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:	An Teaghlach Uilinn Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Kilrainey, Moycullen, Galway
Type of inspection:	Unannounced
Date of inspection:	11 January 2023
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0038381

About the designated centre

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

An Teaghlach Uilinn Nursing Home is a purpose-built designated centre for older people. Residents are accommodated in single and twin bedrooms. A variety of communal rooms are provided for residents' use, including sitting, dining and recreational facilities. The centre is located close to Moycullen village, Galway. Residents have access to a secure enclosed courtyard. The centre provides accommodation for a maximum of 75 male and female residents, over 18 years of age. The service provides care to residents with conditions that affect their physical and psychological function. Each resident's dependency needs are regularly assessed to ensure their care needs are met.

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 11 January 2023	10:00hrs to 18:00hrs	Sean Ryan	Lead
Wednesday 11 January 2023	10:00hrs to 18:00hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

On the day of inspection, inspectors spent time speaking with residents, and observing the care of residents who could not articulate their experience of the service provided to them. Overall, the feedback from residents was poor. While residents were complimentary of the staff who made them feel safe living in the centre, residents described the care they received as 'inconsistent', which they attributed to daily staffing challenges and voiced that they often experienced delays in receiving assistance and support from staff.

On the morning of the inspection, the atmosphere was observed to be busy, but pleasant. Staff were observed busily attending to residents requests for assistance, while also answering the call bells of other residents who were waiting for assistance. Some residents were observed sitting comfortably in the ground floor communal day room, waiting for a religious ceremony to commence.

Inspectors spoke to a number of residents in their bedrooms. Residents were complimentary of the staff and 'the hard work that they do'. Residents told inspectors that while 'staff were kind and caring' and 'would do their best for you', there was 'not enough of them' most days. Residents expressed their dissatisfaction with prolonged wait times for assistance from staff. When asked, a resident told the inspector that when they use their call bell, staff would either respond promptly to tell them they would be back to assist them shortly, or the call bell went unanswered for a long period of time. Another resident told inspectors that while staff came to assist them early in the morning, they were still delayed going to the day room as a result of the staff being interrupted during care delivery to respond to the call bells of other residents. Some residents told the inspectors that they would have to shout for assistance because their call bell was unplugged or out of reach. Inspectors observed that the call bell of one resident was unplugged, while other call bells were out of reach of the residents who were in their beds. While some residents told the inspectors that they liked to get up before 10am, residents stated that this was inconsistent and dependent on the availability of staff. Inspectors observed that some residents were still in bed at Midday.

Inspectors observed that residents on the ground floor were socially engaged throughout the inspection. Residents gathered in the ground floor day room for a variety of activities that included Mass in the morning and a discussion about the daily news headlines. Activities staff were present to provide meaningful social engagement, supervision and assist residents with snacks and refreshments. In the afternoon, a group of residents attended some music activities in a second day room located on the ground floor. However, inspectors observed that residents on the first floor did not have equal access to activities or social engagement. Residents told the inspectors that unless they took part in group activities on the ground floor, there was no alternative activities for them to choose from. Some residents told the inspectors that they enjoyed nothing more than a chat with staff, but that this was not possible as they knew staff were busy and did not have the time to sit and chat

with them.

Inspectors observed that there were many areas of the premises in both resident's private accommodation, and communal areas, that were visibly unclean. Inspectors observed that areas, such as the dining room, had been documented as cleaned, but were visibly unclean on inspection. Inspectors observed spillages around resident's en-suite toilets that were not cleaned. A communal toilet used by residents was malodorous and the toilet seat was visibly soiled. This communal toilet remained in this condition for the duration of the inspection. Clean linen was also observed to be stored on a trolley in this area.

The resident's lunchtime experience was observed by inspectors. Inspectors observed that residents who attended the ground floor dining room were supported and assisted by staff with their meals. Inspectors observed that two residents on the first floor had their meals in the day room. Inspectors observed that both residents experienced some difficulty while eating their meal. However, staff were not available to provide assistance or support to these residents. The remaining 15 residents on the first floor were served their meals in their bedrooms. Inspectors observed that some residents were served their meals while they were lying on their beds. There were two care assistants available to support the 15 residents with their meals. This staffing level was not adequate to ensure that all residents could be assisted and safely monitored while eating. One resident, who appeared to be in bed sleeping had a untouched meal in front of them for 45 minutes. Inspectors observed trays of food returning to the kitchen with meals that had not been eaten. There was no system in place to ensure that residents nutritional intake was appropriately monitored or recorded.

Residents told the inspectors that they were provided with opportunities to meet with the management team to discuss their views and feedback regarding the quality and safety of the service. Residents told the inspector that they were aware of the procedure for making a complaint and had voiced their dissatisfaction with aspects of the service to the staff and management. Some residents had complained about the food standards, laundry, and staffing. Inspectors observed that some of those issues were raised at a resident's forum meeting. However, residents told the inspectors that they had not received a response to their complaints. Some residents told the inspectors that they would like access to a person who could support them in their decision-making regarding long term care but were not aware of the independent advocacy services available in the centre.

Capacity and capability

This was an unannounced risk inspection conducted by inspectors of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors also reviewed the action taken by the provider to address the non-compliant issues

found on inspection in October 2022. The provider had submitted an application to renew the registration of the centre. Inspectors reviewed the detail of this application on this inspection.

The findings of this inspection were that there continued to be inadequate and ineffective management systems in place to ensure the safe, and monitored delivery of care to residents. The governance and oversight of the centre was inadequate and contributed to ineffective systems of monitoring and oversight that resulted in repeated substantial or non-compliance under;

- Regulation 4: Written policies and procedures,
- Regulation 5: Individual assessment and care plan,
- Regulation 6: Health care,
- Regulation 15: Staffing,
- Regulation 16: Training and staff development,
- Regulation 21: Records,
- Regulation 23: Governance and management,
- Regulation 27: Infection control, and,
- Regulation 34: Complaints procedure

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

- Regulation 9: Residents' rights, and,
- Regulation 18: Food and nutrition.

The registered provider had not ensured that the service had sufficient staffing resources in place to meet the needs of the residents living in the centre. The impact of inadequate staffing levels was evidenced in the poor provision of care and support to residents, particularly with regard to the assessment and monitoring of residents' nutritional care needs and in the poor standard of environmental hygiene that placed residents at significant risk of infection. As a consequence of these concerns, an urgent compliance plan was issued to the provider following the inspection.

Knegare Nursing Home Holdings Limited, a company comprising five directors, is the registered provider of An Teaghlach Uilinn Nursing Home. The management structure to operate the designated centre, as set out in the Statement of Purpose, consisted of a representative of the provider, who held a dual role as a director of Knegare Nursing Home Holdings Limited and Clinical Director, a person in charge and assistant director of nursing. On the day of inspection, inspectors found that the management structure did not align with the statement of purpose. For example, the assistant director of nursing post was vacant since August 2022 and the commitment given in the statement of purpose of a once weekly presence in the centre for the post of clinical director was not consistently maintained.

Inspectors were not assured that the provider had adequate resources in place to effectively manage the centre and to ensure the care and welfare of the residents. Inspectors found that both the person in charge and a clinical nurse manager

supported the direct provision of care to residents during periods of staff unplanned leave by completing nursing duties. For example, in the week prior to the inspection, the clinical nurse manager suspended their supervisory role to provide direct nursing care to residents. This meant that there was less time available for nursing oversight and governance. This organisational structure was found to have a negative impact on the service provided to the residents.

The centre had a high turnover of staff. There were significant staffing vacancies in the centre on the day of the inspection. While there was a active programme of recruitment in place, there was also a significant amount of staff leaving the service. While 30 staff had been recruited since July 2022, a total of 35 staff had left the service within the same period of time.

Even though there were 20 vacant beds in the centre, the staffing levels were inadequate to meet the needs of the residents that were in the centre and for the size and layout of the building. A review of the staff rosters found that the staffing level present in the centre on the day of the inspection did not reflect the staffing levels identified on the staff roster. A further review of the staffing allocation records, along with the staffing rosters, found multiple gaps in the planned rosters over a two week periods, where vacant shifts had not been covered. The impact of inadequate staffing was evidenced through the poor quality of care provided to residents and the poor standard of environmental hygiene observed on the day of inspection.

The management systems in place did not ensure that the service provided was safe, appropriate, consistent or effectively monitored. There were inadequate systems in place to monitor, evaluate or improve key aspects of the service, such as, clinical documentation, quality of care, records or infection prevention and control.

A risk management policy, reviewed by inspectors, detailed the management systems that should be in place for the oversight and monitoring of risk in the centre and the personnel responsible for the oversight of risk. However, the policy referred to the previous provider of the service, and management personnel. As part of the risk management policy, a risk register to record all potential risks to resident's safety and welfare was required to be maintained. However, inspectors found that the risk register had not been reviewed or updated in line with known risks, and risks were not appropriately assessed and categorised according to the priority for action.

The record management systems were not effective. The inspectors reviewed a sample of staff personnel files and found gaps in the information required to be maintained as detailed under Schedule 2 of the regulations. Information requested on the day of inspection was not accessible or retrieved in a timely manner. For example, an accurate record of previous and current rosters were not available for review.

Staff had access to education and training appropriate to their role, and a training schedule was in place. Inspectors found that the arrangements in place to supervise

and support staff was not effective. For example, staff were not appropriately supervised to ensure residents received safe and quality care, in line with their assessed needs.

The policies and procedures, as required by Schedule 5 of the regulations, were reviewed by the inspectors. A significant number of policies had not been reviewed or updated by the provider, as required under the regulations. Some policies also referred to the previous provider of the centre.

The provider had reviewed and updated the complaints procedure since the previous inspection. The complaints procedure was prominently displayed in the centre. However, the complaints policy had not been reviewed and contained inaccurate information with regard to the personnel involved in the management of complaints. Inspectors found that the complaints policy was not implemented. For example, complaints received by the management team were not documented or progressed through the centre's complaints management procedure.

Regulation 15: Staffing

Inspectors found that staffing levels and skill mix were not adequate to meet the needs of the residents, or for the size and layout of the centre. The impact of inadequate staffing was evidenced by;

- A review of staffing rosters for the previous two weeks showed that up to 36 care hours had not been filled.
- Residents could not be transferred or be accommodated in the communal day room on the first floor as there was no staff available to supervise them.
- There was inadequate staff on duty to meet the nutrition and hydration needs of the residents.
- Residents reported and were observed waiting long periods of time to receive assistance and support from staff with their personal care needs.
- The centre did not have adequate numbers of cleaning staff available to ensure the environment and equipment was appropriately cleaned and to ensure residents were protected from risk of infection.

An urgent compliance plan was issued in relation to staffing following this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised to carry out their duties to protect and

promote the care and welfare of residents. This was evidenced by:

- inadequate monitoring and supervision of the cleaning processes and infection prevention and control practices in the centre.
- lack of oversight of the residents clinical documentation to ensure the assessment and care planning were accurate and up-to-date.
- poor supervision of staff to ensure residents received care and support in line with their assessed needs.
- inadequate supervision of the activities programme to ensure the social care needs of all residents were met.

Judgment: Not compliant

Regulation 21: Records

The management of records was not in line with regulatory requirements, and records were not kept in a manner that was accessible. For example:

- Staff rosters did not accurately reflect the staffing levels on the day of inspection, and rosters for the weeks prior to the inspection were not reflective of the roster that was actually worked by staff when compared to the the staffing allocation records that identified significant gaps in the worked rosters.
- Staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations. For example, three staff files did not contain two written references and one staff file did not contain a full employment history.
- Finances, received by the provider on the resident's behalf, were not recorded in line with requirements under Schedule 3 (5)(b) of the regulations.
- Records were not easily accessible. Staff rosters were recorded on three electronic systems. Access to these systems was restricted to senior staff members. Records could not be produced for inspectors in a timely manner.

Judgment: Not compliant

Regulation 23: Governance and management

The provider failed to address the non-compliance found in the governance and management of the centre on the last inspection. For example, the provider had committed to completing audits of records, complaints, environmental hygiene, infection prevention and control and care plan audits. These actions, which were due for completion by 31 December 2022, were not completed on the day of

inspection.

The roles and responsibilities of the clinical management team were poorly defined. For example, accountability, responsibility and oversight of key aspects of the service such as the management of risk, infection prevention and control and the oversight of clinical care records were not clear and resulted in poor outcomes for residents.

The registered provider had failed to ensure that there were sufficient staffing resources in place to:

- ensure the management structure was maintained in line with the centre's statement of purpose. This impacted on effective governance and oversight of the service.
- maintain nursing and health care staffing resources in line with the centre's statement of purpose. This impacted on residents receiving timely person-centred care from staff.

The registered provider had failed to ensure there were effective governance and management systems in place to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. For example:

- The management systems to monitor, evaluate and improve the quality of the service were not implemented. There was no evidence of audits completed or quality improvement action plans following the last inspection.
- The risk management systems were not effectively implemented to identify and manage risks in the centre. The policy was not updated to reflect the personnel responsible for the management of risk. Risks were not categorised according to their priority, reviewed or updated to assess the effectiveness of the controls in place to manage the risks.
- There was poor oversight of record- keeping systems to ensure compliance with the regulations. Records requested, that are required by the regulations, were not well maintained or accessible for review.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaints management systems found that complaints were not managed in line with the requirements of Regulation 34, or the centre's own policy. For example, issues of concern in relation to food standards, laundry services and staffing, had been brought to the attention of the management team, but were not documented and managed within the centre's complaints register. This meant that there was no record of how these issues were acknowledged, investigated or resolved to the satisfaction of the complainant, as required under Regulation 34.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Policies and procedures had not been reviewed or updated as required by the regulations.

Judgment: Substantially compliant

Quality and safety

Inspectors found that the the instability in the staffing resource coupled with ineffective systems of governance and oversight impacted on the quality and safety of the service provided to residents. While the interactions between staff and residents was observed to be kind and respectful, significant action was required in relation to the rights of residents and the delivery of safe, high-quality, person-centred care to residents based on their assessment needs. Inspectors found that non-compliance in relation to infection prevention and control, and residents food and nutrition impacted on residents' safety and well-being.

Inspectors reviewed a sample of assessments and care plans and while there was evidence that the residents' needs were being assessed using validated assessment tools, the care plans reviewed were not informed by these assessments and did not reflect person-centred, evidence-based guidance. This is discussed further under Regulation 5: Individual assessment and care plans.

A review of residents' records found that there was regular communication with the residents' general practitioner (GP) regarding their health care needs. Residents had access to a physiotherapist on a weekly basis and residents reported their satisfaction with this service. There were arrangements in place for residents to access the expertise of health and social care professionals through a system of referral. However, due to inadequate and inappropriate care plans, inspectors were not assured that residents were provided with appropriate medical and health care.

Inspectors were not assured that there were robust arrangements in place to identify and monitor the nutritional care and support needs of residents. While nutritional screening was in place for some residents, the pathway of action to take in response to nutritional assessment findings was not implemented. For example, there was no evidence of action taken in relation to a number of residents identified as at risk of malnutrition. Further findings are discussed under Regulation 18, Food and nutrition.

A review of the care environment found that the provider had not maintained an

appropriate standard of environmental and equipment hygiene. A review of the cleaning records found that areas of the premises documented as being deep cleaned were visibly unclean on inspection. For example, the dining room floor and furniture were visibly dirty. In addition, there was no cleaning schedule available for review. Poor standards of hygiene were observed in communal bathrooms where toilets were visibly soiled and stained for the duration of the inspection. The findings identified repeated non-compliance with regard to the oversight of infection prevention and control practices and the cleaning procedure and were indicative of a lack of a robust infection prevention and control monitoring and auditing system. Action was required in relation to oversight of infection prevention and control. This issue is further discussed under Regulation 27: Infection control.

Staff spoken with demonstrated an appropriate awareness of their safeguarding training and detailed their responsibility in recognising and responding to allegations of abuse. Procedures were in place for the management of residents' monies and locked storage was provided for residents' valuables. The provider supported a number of residents in the centre to manage their pension and welfare payments. However, records of the management of resident's pension payments were not provided for review. This is documented under Regulation 21, Records.

Residents told the inspectors that they felt safe living in the centre and that staff treated them with dignity and respect. Residents were satisfied with the arrangements in place for them to access religious services on a weekly basis. Residents were provided with access to daily newspapers, television and radio. While residents were facilitated to meet the management at scheduled meetings, residents told inspectors that they felt their feedback was not responded to, as issues raised with management team had not been addressed. Residents also reported that their right to exercise choice was impacted upon by the availability of staff. For example, residents waiting extended periods of time to receive assistance and support from staff.

Regulation 18: Food and nutrition

Immediate action was required to ensure the nutritional needs of residents were met. This was evidenced by;

- There was an inadequate number of staff available to assist residents with their meals. Inspectors observed residents in their bedrooms did not receive assistance with their meals and food trays were collected from their bedrooms with the meals untouched.
- There was poor monitoring and assessment of residents nutritional care and support needs. For example, one resident who told the inspectors that they were concerned that they had lost weight had not had their weight recorded since their admission, two months prior to this inspection. Consequently, there was no appropriate care plan in place to support their nutritional needs.
- Two residents told inspectors that the quantity of food offered at the evening

meals was not sufficient. This was also reflected in comments recorded in the residents meetings. No action had been taken to address the issue.

An urgent compliance plan was issued to the provider following the inspection.

Judgment: Not compliant

Regulation 27: Infection control

The provider did not ensure that infection prevention and control procedures were consistent with National Standards for Infection Prevention and Control in Community Services published by HIQA. This was evidenced by;

- There was poor oversight of the cleaning procedure and the quality of environmental hygiene. The centre was visibly unclean on inspection. For example, the dining room was documented as being deep cleaned on the morning of the inspection but was visibly unclean.
- Sanitary ware in communal bathrooms were soiled and unclean when checked multiple times during the inspection. This posed a risk of cross infection to residents.
- Poor practice was observed where soiled linen was left on top of a residents bed. This posed a risk of cross infection to the resident.
- Cleaning equipment was stored inappropriately in the dirty utility and there was no dedicated room for the storage or preparation of cleaning agents or equipment.
- Some equipment used by residents was in a poor state of repair and visibly unclean on inspection. For example, shower chairs were visibly rusted and had a build up of organic matter on their underside.

This is a repeated non-compliance from the previous inspection. An urgent compliance plan was issued to the provider following the inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of residents assessments and care plans found that they were not compliant with regulatory requirements. For example:

- Care plans were not guided by a comprehensive assessment of the residents care needs. For example, some resident's care plans did not accurately reflect the needs of the residents and did not identify interventions in place to protect residents when identified as a high risk of falls. Consequently, staff did not have accurate information to guide the care to be provided to the

residents.

- Resident's assessed as being at high risk of malnutrition were not identified as such within their nutritional care plan. The interventions in place to support the residents were not detailed in the resident's care plan.
- Residents were inappropriately assessed. For example, assessment and care plan reviews had been carried out during a time when a resident was not in the centre.
- While inspectors were informed that some residents preferred to remain in bed or have their meals in their bedrooms, this was not reflected in either the feedback from residents or within their individual care plan.

Judgment: Not compliant

Regulation 6: Health care

The registered provider failed to provide appropriate medical and health care including a high standard of evidence-based nursing care in accordance with professional guidance. This is evidenced by;

- failure to identify and deliver appropriate care for a resident hygiene needs and those with significant nutritional risk.
- failure to provide a resident with appropriate assistive equipment to enable the resident to access showering facilities.

Judgment: Substantially compliant

Regulation 9: Residents' rights

While residents meetings were scheduled and documented, the feedback from residents in these meetings in relation to the food standards and laundry services was not acknowledged or responded to.

Not all residents were provided with equal access to activities in accordance with their interests and capacities.

Residents were not made aware of independent advocacy services available to support them in their decision making.

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	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0038381

Date of inspection: 11/01/2023

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: 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.

Post Inspection:4 x HCAs have commenced in the centre with an additional 4 HCAs awaiting compliance paperwork and Garda Vetting. A new Person in Charge has also been appointed to the centre and commenced on 06-02-2023. The role of Assistant Director of Nursing remains vacant with ongoing recruitment both locally and nationally. In the interim the Clinical Nurse Manager is allocated to off the floor supervisory duties and does not perform any nursing duties. A new Compliance and Quality Manager has been appointed to the Brookhaven Group and will commence on April 3rd 2023 adding another layer of support to the Nursing Homes Management Team. The appointment of the Compliance and Quality Manager will ensure the introduction of a robust monitoring programme which see them reviewing and monitoring audits within the centre on a monthly basis.
The staffing arrangements in the centre are reviewed formally weekly by the PiC and the Clinical Director, who is also on site. This review takes into consider the dependencies of the residents and the skill mix required. Currently we have 50 residents with 2 x Staff Nurses daily and 8 x HCAs supported by the PiC and CNM. At night the centre has 2 x Staff Nurses and 3 x HCAs supported by Management with on call rota and out of hours audits. Mealtimes are supervised by the PiC and CNM to ensure adequate support for the residents. The centre has a full complement of Housekeeping staff and 2 x staff are rostered daily to ensure appropriate cleaning of centre takes place. All rosters are released in advance with a full and adequate staff complement daily.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Regulation 16(1)(b) The person in charge shall ensure that staff are appropriately supervised.

In order to ensure staff are suitable equipped to perform their roles a review of training needs has been completed. Staff roles and responsibilities have been discussed and roles and responsibilities outlined. Escalation pathways have been refreshed and are visible throughout the centre to ensure clarity for all staff.

Regular feedback is given by the PiC and CNM throughout the day to all staff regarding any issues noted during observations and supervision of the units. The PiC attends the handover daily and debrief and huddle sessions are conducted on a daily basis to ensure staff are knowledgeable and have the skills to perform their roles. This knowledge is audited by the PiC and CNM through daily observations (e.g manual handling, resident care delivery) and through weekly/monthly audit.

Staff are supervised by the PiC and CNM. A very detailed staff allocations form is in place defining the roles and responsibilities of each staff throughout the day.

Activities team have met with the PiC and will continue to do so informally weekly and formally monthly to ensure appropriate activities are provided and booked in advance.

Senior Management will continue to meet with the nursing staff quarterly as previously documented in relation to their roles, responsibilities and accountability as outlined in their regulatory documents.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
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.

A review of the staff files has been undertaken and any deficits noted are currently being gathered to ensure compliance. A checklist which had been in place has been refreshed with all administration staff to ensure they are fully aware of the requirement for mandatory information on all staff. Monthly staff audits will resume with the PiC and administration staff to ensure all required documentation for staff is available and in place. The Administrator is currently auditing all non-compliant staff files every 2 days to ensure the information required has been requested and is gathered. It is expected this

project will be completed 24/02/2023.

The Statement of Purpose and Residents guide will be updated to provide information of the newly appointed PiC. Previous inspection reports continue to be openly displayed in the reception area of the centre.

Daily menus are maintained by the Chef for inspection/review.

Proposed rosters are maintained in paper format at reception. Actual and worked rosters are maintained both in paper copy and on computerised platform to ensure they are accessible. The computerised platform used for roster management has limitations in relation to recording of annual leave and other leaves. We have engaged with the provider in respect of these limitations, and they have committed to ensure this is rectified.

The roster is completed by the PiC and daily allocations of staff are completed 72 hours in advance. The PiC and CNM sign off on all staffing and ensure the daily allocations are sufficient to meet the needs of the residents on site.

Regulation 21(6) Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.

All records maintained at the centre are safe and accessible.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
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.

The statement of purpose will be updated to reflect the appointment of the new PiC. Currently staffing levels within the centre are outlined below and are informed by a recognised tool using both residents' dependencies and staffing numbers to determine the needs of residents. Agency staff were being used in the centre to complement our own team. Presently, we continue to use Nursing Agency Staff to support the Nursing Home whilst we await the arrival of 7 recruited Nurses from overseas between now and April 31st, 2023.
6 x new HCAs have commenced in the centre post inspection, and we await compliance for an additional 6 HCA staff and 1 x Kitchen Porter. We will not require agency HCA staff usage from 20/02/2023.
Staff within the centre are being supervised by the CNM and PiC with support from a

nominated buddy. All inductions are formally recorded and documented.

In the absence of an ADoN the CNM is off the floor in a supervisory capacity.
An additional role of CNM has been advertised so that in the event an ADoN is not forthcoming, clinical governance can be strengthened through 2 x CNMs working opposite each other to provide 7-day management cover across the Nursing Home.
Current CNM has been enrolled on a Management and Leadership course to equip her to assist with the management of the centre.

Team Leader roles have been advertised internally to provide an additional layer of supervisory support for the Health Care Assistants. This role will manage the allocation of staff across each shift and ensure monitoring of all ADLs for residents. The Team Leader will also be responsible for the induction and mentoring of all new staff in the centre and provide a stable consistent approach to the onboarding process.
Group Director of Operations appointed on 20-02-2023 who is currently assisting the centre with all non clinical compliance issues.
Group HR Manager commencing on 27-03-2023.

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.

All staff are aware of their roles and responsibilities. This has been discussed again with all staff. Escalation pathways are clearly displayed throughout the centre. The Management Team have clearly defined responsibilities and are supported by the Clinical Director.

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.

A robust auditing schedule was in place but had not been adhered to. The PiC will adhere to this schedule and ensure audits with associated action plans are completed by the on site management team. The PiC will review these audits daily/weekly/monthly as appropriate and ensure any issues noted or recommended are dealt with and recorded. Where change to practices are required these will be shared with staff, training provided if required, implemented, evaluated and reviewed on a continuous basis to ensure the service and or practice provide is consistent.

Audits within the centre include but are not limited to IPC, Falls, Tissue Viability Issues, care planning, Nutrition and Risk Management. These audits have been completed on site and inform the PiC on the immediate risks within the centre. All audit findings will be addressed by the PiC and centres management team to ensure any risks noted have evidence of a clear pathway to reduce, minimise or eliminate the risk where possible.

Continuous audit and re-evaluation of practices implemented will reassure the PiC that new practices are embedded and systems put in place to address and eliminate risks around care planning, nutrition and IPC are having a positive impact on care and care delivery.

The provider has sought assistance from an expert agency in respect of Risk Management Processes. This Agency will work along side the PiC to review the risks within the centre and develop a risk management policy that will identify risks and have a clear pathway in relation to their management. Staff will be trained and informed regarding the policy and procedures to ensure any new developments are clear and understood. A Risk Management Committee has been formed within the centre and will meet monthly. The Risk Register will be reviewed at least every 2 months by the new Compliance and Quality Manager to ensure it is managed in line with best practice requirements and the policy for the centre.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Regulation 34(1)(d) The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.

The complaints policy on display in the centre has been updated to reflect the new PiC. All residents have been reminded of the policy both verbally and in writing and how to log a complaint and the complaints process will be discussed at the next resident's forum.

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.

Complaints within the centre are being managed by the PiC. The complaints policy is clearly displayed for residents, families, and visitors. A suggestion box is also available at reception for those residents or families that wish to raise an anonymous concern or complaint.

The PiC is the nominated complaints person for the centre. All complaints will be managed and maintained by the PiC to ensure consistency in the process.

Resident surveys will commence in the centre from week beginning 27-02-2023 to ensure residents and families have an additional avenue to report on or voice opinions in relation to service delivery. These surveys will be reviewed by the Pic and a reported on at resident meetings and monthly governance meetings. All issues noted will be actioned and reviewed to ensure satisfaction.

Regulation 34(1)(g) The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.

All previous complainants have been contacted to ensure they have had their complaint managed to their expectation and that satisfaction was achieved.
Complaints will be reviewed and discussed weekly with the senior management team and reported on monthly with updates on investigation progress, if appropriate and record of satisfaction, if achieved. All complainants will be advised of the appeals process formally in writing and where satisfaction cannot be achieved internally they will be informed of the external parties available to assist them further. Complaints management in the centre will be audited on a monthly basis by either the Clinical Director or Compliance and Quality Manager to ensure adherence to the centers complaints policy. Where complaints cannot be managed in house there is an escalation process which is discussed weekly at the Senior Management team meetings.

Regulation 34(1)(h) The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.

The complaints procedure is clearly displayed in reception. The PiC is fully aware of the complaints procedure and policy. All complaints will be managed as per the policy and any measures required will be clearly documented, shared with staff, implemented and reviewed to ensure new practices are embedded and maintained.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Regulation 04(3) The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

The Provider has undertaken a review of all policies and sought assistance from an external agency to ensure that all policies within the centre are evidenced based and provide clear direction for staff in respect of the relevant legislation, standards and processes required to ensure they are knowledgeable and have the appropriate information available to them complete their roles.

As policies are completed they will be shared with staff and acknowledgement sought of their understanding and acceptance of the information contained within them. Policies

are being reviewed by the Clinical Director and shared with staff by the PiC. Adherence to policy and practices is audited through observations, supervision and formal auditing processes either daily/weekly or monthly by the PiC and CNM. Audits are reviewed by the clinical Director monthly and reported on to the Senior Management Team by the PiC in a monthly KPI report.

To date the following policies have been amended and shared with staff:
Nutrition Policy
Policy on Weight Loss
Residents Handbook
Policies pertaining to Staff Leave
Night Duty Policy
Smoking Policy
Recruitment and Selection
Staff Uniform
Staff Training and Development
Vaccination Policy

To ensure that Schedule 5 policies are completed within the timeframe elected the following plan has been devised.

For the week beginning 27-02-2023 the following policies will be amended and shared with staff:

Statement of Purpose
Care Planning Policies
Safeguarding Policy
Health and Safety Policy
Restraint Policy
Management of Complaints and Compliments Policy
Risk Management Policy

For the week beginning 06-03-2023 the following policies will be amended and shared with staff:

Policy on Incidents and Accident
Policy on provision of Personal Care
Policy on Behavioral Support
Admissions Policy
Policy on Residents Personal Property, Finances and Possessions
Communication Policy

For the week beginning 13-03-2023 the following policies will be amended and shared with staff:

Policy on Visiting
Creation of, access to, retention of, maintenance of and destruction of records.
CCTV Policy

Provision of information to Residents.

For the week beginning 20-03-2023 the following policies will be amended and shared with staff:

Medication Management
Infection Control
Resuscitation Policy

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Regulation 18(1)(c)(iii) The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

Dietitian was on site on 19.02-2023 and again on 02-02-2023 to review residents of concern. Nutritional audit has taken place on 09-02-2023 and an action plan developed and underway in the centre.
Nutritional training has taken place and 1:1 training with Nurses on MUST and Nutritional escalation pathways has taken place on site on 02-02-2023, 03-02-2023 and 13-02-2023
Nutritional Training with external agency has also taken place on 09-02-2023.
Nutrition Policy has been reviewed, discussed and distributed to all staff.
Mealtimes are monitored by the PiC and CNM to ensure appropriate supervision of residents is in place and all nutritional needs are met.
Nutritional information folder available at both Nursing stations as an assistive tool for Nurses on MUST Scores, care planning around nutrition and documentation and referrals.
All residents requiring nutritional input and support have had their care plan reviewed and updated by the PiC.

Regulation 18(3) A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

Staffing levels within the centre are reviewed weekly taking into consider the dependencies of the residents and the skill mix required. Currently we have 50 residents with 2 x Staff Nurses daily and 8 x HCAs supported by the PiC and CNM. At night the centre has 2 x Staff Nurses and 3 x HCAs supported by Management an on-call rota and out of hours audits. Mealtimes are supervised by the PiC and CNM to ensure adequate staff are supporting the residents. Daily discussions with residents continue to ensure they are satisfied with the quality and quantity of the foods being provided. The PiC and Chef have a weekly meeting to discuss the menu options for the forthcoming week. Daily

observations by the PiC and CNM of mealtimes continue with meal audits being conducted at least 3 times per week.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
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.

The provider has sought assistance from an expert agency in respect of IPC practices, procedures, documentation and oversight. This agency will work directly with the team in the centre to identify any gaps relating to current IPC governance, management and auditing practices. This agency will support the PiC in the implementation and oversight of any action plans required as well as the monitoring and oversight of IPC- Key Performance Indicators. The agency will provide training for all staff in IPC and assist the Person in Charge with IPC reviews and the updating of the IPC Programme for the centre.
This project will commence on March 14th 2023 and is due to be competed on April 13th 2023.

An external agency is currently providing a deep clean of the entire centre which is being overseen by the CEO. Terminal clean and deep clean processes have been devised and will be implemented to maintain the cleanliness of the Nursing Home post deep cleans.

Additional staff have been appointed to deep clean of the kitchen weekly on a Thursday to ensure kitchen cleanliness is maintained and documented.

IPC training has taken place on 08-02-2023 with a second IPC training course on site for staff on 24-02-2023.

An IPC and Health and Safety committee has commenced in the Nursing Home with the first meetings scheduled on 28-02-2023. A resident has been elected as a committee member on the Health and Safety Committee.

The PiC has completed the IPC Link Nurse Practitioner Programme Training and will oversee the IPC Committee and audits in the Nursing Home.

Dining room table and chairs have been replaced in both upstairs and downstairs dining areas.
All cloth furnishings have been deep cleaned on 18-02-2023.

All sanitary ware across the centre had been cleaned by internal staff post inspection and

prior to the deep clean.

An audit has taken place of all medical equipment within the centre, and where replacement equipment was required, it has been ordered and awaiting delivery. To date we have received 5 x shower Chairs and await delivery of 6 x wheelchairs for the centre. We are also awaiting delivery of a new full body hoist.

Requirements for the kitchen were also audited with additional cutlery, trays and baking utensil ordered for the catering team and due for arrival on 03-03-2023.

Deep clean and regular cleaning schedules are in place and overseen and monitored by the PiC.

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:
Regulation 5(3) The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.

The Provider has sought assistance from an external expert agency in relation to the oversight and management of assessment and care plans. This agency has been employed to complete a review of all residents' care plans, identify the gaps and assist and support the PiC to put in place a robust auditing and review system.
All nursing staff will be supported with care planning training to ensure they are fully aware of the practices required and the appropriate methods of recording and documenting resident's needs. Priority has been given to the assessment and review of falls, malnutrition and activities of daily living.
All Nursing staff will receive additional training on the assessment of residents.
Admission checklists have been updated to ensure there is a recorded process in place which clearly outlines the information obtained, care plans commenced and action plan required to ensure all documentation pertaining to residents is obtained on admission.
Staff will be supported to ensure they are fully aware of the care planning process.

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.

The provider is acutely aware that the expert agency will only review a random selection of care plans and make recommendations for improvement based off its findings. In the interim the provider intends to:

Review the Policies on Care Planning and ensure they provide staff with a step by step nursing process that enables them to capture and record a bespoke tailored care plan that meets the needs of each individual resident. Policies will be reviewed by the clinical director and be ready for distribution to staff on 28-02-2023.

The policies will then be used for 1:1 care plan training with Nursing staff. Training will be completed with all Nursing Staff by March 2nd 2023.

Those residents with nutritional needs and supports have been prioritised for a care plan review. This will be completed on 28-02-2023

Residents with maximum care needs will have care plans reviewed and updated by the PiC and Nursing staff on or prior to 31-03-2023.

Ultimate responsibility for the maintenance and upkeep of care plans will remain with the Nursing Staff once training has been completed. The PiC and CNM will retain responsibility for oversight and auditing of the process to ensure care plans are reflective of the needs and abilities of residents and clearly indicate decisions, choices and preferences.

Care plans will continue to be audited monthly by the PiC and CNM. The PiC will oversee the management of the care planning process and ensure where appropriate and possible all residents will be consulted in the preparation of their care plans and if appropriate family will be included.

The Clinical Director will review all care plan audits monthly to ensure action plans are followed up and completed as per the process outlined in the Care Planning Policy and delivered at training.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: 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.

Dietitian was on site on 19.02-2023 and again on 02-02-2023 to review residents of concern. Nutritional audit has taken place on 09-02-2023 and an action plan developed and underway in the centre. Nutritional training has taken place and 1:1 training with Nurses on MUST and Nutritional escalation pathways has taken place on site on 02-02-2023, 03-02-2023 and 13-02-2023
Nutritional Training with external agency has also taken place on 09-02-2023.

Nutrition Policy has been reviewed, discussed and distributed to all staff.
Mealtimes are monitored by the PiC and CNM to ensure appropriate supervision of residents is in place and all nutritional needs are met.
Nutritional information folder available at both Nursing stations as an assistive tool for Nurses on MUST Scores, care planning around nutrition and documentation and referrals.
All residents personal care needs have been audited to ensure they have the correct assistive equipment in place that enables them to access appropriate showering/washing facilities.
Following a review of the care planning policies due for completion on 27-02-2023, 1:1 care planning training will be facilitated by the Clinical Director from 28-02-2023. Training with all Nursing Staff will be completed on 02-03-2023.

Post training all named Nursing staff will have responsibility for the review of their dedicated residents to ensure care plans are reflective of individual needs and preferences for care.

The Care plans will continue to be reviewed monthly by the PiC and audited again by the Clinical director to ensure compliance with the Nursing process and Policies implemented to direct it.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Regulation 9(2)(b) The registered provider shall provide for resident's opportunities to participate in activities in accordance with their interests and capacities.

A residents meeting has taken place on 27-01-2023 with a good attendance from residents. Issues identified as having been raised previously were readdressed with residents and an action plan put in place.
A Resident Representative has been appointed by the residents.
Minutes of all residents' meetings are displayed openly in the Nursing Home and available for review. Copies of minutes are shared with the resident's representative.
Meetings are now scheduled every 2 weeks and will be advertised in advance on the resident's information boards.
Some residents requested 1;1 meetings with management which have been facilitated to voice any/all concerns.
The Activity Team will have overall responsibility for the scheduling and management of Residents Forum Meetings.

Residents' meetings are taking place on site at least every 2 weeks to ensure all residents have an opportunity to voice their concerns and opinions in relation to the services provided in the centre. At the residents request these meetings are held by the

PiC and attended by other key department heads when invited.

Regulation 9(3)(d) A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned

The activity team have undertaken a review with all residents to determine their wishes, interests and capacity. Once this review has been completed, they will engage with residents during the residents meetings to determine what new activities residents would like to be implemented within the centre

The activity team have commenced their review with all residents, clearly noting all likes and dislikes as well as opportunities to implement new activities. Residents Forum meetings have enabled discussion with residents on activity provision within the centre and those activities residents would wish to trial and /or engage in.

Resident have been actively involved in decisions around paint colours for rooms being decorated and have chosen colours for areas throughout the Nursing Home.

The upstairs dining room has been rearranged and now holds 4 dining tables for residents to enjoy meals outside of their rooms.

Regulation 9(3)(f) A registered provider shall, in so far as is reasonably practical, ensure that a resident has access to independent advocacy services.

Information pertaining to the advocate for the Nursing Home will also openly displayed in the residents information area on each floor and discussed at the Residents Forum. The Resident Representative also has this information available to her should any resident request it.
Each floor within the centre has a dedicated resident information area which clearly displays all the information needed by the residents. This information area was implemented on 15-02-2023 and allows residents to freely access information on the advocates, their telephone numbers, minutes of resident meetings and action plan as well as information on committees and members within the centre. The area also has information relevant to the resident representative and forthcoming resident forum meetings.

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	16/01/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	06/02/2023
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff,	Not Compliant	Red	16/01/2023

	based on nutritional assessment in accordance with the individual care plan of the resident concerned.			
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Not Compliant	Red	16/01/2023
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	28/02/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	28/02/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	03/04/2023
Regulation 23(b)	The registered provider shall ensure that there	Not Compliant	Orange	28/02/2023

	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.			
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	03/04/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Red	16/01/2023
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all	Not Compliant	Orange	28/02/2023

	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.	Not Compliant	Orange	28/02/2023
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Orange	28/02/2023
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure,	Not Compliant	Orange	28/02/2023

	and shall put in place any measures required for improvement in response to a complaint.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	31/03/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/03/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and	Not Compliant	Orange	31/03/2023

	where appropriate 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.	Substantially Compliant	Yellow	31/03/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/03/2023
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	31/03/2023
Regulation 9(3)(f)	A registered provider shall, in so far as is	Not Compliant	Orange	28/02/2023

	reasonably practical, ensure that a resident has access to independent advocacy services.			