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:	Ferbane Care Centre
Name of provider:	Maracrest Ltd.
Address of centre:	Main Street, Ferbane, Offaly
Type of inspection:	Unannounced
Date of inspection:	01 December 2021
Centre ID:	OSV-0004690
Fieldwork ID:	MON-0033188

About the designated centre

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

Ferbane Nursing Home is a 65 bedded facility set in mature grounds in an urban area. It is a three-storey building and a lift and stairs provide access to each floor. It consists of 51 single rooms and seven twin rooms some of which are en suite. Residents' communal accommodation included a day room and dining area on each floor as well as a chapel and a drawing room. There are a number of toilets and bathrooms throughout the building. Kitchen and laundry facilities are located on the lower ground floor. There are nurses and care assistants on duty covering day and night shifts. The centre's statement of purpose outlines that the ethos of care is to promote the dignity, individuality and independence of all residents. The centre provides general nursing care predominately for older people but also for residents over 18 years of age. People who require short term and long term care are also accommodated in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	55

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
Wednesday 1 December 2021	08:30hrs to 16:30hrs	Sean Ryan	Lead
Friday 17 December 2021	09:30hrs to 16:00hrs	Sean Ryan	Lead
Wednesday 1 December 2021	08:30hrs to 16:30hrs	Claire McGinley	Support
Friday 17 December 2021	09:30hrs to 16:00hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

Overall, inspectors found that residents received a good standard of care from a team of dedicated staff that knew each resident's individual likes and preferences well. Residents reported feeling safe and comfortable in the care of staff in Ferbane Care Centre.

Inspectors spoke with 11 residents and a small number of visitors during this two day inspection. The feedback from residents was that the staff were 'the most kind and caring you could ask for' and that staff supported them to carry out aspects of their daily routine where they needed assistance. However, residents were acutely aware that there was a shortage of staff in the centre and detailed how this impacted on the care they received.

Residents reported having to wait for periods of time to receive assistance from staff because 'staff were run off their feet'. Some residents had been informed by the staff that delays in answering call bells was a result of staffing issues and residents told the inspectors that they were used to having to wait. Some residents commented that there were many 'new faces coming and going' and that it took them time for them to get to know new staff. Some residents commented that staff would have to sit with residents 'who needed them more' and as a result they would have to 'wait their turn'. Visitors whom the inspectors spoke with were also aware of this issue.

At the beginning of the inspection inspectors walked through each of the three floors, the lower ground floor, the ground floor and the first floor of the centre with the person in charge. From the inspectors' observations and conversations with residents, visitors and staff, it was evident that the person in charge was well known by all and identified as the person responsible for the day to day running of the centre and the management of any issues that arose.

While inspectors observed the atmosphere to be pleasant for residents, it was evident that staff were very busy attending to residents and assisting them with their morning care needs. Inspectors heard polite conversation between residents and staff as they discussed the weather, news and Christmas. Staff were observed attempting to pace their work to facilitate time to engage with residents socially when providing assistance with care but once residents were assisted to dayrooms inspectors observed long periods where no staff were available to supervise or provide meaningful engagement and activities. Inspectors observed one resident in the dayroom slipping down from their chair and intervened to assist the resident as there were no staff present or call bell available to call for assistance. This was brought to the attention of the person in charge who rectified the issue through providing a call bell in the dayroom.

Inspectors observed that the centre was bright, spacious and visibly clean in areas occupied by residents. Significant refurbishment works had been undertaken by the

registered provider to ensure the centre was fit for purpose through providing a suitable environment, personal accommodation and storage for residents. Residents with whom inspectors spoke with were very complimentary of their accommodation and accessible facilities that supported residents to move safely and freely to use their showers and toilets. There were appropriate handrails and grab-rails available in the bathrooms and along the corridors to support residents moving freely through the centre and maintain their safety.

Residents were encouraged to personalise their bedrooms with personal items of significance such as ornaments and photographs. Inspectors observed that en-suite facilities required review to ensure residents had appropriate storage for toiletries and personal care items. Furnishings in communal areas and bedrooms were observed to well maintained, soft and comfortable for residents. The secured courtyard was accessed through the lower ground floor. This door was key code protected and the person in charge informed inspectors that residents were provided with the codes to use this space at their leisure. Inspectors did not observed this space to be in use during the inspection but there was evidence that this area was used as an undesignated smoking area and this required review by the management team.

Inspectors spent time listening to residents experiences of the COVID-19 pandemic and their compliments to the management team and staff who they credited with keeping them safe from the virus to date. Residents detailed the challenges they faced when restrictions meant they could not receive visitors but detailed how staff supported them to maintain communication with their family and friends. Residents told inspectors that they feared contracting the virus but staff reassured them and this made them feel safe. The vaccination programme had also reassured residents that they were protected and they celebrated this achievement. Visiting had resumed in the centre in line with current guidelines. This had a marked positive impact on residents overall wellbeing and inspectors observed visitors coming and going throughout the day.

Residents were complimentary with regard to the food they received and confirmed the availability of snacks and drinks at their request. Residents described the food as 'top class' and some residents attended the dining rooms while others chose to have their meals in their bedrooms. Staff were available to support residents and provide discrete assistance to residents. Inspectors observed that meals were served on trays to residents in the dining room. While inspectors were informed that this was an infection prevention and control measure, inspectors found that this should be reviewed to ensure a pleasant dining experience for residents.

Residents were kept informed about changes occurring in the centre through resident meetings and their feedback on the quality of the service was sought. A music therapist visited the centre on a weekly basis. Residents had access to religious services weekly in the centres Chapel. An activities schedule was on display for residents and staff which indicated that activities should were scheduled for the first morning of the inspection, however no activities were taking place in the communal areas. Inspectors noted that when activities occurred in the afternoon the residents engaged with and enjoyed the activities. Both residents and staff informed

inspectors that activities were not provided most days due to staffing challenges.

The following sections of this report details the inspection findings in regard to the capacity and management of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

Notwithstanding the above positive feedback from the residents the findings from this inspection were that the management oversight of the service required urgent action to ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored.

This was evidenced by:

- There was inadequate monitoring and oversight of resident care to ensure the safety and protection of residents at all times.
- Inspectors were not assured that there was sufficient staff with the appropriate skills to meet the assessed care and supervision and safeguarding needs of residents.
- The system of risk identification was not adequate, for example, inspectors identified a number of risks during the inspection that had not been identified and as a result to mitigate the risk were not in place.
- Residents assessed needs and associated risks did not always have an appropriate care plan in place to support them.
- The provider had not fully implemented or sustained their own compliance plan following the last inspection of the centre in September 2020.

As a consequence of these concerns, the provider was required to provide an urgent compliance plan response regarding residents' safety and wellbeing to the Chief Inspector by 08 December 2021. Assurances were required in regard to the supervision of residents and their protection, staffing and the supervision of staff in addition to assurances that the systems for clinical oversight and the management of risk were monitored. Following receipt and review of the urgent compliance plan, the centre was inspected on a second day.

Previously, significant regulatory non-compliances were identified to the provider on the inspection on 30 September 2020. Following that inspection and subsequent engagement with the Registered Provider, the Chief Inspector renewed the registration of this centre with an additional restrictive condition aimed at improving the governance and management of the centre and improving the quality of life for residents. The registered provider was required to comply with this condition by 30 October 2021.

Inspectors found that although the registered provider had addressed some of the regulatory non-compliance's with regard to the premises identified in the previous

inspection, some actions proposed by the provider were not completed or sustained and as a result the provider had not complied with condition 4 of their registration. Repeated non-compliance were found in:

- Regulation 15: Staffing
- Regulation 23: Governance and management
- Regulation 27: Infection prevention and control
- Regulation 8: Protection.

In addition, the following regulations were found to be found to be non-compliant on this inspection:

- Regulation 5: Assessment and care plans
- Regulation 9: Residents rights
- Regulation 21: Records
- Regulation 28: Fire precautions.

Maracrest Limited is the registered provider of Ferbane Care Centre. The management team for the designated centre consisted of the group director of quality and safety, the person in charge and two clinical nurse managers. However, on the days of inspection, in the absence of sufficient nurses, the clinical nurse managers provided direct nursing care to residents and as a result the inspectors found that the management structure as outlined in the statement of purpose and function was not in place. This was also a finding of the previous inspection.

The designated centre was not adequately resourced to meet the needs of all residents. Over the course of the inspection, inspectors observed many occasions where it was apparent that there was insufficient staff to meet the assessed care, supervision and safeguarding needs of residents and following day one of the inspection, the provider gave assurances to increase the staffing resources in the centre and a compliance plan was submitted to that effect. However, on day two of the inspection, inspectors found that the additional staffing resources were not in place.

The inspectors found that the systems in place to monitor, evaluate and improve the quality of the service were not implemented by the management team. For example, audit templates were available to analyse falls, the quality of care, clinical documentation and fire safety, however these audits were not being carried out. In addition, incidents involving residents had not been reviewed and the system of risk identification required further oversight.

Arrangements were in place to record incidents and accidents on a computerised system. However, not all incidents involving residents were analysed and, where appropriate, progressed to notify the Chief Inspector as required by the regulations. For example, an incident involving the unexplained absence of a resident from the designated centre had not been notified to the Chief Inspector as required by the regulations.

Inspectors found that the supervision of staff required improvement to ensure staff were supported and directed to carry out their role and responsibilities. For example,

the allocation of staff to communal areas to supervise residents. Arrangements in place for newly appointed staff to complete a period of induction required further oversight as one staff personnel file reviewed on day two of the inspection did not evidence a record of induction for a healthcare staff.

Over the course of the two days inspection, inspectors reviewed a sample of seven staff files and found that further oversight of these records was required. For example, three staff personnel files did not contain the information as required by the Schedule 2 of the regulations. Where residents records were not securely stored at the nurses station on the first day of inspection, action had been taken by the person in charge and all records were observed to be securely stored and maintained on the second day of inspection.

A policy was available to inform the procedures for receiving and managing complaints from residents or visitors. The person in charge was responsive to the receipt and resolution of complaints in the centre and maintained a complaints log. Inspectors reviewed the complaints log and all reviewed had been closed. The complaints procedure was prominently displayed on each floor in the centre and was accessible to residents and visitors. Further improvements were required in the documentation of complaints.

On a positive note, there was evidence of good systems of communication that included monthly governance and management meetings, staff meetings and group meetings.

Through discussions with the staff, inspectors were assured that staff were kept informed in regard to infection prevention and control measures and updated guidelines in regard to COVID-19. The person in charge had a detailed preparedness plan in place and it was reviewed frequently.

A review of the training records evidenced that staff were supported and facilitated to attend training relevant to their role such as fire safety training, cardio-pulmonary resuscitation (CPR), infection prevention and control, manual handling and the safeguarding of vulnerable adults.

The annual review of the quality and safety of the service for 2020 had been completed and shared with residents.

Regulation 15: Staffing

The staffing resources and requirements of the centre in place on the days of inspection dis not ensure that there were sufficient staff to deliver person-centred, effective and safe care to all residents. On the days of inspection, inspectors found that the care hours were not sufficient to meet the clinical and social care needs of the residents.

Rosters reviewed by the inspectors evidenced significant challenges in maintaining

the appropriate number and skill mix of staff to meet the assessed health and social care needs of the residents. For example:

- There were 12 vacant positions across multiple disciplines including nursing, healthcare assistants and activities staff.
- A review of the staff rosters from 22 November to 5 December evidenced 10 days where planned healthcare assistant staffing levels were not maintained with a deficit of between six and 18 care hours noted on some days.
- Activities for residents were curtailed as a result of insufficient staffing.
- An 8pm to midnight healthcare assistant shift had been suspended as a result of insufficient numbers of staff available.
- Staff levels were not adequate to meet the assessed care and supervision and safeguarding needs of residents at all times.

Insufficient staff to meet the needs of residents was identified on inspection in December 2018 and again in September 2020 and is a repeated non-compliance on this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

All staff had up-to-date training in fire safety, manual handling and safeguarding of vulnerable people. However, inspectors found that further analysis of staff training needs was required. For example:

- Inspectors found that eight staff required training in infection prevention and control.
- Only nine staff providing direct care to residents had received end of life care training.
- 44% of staff had not completed training relevant to support residents living with responsive behaviour.

As identified on the previous inspection, the supervision of staff required improvement. Inspectors found that:

- The supervision of newly appointed staff was not assured due to nursing shortages and redeployment of the management team to provide direct nursing care.
- Inspectors found that residents were not supervised by allocated staff in communal areas. For example, residents with high support needs, residents at risk of falls and residents identified as requiring close supervision were not supervised by staff.
- Further supervision of staff in regard to the appropriate wearing of personal protective equipment, in line with current guidelines, was required.

Judgment: Substantially compliant

Regulation 21: Records

Record-keeping and file-management systems required review to ensure records were appropriately maintained and securely stored. The inspectors findings over the course of the two day inspection were as follows:

Inspectors reviewed a sample of seven staff personnel files over the two days of inspection and found that:

- While all files contained a valid An Garda Síochána (police) vetting disclosure, records evidenced that two staff had commenced employment in the centre in advance of this disclosure being processed.
- One staff personnel file did not contain two employment references or valid photo identification as required by the regulations.
- There were gaps in the employment history and no evidence of induction in one staff personnel file reviewed.

Information and records pertinent to the care provided to residents by healthcare staff was not maintained as the online record system was not accessible to care staff.

Judgment: Not compliant

Regulation 23: Governance and management

There were inadequate resources in place to ensure the effective delivery of care in accordance with the statement of purpose. For example:

- The staffing resource provided did not assure that the care and assessed supervision needs of residents were met in line with their assessed needs.
- Inspectors found that the management team resources were redeployed to the provision of direct resident care and this detracted from implementing the systems to monitor, evaluate and improve the quality of the service provided to residents.

The management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. This was evidenced by:

- The audit system to monitor, evaluate and improve the quality of the service had not been implemented. As a result, the inspectors found that the oversight of a number of key areas was not robust and a number of areas of

non-compliance found on day one of the inspection were not identified by the management team. When reviewed on day two of inspection, the systems were in the process of being implemented with oversight by the person in charge and director of quality and safety.
- Inspectors were not assured that clinical oversight systems were robust.
- Further oversight of key clinical information was required as information provided to inspectors on the first day of inspection in regard to residents receiving end-of-life care, restrictive practices and the number of residents under the age of 65 years living in the centre was not accurate.

Although a risk register was maintained by the person in charge. The system of risk identification required improvement as inspectors identified a number of risks that had not been entered into the risk register and controls to mitigate the risk were not identified. For example:

- The risk associated with ongoing challenges in maintaining safe staffing in the centre.
- The fire risk identified under Regulation 28: Fire precautions.

The systems of risk review, investigation and learning from incidents involving residents required immediate review. For example:

- 25 incidents recorded since September 2021, including thirteen residents falls, had not been reviewed or corrective action implemented.
- There was no root cause analysis or evidence of learning from the incidents as evidenced by repeated falls involving the same residents.
- There was no risk analysis or trend analysis of these incidents.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Each resident had a contract of care that met the requirements of the regulation and described the terms of residency in the centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The centres statement of purpose and function was recently reviewed and updated but required further review to ensure it accurately reflected the service provided. For example:

- The staffing whole time equivalents were not aligned with those previously

submitted to the Chief Inspector for the purpose of registration.
- The design and layout of the building described in the statement of purpose did not accurately reflect what was observed by inspectors on the day of inspection.
- The clinical governance structure described in the document required review to ensure all personnel involved in the management of the centre were identified.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge was aware of their statutory responsibility to notify the Chief Inspector in writing of specific incidents involving residents in the centre.

An incident regarding the unexplained absence of a resident from the designated centre in May 2021 was not notified to the Chief Inspector as set out in set out in paragraphs 7 (1) (g) of Schedule 4 of the regulations.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Inspectors reviewed a sample of complaints that had been received in 2021 and found that further improvement was required in the documentation of complaints. For example:

- One complaint of concern detailed the actions taken to address the complaint but did not detail if an investigation had been completed or if this had been communicated to the complainant.
- Complaints did not consistently record if the complainant was satisfied with the actions taken to resolve the complaint.
- Of the complaints reviewed, there was no evidence of learning from complaints or associated quality improvement plans.

Judgment: Substantially compliant

Quality and safety

Inspectors found that residents in Ferbane Care centre received a good standard of

nursing and medical care from a team of staff who knew their individual needs and preferences well. Nonetheless, the social care needs of residents was found to be affected by poor staffing levels and inadequate supervision. Improvements were required in relation to residents' assessments and care plans, protection and residents rights. Further oversight of fire precautions and infection prevention and control were required to ensure a safe, quality service was provided to residents.

Record-keeping and file-management systems were largely computerised and inspectors were provided with access to the online record systems. Records were maintained by nursing staff in respect of the daily care and treatment provided to residents but it was found on day two of inspection that healthcare staff had not been able to record the care provided to residents as a result of issues with the online record system. Inspectors reviewed a sample of resident records and found that a comprehensive assessment of needs was completed on admission to the centre. Validated nursing assessments were used to assess residents risk of impaired skin integrity, falls risk, risk of malnutrition, dependency level and a social care needs. Care plans were then developed from these assessments to guide staff on how to support residents with their care needs. While it was evident that staff knew residents individual needs well, further oversight was required to ensure that residents assessed needs and associated risks had an appropriate care plan in place to support them. Further findings are discussed under Regulation 5: Assessments and Care Plans.

Residents had unrestricted access to a General Practitioner (GP) and records reviewed evidence that residents were supported to meet with their GP in the centre when required or requested. Medication reviews occurred on a quarterly basis with the GP and the person in charge informed inspectors this had contributed to an overall reduction in the use of 'as required' medications and particularly with the use of psychotropic medications. Where residents required further health and social care expertise, they were supported to access these services which included dietitian services, speech and language, physiotherapy, occupational therapy and psychiatry of later life. However, where changes in the residents care and treatment were recommended, these changes were not consistently updated into the resident's plan of care. Residents were supported to access dental, auditory and optician services in the local village.

A small number of residents were predisposed to episodes of responsive behaviour. Inspectors reviewed a sample of records for these residents and found that behaviour support logs were maintained, a person-centred care was in place and staff were aware of each residents individual needs and de-escalation techniques. A multi-disciplinary team approach was implemented in the management of restrictive practices in the centre and inspectors found that this approach supported a low incidence of bedrail use in the centre.

Staff were observed to provide compassionate care to residents during their end-of-life journey and palliative care services were available to provide additional support to residents if required. The provision of single rooms for residents who wished for complete privacy during end of life care was made possible. However, inspectors found that end-of-life care plans required review to ensure they reflected residents

changing needs. Records did not evidence that relatives, where appropriate, were kept informed in regard to the decisions made around the end of life care needs of residents. Further oversight of this process is required.

The layout and design of the centre met the individual and collective needs of residents and provided them with a therapeutic and comfortable living environment. The provider had taken action to ensure that the designated centre was fit for purpose and an extensive building programme had been undertaken which included refurbishment of residents accommodation and the provision of additional en-suite facilities.

To date, the centre had not experienced and outbreak of COVID-19. There had been isolated positive COVID-19 cases among staff and these were managed in line with public health support and guidance. Inspectors identified many examples of good practice in the prevention and control of infection and many of the actions from the previous inspection had been completed. This included:

- Symptom screening station at the main entrance to the building.
- Twice daily symptom monitoring for residents and staff.
- Alcohol hand sanitisers were available throughout the centre.
- Sluice rooms reconfigured and drip trays installed to appropriately store continence care aids.
- Adequate stocks of personal protective equipment were available.
- New cleaning trollies had been purchased and were observed in use and a cleaning schedule was maintained.
- Appropriate signage was in place to prompt staff, visitors and residents to perform frequent hand hygiene.

Inspectors were informed that there were sufficient cleaning resources to meet the needs of the centre. Housekeeping staff provided a demonstration of the cleaning procedure and system that was observed to conform to best practice guidelines. The provider had a number of assurance processes in place in relation to the standard of hygiene which included specifications and checklists, colour coding to reduce cross infection and guidance documents. Infection prevention and control audits were completed to assess the centres performance against IPC standards. However, where deficits had been identified, actions and timelines for completion had yet to be developed but on day two of this inspection action plans were observed by inspectors to be in place. While the centre was observed to be visibly clean in areas occupied by residents, further oversight was required in areas such as store rooms, a laundry storage area, treatment rooms and the catering department which were not clean on inspection. Further findings are discussed under Regulation 27: Infection Control.

Inspectors reviewed the maintenance and service records of the fire equipment were available and up-to-date. There was daily checks on the means of escape and some gaps were observed in the weekly fire alarm testing. The inspector observed that some cross corridor fire doors required review as magnets and wall plugs were lose and easily dislodged from the wall. The person in charge addressed this issue on the day of inspection. Emergency lights had been reviewed and escape routes

were well lit. Staff had good knowledge of fire safety procedures in the centre and were clear on what action to take in the event of the fire alarm being activated. Each resident had a personal emergency evacuation plan in their bedroom and a copy was available at reception. However, these required updating to accurately reflect the residents assessed evacuation needs. The fire drill evacuation procedure required improvement to ensure it progressed to a simulated compartment evacuation and further training and support was required to ensure all staff are knowledgeable regarding the procedure for progressive horizontal evacuation. Inspectors identified a number of fire risks on day one of inspection that included the safe evacuation of residents in the event of a fire. The assurances received and actions taken by the provider were reviewed on day two of inspection. This is discussed further under Regulation 28: Fire Precautions.

Residents reported that they felt safe in the centre and were well cared for by a team of staff who were respectful to their needs and wishes. Staff whom the inspectors spoke with were knowledgeable regarding their role and responsibility in protecting residents from the risk of abuse. Safeguarding training was facilitated and attended by all staff. The person in charge had developed safeguarding plans for a small number of residents with specific safeguarding needs and these plans outlined the planned actions to be implemented to mitigate the risk to other residents living in the centre. Further improvement was required in regard to the assessment of residents safeguarding needs. Only one record evidenced a multi- disciplinary (MDT) team approach to the assessment of a residents safeguarding needs. The management team informed inspectors that an MDT meeting was scheduled for January 2022 to review and update all safeguarding risk assessments and safeguarding plans for residents that had specific safeguarding needs. However, inspectors found that planned actions to mitigate the risk of peer-to-peer abuse, such as the supervision of a small number of residents in communal areas, was not in place. This was a similar finding from the previous inspection and is discussed further under Regulation 8: Protection.

Residents told inspectors that they were kept informed about any changes occurring in the centre and this included building works and information specific to the management of COVID-19. Residents told inspectors that they looked forward to having visitors each week and it made them feel connected to their families and community again. Residents had access to religious services weekly in the centres' Chapel and residents were observed attending morning mass live streamed to their television. The refurbishment of the centre had enhanced the facilities for residents that protected their privacy and dignity and the installation of showering and toilet facilities meant that all residents had access to these facilities in close proximity to their accommodation. Inspectors observed that staff in the centre made efforts to ensure residents privacy and dignity needs were met. Personal care and assistance was provided discreetly with consent behind privacy screens in shared bedrooms and bedroom door were closed. Inspectors observed that residents did not have opportunities to participate in activities in accordance with their interests and capacities. Residents and staff confirmed to inspectors that the provision of activities was a challenge as there was no activities coordinator or additional staff rostered on duty to provide meaningful activities to staff.

Regulation 11: Visits

Residents were supported to maintain personal relationships with families and friends. The centre was facilitating visits in line with the current Health Protection Surveillance Centre (HPSC) COVID-19 visiting guidelines.

Visitors were guided through the centres infection prevention and control procedures prior to entering the centre and systems were in place to ensure residents, visitors and staff were protected.

Judgment: Compliant

Regulation 13: End of life

Compassionate end of life care was provided to residents, and support was provided to their families. Visits were facilitated for residents to be visited by their family member or friends during their last days and hours.

Advanced care plans were in place for some residents and this plan adopted a holistic approach to addressing the residents' physical, psychological, emotional, social and spiritual needs. However, in some records reviewed, residents end-of-life care wishes had not been obtained and this required further oversight. Inspectors found that records did not evidence if family or friends were kept informed of the residents condition.

Judgment: Substantially compliant

Regulation 17: Premises

Inspectors were satisfied that significant refurbishment works had resulted in the enhancement of the facilities provided to residents living in the centre.

Since the previous inspection, refurbishment of 15 bedrooms and the addition of full en-suite facilities had been completed. On inspection, these facilities were bright, wheelchair accessible, spacious and finished to a good standard. The building works had resulted in a reduction of twin bedrooms from six to four on the first floor.

Works were completed on the ground floor to provide a shower room and toilet in close proximity to residents accommodated in three bedrooms where it was previously identified that there was an excessive distance for residents to travel to

access such facilities and impacted on the residents' privacy and dignity.

Action had been taken on the lower ground floor to address the deficit in lighting found on the previous inspection. The lower ground floor dining and sitting rooms, despite having limited natural light, were well lit with newly installed light fixtures and the area was homely in appearance. Bedrooms and corridors in this area had been painted and redecorated.

Inspectors were informed that the provider had completed phase two of building works and a plan was in place to commence phase three in early 2022 to refurbish the remaining sections of the building.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were complimentary of food they received and the availability of snacks and refreshments. Residents were offered a choice at each meal time and meals were prepared specific to each residents individual requirement.

Residents nutritional status was monitored and where specific dietary requirements were prescribed, this was seen to be implemented. Residents identified as nutritionally at risk were appropriately assessed and referred to dietician services for further assessment.

Staff were available to provide support and assistance in a respectful and discreet manner.

Judgment: Compliant

Regulation 27: Infection control

A number of issues that had the potential to impact on infection prevention and control measures were identified during the course of the inspection. For example:

- Single use clinical care equipment, such as a percutaneous endoscopic gastrostomy (PEG) feeding tube, was not appropriately disposed of after use.
- Several surfaces, finishes, walls, handrails, resident furniture and flooring in the centre were worn, paint chipped and poorly maintained and as such did not enable effective cleaning.
- The floor in the kitchen and service area in this department required repair as a number of tiles were broken and impacted on effective cleaning. On inspection, the floors in the kitchen and kitchen store rooms were not clean.
- The seals around some shower trays had worn away resulting is a build-up of

debris around its base and skirting in close proximity to showers in en-suites were damaged by water and not amenable to cleaning.
- Carpets in the Chapel, stairwells and staff areas were not clean on inspection and there was no schedule for decontamination of carpets or fabric covered furnishings in place.
- There was inappropriate storage of residents equipment, hoists and clean linen in a communal bathroom used by residents. This also impeded access to the hand wash sink.
- Hand hygiene sinks did not comply with current recommended specifications.
- Housekeeping store room had inadequate shelving and chemicals were stored on an exposed concrete floor that could not be cleaned effectively. There was no hand wash sink or sink disposal for waste water in this area.
- Bottles of cleaning preparations prepared by cleaning staff were not labled to identify the contents or dated to ensure they were discarded of after each 24 hour period.

Judgment: Not compliant

Regulation 28: Fire precautions

Further oversight and monitoring was required in regard to fire safety precautions in the centre. For example:

- There were gaps in the weekly documentation of the fire alarm checks.
- There were areas of the centre that required review by a suitably qualified person to ensure that areas of the centre were appropriately fire stopped. For example, the wood ceiling in the kitchen store room.
- Floor plans did not detail the changes made to the layout of bedrooms on the first floor and escape routes.
- Some doors were observed to be wedged open with chairs.
- A smoke sensor in the sluice room had become dislodged from the ceiling.
- There was evidence of smoking in an undesignated area, the enclosed garden, and appropriate fire safety measures were not in place. For example, there was no fire blanket or appropriate bin to dispose of cigarette butts.

Following the first day of inspection, further assurances were requested in regard to the safe and timely evacuation of residents from:

- The largest compartment in the centre that accommodated 10 residents.
- A corridor that accommodated eight residents that were required to descend nine steps outside an emergency exit to a place of safety.

Inspectors reviewed the above records on day two of inspection and were assured that residents could safely descend the steps outside the emergency exit. However, the residents personal evacuation plans were not accurate as they detailed that six residents required 'ski sheet' evacuation when they were in fact mobile. These

records required immediate updating to ensure all staff, including agency staff, were aware of each residents individual and accurate evacuation plan to ensure a timely and safe evacuation.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While staff were knowledgeable regarding residents care needs, this person-centred information was not consistently captured in the residents care plans. This is particularly pertinent where agency staff are used to staff the roster as the residents care plan is the guiding care document to effectively support their needs. Further improvement were required to ensure care plans were developed in response to residents assessed needs and associated risks. For example:

- A care plan was not completed for a resident admitted to the centre in October 2021.
- Where changes in a residents needs were identified, this was not consistently updated into the residents care plan. For example, a resident assessed as a high risk of falls.
- Where a resident was identified as a high risk of malnutrition and had a history of weight loss, there were gaps in the weight records.
- A resident with a history of pressure wounds and identified as a high risk of developing pressure wounds did not have pressure relieving equipment in the form of an alternating air mattress as described in their care plan. Inspectors followed up on this residents care plan on day two of inspection and the interventions described in the care plan had not been implemented.
- Residents receiving antibiotic therapy did not have a care plan in place.
- A social activity care plan was not developed for a younger resident living in the centre.
- There was no assessment or care plan in place in regard to the pain management of a resident receiving analgesia.

The person in charge and nursing staff confirmed that residents and, where appropriate, their relatives were consulted in regard to their changing needs and consulted when care plan reviewed occurred. However, the records maintained and conversations with residents did not provide assurance in regard to this process. This is a repeated finding from the previous inspection.

Judgment: Not compliant

Regulation 6: Health care

Through a review of residents clinical records and conversations with residents, inspectors were assured that arrangements were in place for residents to access their general practitioner (GP) when required or requested. There was evidence that residents were supported to access allied health and social care professionals for additional expertise such as dietitian, physiotherapy and occupational therapy services.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

While the centre implemented a strategy based on national policy to continually diminish the use of restraint, improved oversight was required to ensure the least restrictive strategies were trialled prior to implementing the use of bedrails.

Inspectors were informed that three residents in the centre required the use of bedrails. However, on review of residents care records, inspectors observed a fourth residents that was using bedrails since the time of their admission to the centre. For that individual resident, Inspectors found that:

- there was no risk assessment completed prior to their use.
- there was no care plan in place.
- there was no record of alternative trialled prior to their use or consent obtained from the resident or, where appropriate, their relative.

Judgment: Substantially compliant

Regulation 8: Protection

A small number of residents living in the centre had specific safeguarding needs. While safeguarding risk assessments and safeguarding plans were in place for those residents, further improvement was required to ensure each residents was provided with a multi-disciplinary team (MDT) approach to assessment of their needs, that staff were aware of each residents safeguarding plans and that the planned actions to mitigate risk were implemented to ensure that residents were adequately safeguarded from the risk of peer-to-peer abuse.

A multi- disciplinary (MDT) team approach to the assessment of a residents safeguarding needs was evident in just one record reviewed by inspectors.

Inspectors found that safeguarding plans outlined the planned actions to be implemented to safeguard residents from the risk of abuse. For example, a number of residents were assessed as requiring close supervision by staff when attending communal areas while some residents were assessed as requiring observation

checks every 15 minutes to ensure the protection of others living in the centre. However, inspectors observed over the two days of inspection that the supervision of residents by staff was not in place.

While staff were aware that a number of residents had safeguarding needs, some staff were unaware of the planned actions, such as supervision of residents, to be implemented to ensure residents were safeguarded from the risk of abuse and as a result residents were not appropriately supervised.

Through the inspectors observations and discussions with staff over the two days of inspection, inspectors were not assured that the staffing resources could meet the supervision needs of residents to ensure all residents were safeguarded from the risk of peer-to-peer abuse. This was also a finding from the previous inspection and previously brought to the attention of the provider.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider was not providing opportunities for all residents to participate in activities in accordance with their assessed needs and preferences. Residents had restricted access to an activity schedule and social engagement due to the allocation of social care staff.

While some group activities were facilitates by healthcare staff in the afternoon on both days of inspection, there was no activities for residents who chose to remain in their bedroom. Residents who chose to remain in their bedrooms told inspectors that they were not provided with meaningful activities or one-to-one engagement unless they used their call bell for assistance and attributed this to the staff being busy.

The centre accommodated a small number of residents under the age of 65 with complex health and social care needs and in the absence of dedicated activities and occupational therapy staff, their social activities care needs were not consistently met. The prospect of additional social support or advocacy for younger residents had not yet been explored.

Inspectors found that on day two of the inspection, the ongoing staffing challenges impacted on residents choice in regards to the provision of showers and staff reported that only one resident had received a shower on the morning of inspection but all residents had received assistance with personal hygiene needs. Staff reported that they were attempting to complete residents showers in the afternoon when it was not as busy.

While all bedrooms had television access for residents, some residents in multi-occupancy bedrooms did not have a choice of television viewing as they shared a television with another resident. In some cases, privacy screens, when drawn,

obstructed the view of the television while the layout of some privacy screens meant that a resident had to enter the bedspace of another resident to access en-suite facilities. Inspectors found that the layout of a twin room on the ground floor required review as there was inadequate space between the foot of the bed and a wardrobe for a resident to pass through with ease.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ferbane Care Centre OSV-0004690

Inspection ID: MON-0033188

Date of inspection: 01/12/2021

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: 1. Review of roster is completed and staffing levels agreed to ensure sufficient care hours identified to meet the clinical and social care needs of the residents. 2. Recruitment drive by HR, both locally and abroad (ongoing): 13 Staff recruited across disciplines including management (1), nursing (2), healthcare assistants (7), administration (1) and activities staff (2) 5 International HCAs are due to commence duty from 1/04/2022 3. Agency staff engaged to support resident care needs and supervision until further permanent staff recruited and inducted. 4. Activities Coordinator and an activities assistant are appointed and in place, to ensure the social care needs of the residents are met	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. Training matrix reviewed and training schedule updated to include IPC, End of Life and Responsive behaviour training to be completed by end of April to include all new staff. 2. Staff induction pack reviewed, updated with the addition of staff training record card. 3. CNM2 recruited on 5/12/2021 to support the DON and ADON with the induction and supervision of new staff, the allocation and oversight of staff assigned to supervise residents with high support needs, those at risk of falls and those recognized as requiring close supervision and to ensure compliance with IPC.	

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. Audit of all staff personal files by HR completed. Gaps identified and staff contacted to provide missing information within 2 weeks.
2. HR audit of staff files added to master audit schedule planner, to ensure consistent upkeep of staff files
3. Induction pack for New Staff reviewed and Staff file checklist added to be completed by end of induction.
4. New Broadband provider commenced on 20/12/2021, updated the system and retrained current staff and trained new staff. Individual log in for all staff completed. This will ensure online record system is always accessible to healthcare staff.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. Appointment of Director of Quality & Safety as PPIM to support the Nursing Management team in Ferbane Care Centre
2. Internal appointment of a CNM2 on 5/12/2021, commenced new role on 3/01/2022, to support the PIC and ADON to provide effective oversight of care, governance and management of Ferbane Care Centre
3. Staffing resource reviewed, increased and active recruitment drive ongoing both locally and with international agencies.
4. New audit schedule implemented as of 9/12/2021 with oversight by the PIC and Director of Q&S.
5. Weekly care indicators recorded and reviewed by the RPR and Director of Q&S
6. Monthly KPI's recorded, reviewed with action plan/ learnings to be disseminated to staff through monthly staff meetings, daily debrief and safety pauses.
7. The audit schedule was implemented on 9/12/2021 with follow up action plans and evidence of triangulation.
8. Schedule of meetings updated to include monthly providers meeting and monthly Q&S meetings, where a comprehensive review of the monthly KPI's and proposed actions are agreed to ensure a safe appropriate service is provided to the Residents
9. Risk Register reviewed and updated.
10. An MDT Falls Committee was initiated in January 2022, to review the monthly falls and to develop a Falls prevention strategy. A Falls Prevention audit was completed and is to be completed each month going forward, with learnings and actions to be relayed to staff at handover, safety pauses during the day and through minutes from the monthly

meeting. Care plans have been updated to include the findings. 11. Annual Review for 2021 has been completed

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose for the Centre has been reviewed and updated as of 17/02/2022 to reflect the updated staffing levels, the design and layout of the building and the clinical governance structure

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. NF05 completed and submitted on 1/12/2021
2. To ensure Notifications of Incidents are reported to HIQA within the timescale specified by the regulations, the ADON/CNM2 has access to the HIQA portal in the absence of the DON

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. Complaint's policy reviewed.
2. The system for documenting complaints was changed to an online system. This system will reflect the investigation process, the outcome and any feedback and learnings from the complaint, the communication with the complainant and their response.
3. Complaints will be reviewed as part of the weekly and monthly KPI's with actions agreed disseminated to all staff at handover and staff meetings
4. An annual review of complaints will be completed by the DON at the start of each calendar year and included as part of the Annual Review

Regulation 13: End of life	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: End of life: 1. Family and Staff Communication logged under "Communication" rather than in the "Daily Notes" in the online record system 2. 4 monthly review of care plans completed by named RGNs. 3. End of Life training scheduled for staff 9/02/2022 completed. Further training scheduled in February	
Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: 1. Closed pedal bins in place for disposal of PEG equipment. 2. Waste management and disposal training organized for staff 3. Maintenance schedule in place with ongoing decoration and improvements to surfaces. Any ripped or torn furniture removed from centre. 4. Cleaning schedule for the decontamination of fabric coverings, furnishing and carpet in place. 5. Meeting with domestic staff completed, decontamination training completed 13.12.21, discussed how labelling of disinfectant to be carried out daily. 6. ADON met with Domestic supervisor meeting 19.01.22. to discuss inspection findings and develop action plan 7. Engineer engaged to review the findings of the inspection. Meeting on site with DON on 2/02/2022. Currently awaiting solutions to address the following issues: hand wash sinks, wastewater disposal, storage areas and refurbishment of the kitchen and service areas and their surfaces to ensure effective cleaning. 8. As part of Phase 3 of the restoration and refurbishment of the Centre, increased storage facilities will be incorporated to accommodate resident equipment, hoists and the clean linen. 9. All chemicals stored above floor level.	
Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. The PEEP Charts from room 19 to 26 reviewed and updated
Risk Assessments updated on 1.12.21.
2. Fire extinguisher – (light weight water) and fire blankets ordered and put in designated smoking areas
3. Fire induction checklist for all new staff and agency staff completed prior to commencing shift.
4. Smoke sensor in sluice room repair completed
5. Ongoing weekly fire alarm checks, completed by maintenance officer and reviewed by DON/ADON.
6. Daily Maintenance checks of door guards in the morning to ensure they are in working order and in place to ensure no obstacles are blocking entrances.
7. Ongoing monthly Fire Evacuation Drills for both day and night duty staff
8. The roster reviewed and an additional HCA is rostered on night duty to support the supervision of residents in the event of an evacuation.
9. The Group are currently undertaking a full review of Fire Safety Compliance in its six centres. An Engineer has been engaged to carry out a full fire safety audit of Ferbane Care Centre, as per regulation 28 of the standards. This audit is expected to be carried out on the 04/04/2022 and reported on by 18/04/2022. Works will be scheduled accordingly following the outcome of this audit
10. The kitchen storeroom was reviewed by the local Engineer and the DON on 2/02/2022. It has been emptied and will remain empty until the required works are completed.
11. The local Engineer has engaged with the local Fire Officer on an ongoing basis throughout each phase of refurbishment in Ferbane Care Centre, to ensure good fire safety compliance.

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:
1. An audit on the care plans of all Residents was completed by the DON/ADON/CNMs by 5/02/2022, their care plans updated, and an action plan agreed to ensure compliance with Regulation 5. going forward.
2. All care plans will be reviewed and updated 4-monthly in consultation with the residents and their families. Residents will be continuously monitored, and individual care plans will be audited more frequently where necessary for any additions/amendments that are required
3. A meeting was held with the RGN's on 8/02/2022, to discuss the findings of the audit and the action plan was implemented. They were advised of the change over to an online system for complaints, and incidents. They were shown where communication with families and relatives is to be logged on the online system going forward.
4. A CNM was assigned to oversee the nutritional status of all residents following their

monthly weights and MUST score assessments.
5. All Residents with a safeguarding care plan have had their care plan reviewed and updated
6. All Residents receiving antibiotic therapy now have a care plan in place
7. A social activity care plan has been developed with the assistance of family for a younger resident living at the Centre
8. Residents receiving analgesia for pain management have care plans in place

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
1. Risk assessment, bedrail assessment and care plan in place for all residents using bedrails.
2. CNM assigned to oversee that the least restrictive strategies are applied prior to implementing the use of siderails and to ensure individual care plans reflect same

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. Immediate review of resident's safeguarding care plans with a 4 monthly review date completed
2. Roster reviewed to ensure adequate staffing resources in place to provide adequate supervision of Residents
3. Daily review of Roster/ Staff allocation by Senior Manager on duty
4. Daily narrative at staff handover reports and Senior Management daily debrief record, with management walk around 3 times a day.
5. Incident reporting through an online system updated, learnings shared through regular staff meetings, monthly minutes Provider's meetings, and monthly Q&S meetings. Provider's meeting with PIC/ Director Q&S monthly to review Inspection findings and develop action plan
6. Complaints log management through use of an online system. Review of complaints monthly by PIC
7. Implementation of new audit schedule on 3/12/2021
8. A multi-disciplinary (MDT) team meeting was held on 4/01/2022 to discuss residents safeguarding needs. Individual resident risk assessments and care plans were updated following this meeting and staff were informed of the outcomes.
9. Safeguarding training for new staff scheduled for February 2022.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. An Activities Co Ordinator has commenced in her role as of 03/1/2022. She will work 36 hours a week and has a "Sonas" qualification. An Activities Assistant was also appointed on 29/12/2021, to ensure that all residents can participate in activities in accordance with their assessed needs and preferences. They will both work under the supervision of the ADON who will have oversight of all activities
2. The Social care needs of the residents under 65, were reviewed with the relevant resident's families and updated in their care plans.
3. The local Disabilities service was contacted to establish availability of a PA/ key worker for the residents under 65. Response awaited. A relevant Foundation was contacted, await on going input. Added to care plans.
4. Social worker involved and occupational therapy as indicated for residents under 65.
5. Individualised social care plans completed as part of holistic care plans for each resident.
6. The roster was reviewed and the staffing increased to ensure the care needs of the residents are met.
7. The layout of the double rooms mentioned by the inspector were reviewed and an action plan devised to address same. Both Residents wish to stay in that bedroom due to its location in the building and we will respect their wishes. The wardrobes and beds will be reconfigured, and a second TV sourced for the room.

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 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Substantially Compliant	Yellow	31/03/2022
Regulation 13(1)(c)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that the family and friends of the resident concerned are, with the resident's consent, informed of the resident's condition, and permitted to be with the resident and suitable	Substantially Compliant	Yellow	31/03/2022

	facilities are provided for such persons.			
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	31/03/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/03/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/03/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/03/2022
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	31/03/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre	Not Compliant	Red	08/12/2021

	has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	08/12/2021
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	Orange	31/12/2022
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	30/04/2022
Regulation	The registered	Substantially	Yellow	30/04/2022

28(1)(c)(i)	provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Compliant		
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	06/04/2022
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	31/03/2022
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	31/03/2022
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	08/12/2021
Regulation 34(1)(d)	The registered provider shall provide an	Substantially Compliant	Yellow	31/01/2022

	accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.			
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/01/2022
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).	Substantially Compliant	Yellow	05/02/2022
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in	Substantially Compliant	Yellow	05/02/2022

	paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	18/02/2022
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	18/02/2022
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	31/03/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in	Not Compliant	Orange	03/01/2022

	activities in accordance with their interests and capacities.			
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	03/01/2022
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	03/01/2022