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:	Esker Ri Nursing Home
Name of provider:	Blackden Limited
Address of centre:	Kilnabin, Clara, Offaly
Type of inspection:	Unannounced
Date of inspection:	07 December 2023
Centre ID:	OSV-0000733
Fieldwork ID:	MON-0041475

About the designated centre

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

Esker Ri Nursing Home is a purpose-built premises. The designated centre is situated on an elevated site off the Tullamore road on the way out of the village of Clara. The designated centre currently provides accommodation for a maximum of 143 male and female residents aged over 18 years of age. Residents' accommodation is provider on three floors. Residents are accommodated in single and twin bedrooms with full en suite facilities. The designated centre provides mainly residential care to older adults and also provides respite, convalescence and care for people with an intellectual disability, physical disability, acquired brain injury, dementia and palliative care needs. The provider employs a staff team consisting of registered nurses, care assistants, activity coordination staff, administration, maintenance, housekeeping and catering staff. The provider states in their statement of purpose for the designated centre that their aim is to provide a residential setting wherein residents are cared for, supported and valued within a care environment that promotes their health and well being.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	126

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 7 December 2023	09:00hrs to 16:30hrs	Sean Ryan	Lead
Thursday 7 December 2023	09:00hrs to 16:30hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Resident's living in Esker Ri Nursing Home told inspectors that the care and support they received was of a good standard. Residents told the inspector that they 'felt at home' and 'relaxed' living in the centre. Residents described the staff as kind, respectful, and attentive to their needs and this made the residents feel safe in their care.

Inspectors were met by an assistant director of nursing on arrival at the centre. Following an introductory meeting, inspectors walked through the premises and met with a number of residents and staff. On the day of inspection, the centre was experiencing an outbreak of COVID-19. A number of residents were cared for in a dedicated isolation area that was separately staffed. Inspectors observed that the remaining residents spent their day in their bedroom or other communal areas and were not impacted by the outbreak.

Inspectors met with a number of residents in the communal dayrooms in each unit and in their bedrooms. Inspectors spoke to six residents in detail about their experience of living in the centre. Overall, residents reported improvements in the quality of care they received. Residents described how staff were 'very helpful' and although some staff were new, they 'spent time getting to know' residents. Residents told inspectors that staff were prompt to respond to their requests for assistance and did not make them feel rushed. There was a friendly and relaxed atmosphere in the centre. Residents were observed chatting with one another in communal dayrooms and enjoying a variety of activities throughout the day. Staff were observed to engage with residents in a meaningful manner and there was a friendly relationship between staff and residents.

The premises was warm, bright, spacious, clean, and appropriately decorated for residents. There was a schedule of planned redecoration works underway to ensure the premises was appropriately maintained. This included redecoration of the activities room for residents. Externally, the installation of gates at the main entrance was progressing to ensure the safety of residents.

Inspectors observed that doors within the centre were fitted with automatic door closure devices. This ensured that doors would remain closed to support fire containment measures. However, inspectors observed that a significant number of doors were held open with pieces of furniture and rubber wedges. This practice had the potential to impact on the function of the fire doors to contain smoke and fire in the event of a fire emergency.

Residents bedrooms were personalised with items such as family photographs, colour coordinated soft furnishings, and ornaments. Residents told the inspector that they were happy with their rooms and they found they were comfortable.

All residents in the centre were seen to be well dressed and it was apparent that staff supported residents to maintain their individual style and appearance. Residents told inspectors that staff helped them to choose their clothing daily, and apply their jewellery and make-up with care.

Residents were facilitated to provide feedback on the quality of the service through formal scheduled residents meetings and surveys. This included feedback on the activities programme and menu options. Residents reported that when they provided feedback, the management team ensured their feedback was used to implement changes to the service.

There were activities provided to residents through the day. There was a lively activity session in one dayroom which was attended by a number of residents. Residents who were present at the activity said they really enjoyed it and liked listening to the staff sing Christmas carols.

Visitors were informed that there was an outbreak of COVID-19 in the centre. Visiting was not restricted and a number of visitors were observed attending the centre on the day of inspection. Visitors were complimentary of the staff. However, while the service was receptive to complaints, the feedback from visitors and residents was that concerns and complaints were not always addressed in a timely manner.

The following sections of this report details the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended). Inspectors followed up on the actions taken by the provider to address significant issues of non-compliance found on the last inspection in August 2022. Inspectors also followed up on unsolicited information received by the Chief Inspector in relation to the management of the centre.

The findings of this inspection were that the provider had taken some action with regard to their governance and oversight of the service, and the implementation of systems to support the safeguarding and protection of residents. Inspectors noted improvements in the quality of clinical care records, and the training of staff to ensure safe and effective care was provided to residents, in line with the policies and procedures. However, inspectors found that a poorly defined organisational structure resulted in unclear roles and responsibilities of the management team. This impacted on establishing, implementing and maintaining effective management

systems that included the oversight and management of risk, the management of adverse incidents involving residents, complaints, and records management.

Inspectors reviewed unsolicited information received by the office of the Chief Inspector. The information pertained to concerns regarding the governance and management of the centre, medication management, and the supervision of the quality of care provided to residents. This information was found to be substantiated on this inspection.

Blackden Limited is the registered provider of Esker Ri Nursing Home. It is a company consisting of two directors, one of who represents the registered provider. The management structure supporting the designated centre consisted of a regional operations manager, who was a person participating in the management of the centre. The increased presence of the regional operations manager in the centre was found to have improved the organisation and management of the staffing resources, the management of risks specific to the absconsion of residents, and the quality of residents clinical care records. However, the presence of the regional operations manager in the centre had reduced since the previous inspection and this resulted in reduced management resources, oversight of the service, and support for the person in charge.

Inspectors were not assured that the provider had adequate resources in place to effectively manage the centre and to ensure the supervision, and the care and welfare of the residents. On the day of inspection, the person in charge was on leave and an assistant director of nursing deputised in their absence. The clinical management in place to support the assistant director of nursing was not in line with the centre's statement of purpose, which outlined an organisational structure consisting of two clinical nurse managers (CNM) on duty daily. As a result of planned and unplanned leave, and one CNM vacancy, the assistant director of nursing was supported by only one clinical nurse manager. Clinical nurse managers had responsibility for monitoring the quality and safety of the service such as infection prevention and control, clinical documentation and providing supervision and support to the staff to ensure residents receive safe quality care. However, deficits in the clinical nurse management resource resulted in the assistant director of nursing filling vacant CNM shifts. This impacted on nursing oversight and governance.

Inspectors reviewed the management systems in place to monitor the quality of the service and found that while some audits were effective to improve aspects of the service, such as improved call bell response times, the auditing systems in place to monitor records, clinical care records, incidents and complaints did not facilitate the development of any quality improvement plans for the centre. This was compounded by unclear roles and responsibilities of the management team and that some of the management systems were not known to the personnel responsible for the administration and oversight of the service. Consequently, this governance and management issue continued to impact on regulatory compliance across the regulations reviewed on this inspection.

Communication systems in place to escalate risks and concerns to the senior management team were not effective. For example, inspectors found incidence of complaints, and adverse incidents involving residents that had not been appropriately managed in line with the centre's policies and associated procedures, or escalated to the senior management team.

A review of the centre's risk management systems found that the provider had taken action to establish systems to monitor risks in the centre, in line with the centre's risk management policy. A review of the risk register found that some clinical and operational risks were identified and recorded. However, the actions detailed in the risk register to managed identified risks were not robust and did not provide assurance that the impact of potential risks were effectively managed to protect residents. Additionally, adverse incidents involving residents were not appropriately investigated in line with the centre's risk management policy.

A review of the record management systems in the centre found that records of incidents and adverse events were documented in line with professional guidelines, regulatory requirements, and the centre's own policy. However, records to be held for each member of staff were not maintained in line with the requirements of Schedule 2. For example, some staff personnel records did not contain a satisfactory history of employment. In addition, records of staffing rosters were not maintained in line with the requirements of Schedule 4 of the regulations. Also, some records were not maintained in a manner that was accessible.

While complaints were documented, there was poor oversight of the management systems in place to investigate and respond to complaints and concerns in a timely manner. Records of complaints received by the centre in August and October 2023 regarding medication management and the quality of care had not been reviewed or investigated by the personnel responsible for the management of complaints, in line with the centre's complaints management policy.

A directory of residents was maintained by the registered provider and was available for review.

The centre had sufficient staffing resources to ensure effective delivery of care and support to residents. The team providing direct care to residents consisted of registered nurses, and a team of health care assistants. There were sufficient numbers of housekeeping, activities, catering and maintenance staff in place.

A review of staff training records found that all staff had up-to-date training in fire safety, safeguarding of vulnerable adults, and infection prevention and control. Additional training had been provided to staff with regard to the nutritional care of residents and staff demonstrated an appropriate awareness of the actions to take to support residents at risk of malnutrition. While staff had been provided with training specific to the management of complaints, there was no system in place to supervise staff and evaluate the quality of the training provided and the management of complaints continued to be ineffective. Additionally, staff were not appropriately supervised to ensure fire safety procedures were adhered to as

evidenced by poor practice where multiple fire doors were held open by pieces of furniture.

Regulation 15: Staffing

There was sufficient staff with an appropriate skill mix on duty to meet the needs of residents and having regard to the size and layout of the centre.

Judgment: 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 all residents. This was evidenced by;

- poor fire safety awareness as evidenced by fire doors wedged open.
- poor supervision of staff to ensure that policies and procedures in place to manage complaints were implemented.

Judgment: Substantially compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements. For example;

- Staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations. For example, two staff file did not contain a full employment history, together with a satisfactory history of any gaps in employment. One staff file did not contain two written references.
- Records of staff rosters were not maintained in line with the requirements of Schedule 4(9). For example, rosters did not reflect the roster that was actually worked by staff. In addition, roles were not accurately described within the roster. For example, the assistant director of nursing was identified in the roster as a clinical nurse manager.
- The hours worked by the regional manager in the centre were not recorded on the staff roster. This meant that the organisational support for the person in charge was not clearly evidenced.
- Some records were not maintained in a manner that was accessible. For example, while policies and procedures as required by Schedule 5 of the

regulations were available, they were poorly organised, difficult to review, and not easily accessible.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had failed to ensure that there were sufficient staffing resources in place to consistently maintain planned staffing levels and that the clinical nurse management structure was maintained, in line with the centre's statement of purpose. This impacted on the overall governance and oversight of the service. The service was dependent on the use of agency staff to support the nursing rosters. While there was evidence of ongoing recruitment, on the day of inspection the provider did not have the staffing resources to cover planned and unplanned leave.

The organisational structure, as described in the centre's statement of purpose, was not consistently available and, therefore, not effective. The inadequate level of available clinical nurse managers resulted in the assistant director of nursing suspending their management and supervisory role. On the day of the inspection, the assistant director of nursing was deputising for the person in charge, however a review of the staffing allocation documents and rosters found that they were working as a clinical nurse manager. In light of this, accountability and responsibility for the oversight and monitoring of key aspects of the service were not clear. This included the oversight of risk management systems, complaints, and record management. Additionally, there were inconsistent and poorly defined systems in place to escalate risks to the senior management.

The poorly defined organisational structure impacted on establishing and sustaining effective management systems to ensure the service provided was safe and appropriately monitored. This was evidenced by;

- poorly documented and ineffective risk management systems.
- inadequate staff supervision.
- inadequate oversight of record management.
- inadequate identification and management of a potential safeguarding incident.

Judgment: Not compliant

Quality and safety

Resident's health and social care needs were met to a satisfactory standard of evidenced-based care and support from a team of staff who knew their individual

needs and preferences. Residents were satisfied with their access to health care and reported feeling safe and content living in the centre. Inspectors found that while the quality and safety of the services provided in this centre had improved, action continued to be required to ensure residents were protected and safeguarded, and that resident's care plans reflected their current care needs.

There were arrangements in place to safeguard residents and protect them from the risk of abuse. Residents reported that they felt safe living in the centre. Safeguarding training was up-to-date for all staff and a safeguarding policy provided support and guidance in recognising and responding to allegations of abuse. However, inspectors found that an potential safeguarding incident involving residents had not been investigated in line with the centre's safeguarding policy. This was a repeated finding from the previous inspection.

Residents' care plans and daily nursing notes were recorded on an electronic documentation system. An assessment of residents health and social care needs was completed on admission and ensured that residents' individual care and support needs were being identified and could be met. While there was evidence that resident's needs had been assessed using validated assessment tools, the assessment findings were not always reflective of the residents actual care needs, or incorporated into the residents care plan. Consequently, the care plans did not identify the current care needs of the residents or reflect person-centred guidance on the current care needs of the residents. This is a repeated findings from the previous inspection.

Residents were reviewed by a medical practitioner, as required or requested. Referral systems were in place to ensure residents had timely access to health and social care professionals for additional professional expertise. There was evidence that recommendations made by professionals had been implemented to ensure best outcome for residents.

Procedures had been established to ensure that the transfer of residents from the designated centre occurred in line with the requirements of the regulations. This included arrangements to ensure information pertinent to the care of residents were communicated to the receiving health care facility.

While each resident was provided with a guide to services in the designated centre in an accessible format on admission to the centre, the guide had not been updated to reflect changes to the complaints procedure, including the personnel responsible for the management of complaints.

There were opportunities for residents to consult with management and staff on how the centre was organised. Minutes of residents meetings evidenced that resident’s feedback, with regard to the quality of the service, was used to improve the service.

There was an activity schedule in place and residents were observed to be facilitated with social engagement and appropriate activity throughout the day. Residents had access to television, radio, newspapers, and books.

Visiting was observed to be unrestricted, and residents could receive visitors in either their private accommodation or a designated visitor area, if they wished.

Regulation 11: Visits

The registered provider had arrangements in place to facilitate residents to receive visitors in either their private accommodation, or in a designated visiting area. Visits to residents were not restricted.

Judgment: Compliant

Regulation 20: Information for residents

The resident's guide did not contain accurate information with regard to the procedure respecting complaints.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Arrangements were in place to support the transition of residents from the designated centre to hospital or home in consultation with each resident, including the resident’s general practitioner (GP).

Information regarding the residents health and social care needs were provided to the resident concerned, hospital, general practitioner, family or carer.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A sample of resident's assessments and care plans found that they were not in line with the requirements of the regulations. For example;

- Care plans were not guided by a comprehensive assessment of the residents care needs. 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 being at high risk of falls. Consequently, staff did not have accurate information to guide the care to be provided to the residents.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP).

Residents also had access to a range of health and social care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of later life and palliative care.

Records evidenced that the recommendations of health and social care professionals were implemented and reviewed to ensure best outcomes for residents.

Judgment: Compliant

Regulation 8: Protection

The registered provider failed to take reasonable measures to protect residents from abuse and to provide for appropriate and effective safeguards to prevent abuse. This was evidenced by a repeated failure to;

- recognise and respond appropriately to an allegation of abuse.
- investigate an allegation of abuse.

Judgment: Substantially compliant

Regulation 9: Residents' rights

There was facilities for residents occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. Residents expressed their satisfaction with the variety of activities on offer.

Residents were provided with the opportunity to be consulted about and participate in the organisation of the designated centre by participating in residents meetings and taking part in resident surveys.

Residents told the inspector that they could exercise choice about how they spend their day, and that they were treated with dignify and respect.
Judgment: 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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Esker Ri Nursing Home OSV-0000733

Inspection ID: MON-0041475

Date of inspection: 07/12/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All CNM staff remain fully supernumerary as per SOP requirements, all shifts are covered x7days/week. This ensures the CNM continues to have responsibility for monitoring the quality and safety of the services, and providing the appropriate level of supervision required. Where Esker Ri staff cannot cover absent shifts due to unexpected sickness, the Nurse in Charge will continue to contact the Nursing Agencies to fill the required shift. Where the agency cannot cover the requested shifts the nurse in charge will contact the PIC/Operations manager ,where alternative staff cover will be arranged. We understand the significance of fire safety in a care home environment and the importance of conveying this information to both staff, residents and visitors. The identified door wedges were removed immediately and we have reiterated the prohibition of door wedges in accordance with fire regulations. Daily checks are completed to ensure all fire doors remain clear of any obstructions, at all times . Additional supervision sessions are ongoing on fire safety and complaints management for all staff. Staff remain vigilant to remove any door wedges immediately if found.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A full audit has been commenced on all personnel files to ensure all required schedule 2 documents are accessible in their individual personnel files.	

Staff rosters, as per Schedule4(9) have been reorganised to ensure all roles, including the Regional manager /shifts worked are clearly identifiable.

We have implemented a robust document management system that facilitates the organized storage, retrieval, and tracking of Schedule 5 documents. This system enhances accessibility for all staff members to ensure that all staff members are aware of the importance of Schedule 5 policies and understand how to access them.

Staff inductions include familiarizing staff with the location of the documents, the procedures for updates, and the significance of adhering to the established policies. This ensures that everyone is well-informed and can readily access the most current versions of the policies.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Where CNM supernumerary staff are unexpectedly on leave, a senior nurse will be allocated to cover the allocated CNM hours until they resume. This will ensure sufficient staffing levels are consistent as per SOP, to ensure the clinical nurse management structure is maintained, in line with the centre's statement of purpose.

Additional to daily team meetings with the PIC/DPIC/CNM. All incidents /concerns/complaints are reviewed weekly by Regional manager. This includes oversight regarding completed documentation and oversight of record management, identifying key risks and actions required.

Standardised audit systems are regularly completed to ensure a continuous monitoring system to identify areas for further improvement and to monitor the effectiveness of the improvements achieved.

Staff and relative surveys continue to be completed ,to aid open communication channels to address any concerns or questions that may arise.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents: Current residents guide under review and will include new complaints policy.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: Information relayed to all nurses following HIQA inspection. Each primary Nurse is currently reviewing all resident files to ensure comprehensive assessment/relevant risk assessments and care plans all consistently reflect the individual needs of each resident. Regular monthly care plan audits continue to monitor compliance with same.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Any safeguarding / or potential incidents are reported and investigated immediately by the Person in charge, where appropriate actions are taken to protect residents. Support from the GP /and referral to other members of the Multidisciplinary team is requested immediately, where required . Daily team meetings continue in each Wing, where all incidents /near misses /concerns are discussed. Appropriate referral /notification to is forwarded to Safeguarding Team / HIQA, as required. Additional tool box sessions have been provided with ongoing to support for staff to recognise potential safeguarding incidents or near misses, this will include management of behaviour that is challenging.

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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	28/01/2024
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure respecting complaints, including external complaints processes such as the Ombudsman.	Substantially Compliant	Yellow	19/01/2024
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	23/02/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in	Substantially Compliant	Yellow	12/12/2023

	such manner as to be safe and accessible.			
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	29/03/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	11/12/2023
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	11/12/2023
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health,	Substantially Compliant	Yellow	11/12/2023

	personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	11/12/2023
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	12/02/2024