control practices.

Judgment: Not compliant

Regulation 28: Fire precautions

Arrangements had been made for maintaining all fire equipment. Up-to-date service records were available for the centre's L2/3 fire alarm system, the fire panel, emergency lighting and fire extinguishers.

Inspectors noted that fire evacuation equipment was accessible in all compartments. Corridors were quite narrow and the linen trolley when in use was observed to obstruct escape routes. All bedroom doors were fitted with an automatic self-closing devise. Long-standing staff who spoke with inspectors confirmed that they had attended fire drills and they were familiar with fire safety procedures and the evacuation plan including the need to ensure that all doors were closed. Newer staff

were not sufficiently knowledgeable and required further fire safety training. Records of fire training were made available to confirm if all staff had fire safety training.

Inspectors noted that boxes of PPE stored under an emergency stairwell presented a risk if they combusted.

Simulated fire drills were held regularly. Inspectors reviewed the fire drill records and found that the drills simulated situations such as an emergency in the kitchen or the evacuation of a bedroom. The drill records lacked sufficient details and this is discussed under regulation 21. Following the inspection, the provider representative arranged for a fire drill to simulate the evacuation of the largest compartment with night duty staffing levels which provided assurances that the residents in the compartment could be safely evacuated.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Some medication management practices in the centre were not in line with best practice guidance or with the local policy. The following issues were identified that could impact on resident safety and protection:

- When PRN (as required) medications were prescribed the medicine kardex did not include information regarding the indications for it's use or the maximum daily dosage.
- On one occasion 'as required' medicine was prescribed to be administered once daily and records showed administration of this medicine twice daily.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A sample of residents' care plans were reviewed by the inspectors. Residents had a comprehensive assessment and care plan completed following their admission and care plans were reviewed regularly. However, not all clinical risks were assessed and a resident who returned to the centre following surgery had not had their care plan revised.

Inspectors noted issues with care plans as follows:

- Failure to monitor nutritional risk of high dependent residents using alternative methods of Body Mass Index (BMI) estimation - the mid upper arm circumference (MUAC)

- Care plan for mobility needs was incorporated in manual handling assessment. Insufficient details were provided to ensure consistent safe use of the hoist and equipment used to transfer residents. For example there was information about the type of sling required was absent.
- A resident with dermatitis and two wounds had a pressure mattress but there was no care plan in place for skin integrity. No assessment or care plan was completed for the resident to support wound healing.

Judgment: Not compliant

Regulation 6: Health care

Residents' health care needs were generally met through timely access to medical services and chiropody treatments. However, inspectors found that COVID-19 had impacted on residents access to allied health care. Some care provided did not reflect evidence based nursing. Residents had a choice of general practitioner(GP) and most of the residents were registered with a GP from a local practice. Residents and nursing staff confirmed that residents were reviewed by their GP when required. Telephone consultations were used during level five restrictions and GPs also visited residents in the centre.

Inspectors tracked residents and found that timely referrals to allied health care and psychiatry of older life were not consistently made. Arrangements for access to health and social care professionals such as a occupational therapy, physiotherapy, dietitian, speech and language therapists required review.
The person in charge told inspectors that none of the residents required these specialist services and residents had not accessed these services since March 2020. In addition, residents with a general medical services card were entitled to HSE services but referrals were never made to community services. Given the complex needs of some residents, inspectors requested that the provider arrange for residents to be reviewed and referrals made for allied health care assessments as appropriate.

- The SALT or the dietician had not reviewed residents since March. 13 residents were taking prescribed nutritional supplements and 6 residents with dentition or swallowing difficulties were on modified diet.
- Some residents were using specialist seating- it was not evident that the seating was provided following a specialised seating assessment as their needs changed
- Residents who had a fall or repeat falls had not been assessed by a physiotherapist and they did not have a medication review following a fall. Another resident did not have physiotherapy following surgery for a hip fracture. The PIC confirmed that no physiotherapy assessments or reviews had been done since January 2020.
- Tissue viability (TV) advice had been accessed remotely for a resident. A photograph of the wound was provided to the TVN nurse to inform the

assessment. However, no wound assessment was completed to monitor the progress towards healing and no wound care plan was developed. When inspectors reviewed the resident's file it was evident that the wound dressing was not done in line with specialist advice. A nurse told inspectors that a dietetic referral had not been made because the resident's BMI was good.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

There was a policy in place to inform the management of residents with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). While a significant number of residents had dementia, very few residents had responsive behaviours. Staff relied on their knowledge of individual residents and verbal communication to support the residents. Inspectors reviewed the files and found that residents were not appropriately assessed to identify possible triggers or any unmet need. Consequently behaviours were not analysed to inform a behavioural support plan. In one of the files reviewed an inspector saw a resident was prescribed for PRN anxiolytic medicine (medicine only taken as the need arises) for symptoms of responsive behaviours. The medicine was administered without a behavioural assessment or a behavioural support plan with person centred interventions, which could be tried before chemical restraint was given. This finding did not ensure that PRN medicine was administered as a last resort as outlined in the national policy guideline.

The physical and chemical restraint policy required review to include the identification of environmental restrictive practices. The provider was moving towards a restraint free environment and there were no bed rails used in the centre. There were low beds and crash mats available to support the reduction of restrictive practices.

Some areas required improvement:

- Six residents were using fall alarms, however, the risk assessment reflecting risks with the use of a fall alarm and supportive care plans were not in place. Inspectors observed that alarms were in place while residents were supervised by staff in the sitting room. The alarms were activated whenever the residents moved and this curtailed residents' movements and also created unnecessary noise and disturbance to residents in the day room.
- External doors in the centre could be opened with key code. The code was not available to any residents. The intention was to provide a secure environment and not to restrict movement. However, there was no risk assessment to identify residents who are at risk should they wander out of the building or residents who could be provided with the code to enable them

to go outside independently.

Judgment: Not compliant

Regulation 8: Protection

The policy on safeguarding referenced the Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures 2014 and included the time frames to direct staff when dealing with allegations or suspicions of abuse. There were no records of suspected or confirmed allegations of abuse in the centre. The person in charge was familiar with the policy and her role should a staff member report abuse. Staff who met the inspector confirmed that they had attended training and they were familiar with the Safeguarding Policy and procedures.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence that residents and/or their representatives were consulted with and participated in the organisation of the centre. Residents were kept informed about COVID-19 and the actions that they and the staff were required to take. Residents were consulted about their wishes should they contract COVID -19 and advanced care directives held this information. Care representatives and families were kept updated about changes to individual residents' needs. Staff supported residents to meet or to maintain contact with family and friends through phone calls, social media platforms and window visits.

Residents' privacy and dignity were respected when personal care was delivered in their bedrooms or in bathrooms.

Residents' right to choice and control over their daily life, was facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms. Inspectors observed that residents' right to freedom of movement was curtailed. There were key pad locks on external doors because the centre was close to a busy road but there was no secure outdoor area for residents to access fresh air. Consequently residents were not free to go outside when they wished to do so.

A programme of varied activities was in place for residents and inspectors saw a number of lively and quieter activities taking place. There were no records maintained of individual resident's level of participation or engagement in various activities. Inspectors were told that residents' spiritual needs were met through regular prayers in the centre. Religious services were broadcast on

television. Residents had access to TV, radio, computer and internet access and many residents got an individual daily newspaper delivered to them in the morning.
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 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St. Theresa's Nursing Home OSV-0000434

Inspection ID: MON-0030886

Date of inspection: 12/11/2020

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Two nurses have been recruited enabling the CNM2 to return to supporting role of PIC	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 16(1)(a) Staff have access to training relevant and appropriate to their roles with training matrix is in place 16(1)(b) The PIC and CNM2 supervise staff in their roles and ensure to adhere to training received 16(2) (c) Copies of relevant guidance by government and statuary agencies are available to staff as issued	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 21(1) Records set out in schedule 2, 3, and 4 are kept in the centre and will be updated to reflect the requirements 21(6) The nurse's NMBI is in place 16.11.20	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
23(a) This has been completed 17.11.20
23(b) This has been completed 17.11.20
23 (c) Training records are in place, audits have been completed and a schedule of further audits are in place to be completed by 31.12.20

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
03(1) The statement of purpose reflects the information set out in schedule 1 completed 17.11.20
The floor plans for the laundry and staff facility will be included in the statement of purpose by 31.01.21

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
17(1) The premises are appropriate to the number and needs of current residents in accordance with the statement of purpose
The storage of commodes and linen trolley has been reviewed and staff are reminded to ensure their storage is in line with policy. A separate storage room has been allocated for additional storage requirements.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
26(1) (d) The policy has been reviewed and the risk register will be used as a live document to include audits and risks.
Staff nurses are directed to ensure near misses are detailed and comprehensive review of falls as per the post fall huddle and to document all neurological assessments. A new document has been put in place to ensure the required frequency in line with best practice and a reason if it is not done as per a resident's wishes or refusal.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
An independent IPC review took place 24.11.20 which outlined that the centre is following the recommended COVID 19 HSE/HPSC guidelines
Each resident has their own sling
Radiators and assistive equipment has been treated to allow effective cleaning
A drip tray has been ordered
Stations were in place if and when they are needed
Shelf of PPE store has been raised
The bed pan washer was working, the replacement part was installed 17.11.20
Staff members are reminded to follow best practices in the storage of commodes and urinals
Commodes are decontaminated with the sanitizers

Commodes that are torn have been replaced
High support chair will be replaced

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
28(1) (b) The PPE was removed from under the emergency stair well
Staff are reminded to leave the linen trolley at the linen station
New staff members have been given further training and daily training on the fire safety measures in place
28(1) (e)Simulated fire drill completed to include the largest compartment with night duty staffing levels. 20.11.20

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
29(5) The review of the medication was completed 13.11.20 and the GP has indicated the frequency in writing

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:
5(1) Care plans have been revised and documentation has been strengthened to reflect care given to each resident. Ongoing audits will take place and more frequently by the PIC and CNM2.
5(4) Care plans have been revised and documentation of MUAC BMI and staff nurses have been instructed to complete this.
Mobility needs care plan has been updated to reflect the type of sling required.

Care plan is completed for the wound management and documented care plans will be put in the place as needed for management of wounds

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
6(1) 6(2) (c) A review of the needs for the allied health services has been completed and the restrictions due to COVID have been reviewed with access to allied health assessments as needed now being available.
The documentation of the TVN has been informed to all nurses and adhering to the specialist advice.

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: 7(2) The knowledge that staff have of each resident is now reflected in a behaviour support care plan. Staff are aware that medication is given as a last resort in the event of a responsive behaviour. This will be documented. 7(3)Risk assessment in respect of falls alarms and supportive care plans are in place and staff aware that they are removed when staff members are with present. A risk assessment will be in place to identify a resident who may be at risk in the event the keypad code is given to another resident.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: 9(2) b Residents are encouraged to go outside if they can independently do so. Documentation reflects the resident's interests and capacities to participate in 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	Red	17/11/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	18/11/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	01/12/2020
Regulation 16(2)(c)	The person in charge shall ensure that copies of relevant guidance published from time to time by Government or	Not Compliant	Orange	13/11/2020

	statutory agencies in relation to designated centres for older people are available to staff.			
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.	Substantially Compliant	Yellow	13/11/2020
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant		13/11/2020
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	16/12/2020
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	16/11/2020

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	Red	17/11/2020
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	17/11/2020
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	31/12/2020
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and	Not Compliant	Orange	16/11/2020

	learning from serious incidents or adverse events involving residents.			
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.	Not Compliant	Red	17/11/2020
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	13/11/2020
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	20/11/2020
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in	Substantially Compliant	Yellow	13/11/2020

	accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/01/2021
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	19/12/2020
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate	Not Compliant	Orange	13/11/2020

	that resident's family.			
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 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.	Not Compliant	Orange	24/11/2020
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	04/12/2020
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	Not Compliant	Orange	20/11/2020

	far as possible, in a manner that is 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.	Not Compliant	Orange	15/12/2020
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	14/12/2020
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	15/12/2020
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Substantially Compliant	Yellow	15/12/2020