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:	Ratoath Manor Nursing Home
Name of provider:	Ratoath Nursing Home Limited
Address of centre:	Ratoath, Meath
Type of inspection:	Unannounced
Date of inspection:	24 November 2021
Centre ID:	OSV-0000152
Fieldwork ID:	MON-0034406

About the designated centre

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

Ratoath Manor Nursing Home is set in the village of Ratoath in County Meath. The two-storey premises was originally built in the 1820s and is located on landscaped gardens. It now provides accommodation to 60 male and female residents over 18 years of age. Residents are admitted to the centre on a long-term residential, respite and convalescence care basis. The service provides care to residents with conditions that affect their physical and psychological function. Residents of all dependency levels are provided for. Residents are accommodated in single and twin bedrooms across three units; St Oliver's Unit, St Patrick's Unit and Ground Floor Unit. A proportion of these bedrooms have en-suite sanitary facilities. Communal shower rooms, bathrooms and toilets are available throughout the building. A variety of communal rooms are provided for residents' use across both floors, including sitting, dining and recreational facilities and an oratory. A number of outdoor areas are also available, including large gardens on the ground floor and two internal courtyards on the first floor. The registered provider employs a staff team consisting of managers, registered nurses, care assistants, activity coordination, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	57

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 24 November 2021	09:00hrs to 17:25hrs	Helena Budzicz	Lead
Wednesday 24 November 2021	09:00hrs to 17:25hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

The inspectors spent time observing residents going about their day-to-day lives. The atmosphere in the centre was warm and inviting, and the feedback received from all residents and visitors met throughout the day was overwhelmingly positive. However, due to some immediate risks to health and safety identified on the day and as further presented in the report, the inspectors found that although the residents were content with the care they were receiving, they were not receiving the level of service required to ensure their needs were met in a holistic or safe manner.

Numerous communal areas, as well as individual bedrooms, had been painted since the last inspection, and overall the environment appeared clean and well-maintained. There was a planned schedule of further works in place to further upgrade the premises. Relatives and visitors who spoke with the inspectors praised the staff and the new person in charge for their efforts to create a homely atmosphere and the kindness and compassion they showed to their loved ones.

Inspectors met and spoke with more than ten residents who were also consistent in their feedback that they were happy living in the centre. Examples of comments made were that; 'the care was great', 'the food was lovely', 'activities were plentiful', and the staff were 'all terribly nice'. None of the residents could think of any suggestions for improvement and said that they took part in residents' meetings and were consulted in the running of the centre. They liked that the centre had been repainted and some of the residents chose the colours of the paint. One resident said: 'It is very nice here, as you can see. They are all very nice, everything you ask you get. The food is grand, and there really isn't anything to complain about.'

The inspectors observed visitors coming and going throughout the day and spoke with more than eight different relatives. All relatives praised the care and staff and voiced their appreciation for the improvements completed in the premises in recent months. The high vaccination rate meant that residents could see their visitors in their bedrooms. Visitors who spoke with inspectors confirmed that there was sufficient time and space for residents to receive visitors at the centre; however, they felt that the booking system was overly rigid and sometimes restrictive as they would like to visit their loved one more often, and this was not always possible if all visits were already pre-booked.

While some improvement in infection prevention and control was noted since the last inspection, the inspectors observed staff practices throughout the day and found that they were not consistently safe. Staff were observed using gloves inappropriately, not wearing the masks correctly, carrying used linen through the corridors inappropriately, or wearing rings on their fingers which did not support good hand-washing.

Inspectors also spoke with numerous staff during the day. While they all

acknowledged that the centre had been through a difficult period, they said that things were settling as a new management team was in place.

Throughout the day, inspectors observed residents engaged in physical exercises with the physiotherapist who was present in the centre, or music therapy, nail grooming and painting, hand massage and story-telling. Interactions between staff and residents were courteous and kind.

The inspectors observed a meal serving and found it to be a social and unhurried experience for residents. There was a choice of at least two meals at lunch, the food looked appetising, and portion sizes were generous. There was also a range of drinks available at meal times and throughout the day. Staff were seen to offer choice to residents and to provide the required level of support or assistance. However, some improvements were needed to provide a positive and safe dining experience for residents as discussed further in this report.

The next two sections of the report will describe in more detail the specific findings of this inspection in relation to the governance and management of the centre, and how this impacts on the quality and safety of the service provided to residents.

Capacity and capability

This unannounced risk inspection was completed to follow up on the provider's response to the findings of the previous inspection dated 7 September 2021. The inspectors observed that there was some progress made, specifically in respect of premises; however, significant focus and efforts were further required to ensure the centre was providing a safe and high-quality service for the benefit of the residents living there. While some actions from the September compliance plan have been completed according, they were not sufficient to bring the centre into compliance with the regulations and to demonstrate effective governance and management arrangements in the designated centre. Furthermore, two urgent action plans were issued to the provider on the day of inspection in respect of staff understanding and implementing the COVID-19 contingency plan and Regulation 16: Training and staff development.

The following actions from the inspection of September 2021 had been completed:

- Regulation 9: Residents' rights
- Regulation 10: Communication
- Regulation 13: End of life
- Regulation 15: Staffing

Other actions were still in progress and the inspectors followed up on that during the course of this inspection. These included

- Regulation 27: Infection Prevention and Control

- Regulation 17: Premises
- Regulation 28: Fire safety

However, this inspection identified recurrent non-compliances in a number of areas which the provider had deemed to have completed as part of their response to the findings of the previous inspection:

- Regulation 15: Training and staff development
- Regulation 5: Individual assessment and care plan
- Regulation 6: Healthcare

The registered provider was Ratoath Nursing Home Limited, which is part of the Silverstream Group. There had been changes in the governance and management arrangements in the centre since the last inspection and the provider had a plan in place to further strengthen the clinical and operational oversight. Future inspections will further determine whether these changes will have a positive impact and lead to an improved service for the benefit of the residents.

A new person in charge had been appointed, who facilitated the inspection; they had a good understanding of their statutory role and responsibilities and were aware of the previous inspection findings. Staff reported that the person in charge was approachable and that they felt supported. The operations management attended the centre every other week and was actively involved in supporting the service. A new facility manager had also been appointed.

While supervision structures were in place, they were not effective at ensuring staff implemented local policies in practice. Although staff had completed all the required mandatory training as well as additional relevant courses, the oversight of staff practices required to be considerably improved as outlined under Regulation 16: Training and staff development. Furthermore, this inspection identified an educational deficit and training need in respect of dysphagia, which had not been identified by the registered provider.

The inspectors observed that there were a number of communication processes in place, including regular staff group meetings or regular handovers at the start and end of each shift. However, the information in the daily communication sheet did not assure information on residents' changing needs were accurately documented and that pertinent information was exchanged between staff. For example, staff who spoke with the inspectors were not familiar that there was a resident suspected of COVID-19. Additionally, other staff on duty were not familiar with the contingency plan, and this posed significant risks to the health and safety, as isolation protocols were not timely implemented. Additionally, the management control processes failed to identify a lack of knowledge and precautions in place.

There was a comprehensive programme of audits including environmental audits, care plans, nutrition and infection prevention and control to name a few, which were carried out at regular intervals to monitor the quality and safety of care delivered to residents. However, a number of concerns identified by inspectors such as issues in the medicine management or infection control had not been identified or addressed by these systems. In addition, where areas of improvement were found,

improvements were not timely implemented in line with the action plan.

There was a directory of residents maintained in the centre which was made available to the inspector. The directory was up-to-date and reflected the current status of residents living in the centre.

Regulation 14: Persons in charge

The person in charge is a registered nurse with experience in the care of older persons in a residential setting. They hold a post registration management qualification in health care services and work full-time in the centre. Although they had been recently appointed to the role, the inspectors found that the person in charge was familiar with the needs of residents and committed to a continuous quality improvement strategy to deliver safe consistent and effective services to them.

Judgment: Compliant

Regulation 15: Staffing

On the day of the inspection, there were sufficient staffing levels and an appropriate skill-mix across all departments to meet the assessed needs of the residents. Inspectors observed that the staffing levels in the household department were increased to three household staff a day since the previous inspection.

Judgment: Compliant

Regulation 16: Training and staff development

While the staff in the centre was provided with access to appropriate training and the training matrix was maintained up-to-date, the inspectors observed insufficient managerial oversight of staff practices. The supervision of staff practices was inadequate as per additional details provided under Regulation 5: Individual assessment and care plans, Regulation 29: Medicines and pharmaceutical services and Regulation 18: Food and nutrition.

Furthermore, the provider was required to arrange immediate training for dysphagia (on how to manage food and drinks for the residents with difficulty with swallowing foods and liquids) and medicine management refresher training for all nursing staff.

Additionally, staff had been trained on infection prevention measures; however,

inspectors observed numerous examples where the personal protective equipment (PPE) such as gloves was used inappropriately by staff during the course of the inspection. For example, gloves were not removed immediately after providing care to residents, or staff was wearing gloves around the centre or when assisting residents with the meals.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider had maintained a directory of residents, and this contained the information required in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 22: Insurance

A valid certificate of insurance was in place which included cover for public indemnity against injury to residents and other risks including loss and damage of resident's property.

Judgment: Compliant

Regulation 23: Governance and management

While arrangements had been put in place to strengthen the governance structures, the lines of accountability and responsibility and the operational management structure available within the designated centre required improvement to ensure effective oversight of service and to ensure improvement in staff performance through adequate supervision.

On the day of inspection, the inspectors found immediate risks to health and safety and issued two urgent action plans in respect of staff training in dysphagia and COVID-19 protocol. While a comprehensive COVID-19 contingency plan was in place, inspectors found that it was not consistently implemented by managers and staff and that the oversight of staff practices was poor. Staff were not familiar with the contingency plan and as a result residents that should have restricted their movement in line with COVID-19 protocol were observed socialising with others. There was no cautionary signage in place to alert and inform staff of precautionary measures required and this information had not been effectively communicated at

handover.

Further assurances were required that the audits and management systems to oversee the care and service were effective. For example, a care plan audit had been completed, which identified a number of actions required to improve the documentation. The date for ensuring that all care plans would be reviewed and address identified failings had passed. However, this inspection found recurrent non-compliance in this respect and that the provider's assurances and action plan had not been effective at addressing this area.

In addition, some audits used by the centre to identify shortcomings in the residents' weight-loss monitoring and wound management continued to be in the format of a checklist. As a result, the quality improvement plan and follow up actions were not clearly identified and did not ensure continual improvement progress.

Judgment: Not compliant

Regulation 4: Written policies and procedures

All Schedule 5 policies were available and had been reviewed in the last three years in line with regulatory requirements. However, while policies were evidence-based and in an accessible format, providing good detail on how to deliver care and service, the inspectors found not all policies were implemented in practice. For example, medication management policy, infection prevention and control policies and food and nutrition policy.

Judgment: Substantially compliant

Quality and safety

The findings of this inspection show that overall, the residents accommodated in the designated centre enjoyed a good quality of life and were happy in the centre. However, improvements were required to ensure residents' health and safety was proactively promoted and maintained at all times. Despite the evident progress made since the last inspection in improving the cleanliness and maintenance of the premises, significant concerns remained in respect of ensuring residents received the highest standard of evidence-based nursing care and practice in line with their assessed needs and that medication management practices in the centre were safe.

Although a risk register and a COVID-19 contingency plan were in place, inspectors found that staff were not familiar with it and had not initiated the correct protocol for the management of suspected cases of COVID-19. Additionally, there was no

evidence that staff read and understood current public health guidelines and the COVID-19 contingency plan. This posed a great risk to the health and safety of all residents, and an urgent action plan was issued to the provider to address it before the end of the day. Confirmation was received following the inspection that a COVID-19 protocol was now in place and effectively communicated to all staff.

Following recovery from COVID-19, many residents had lost weight due to poor appetite, and some had developed wounds. The inspector reviewed the care, the weight and wound management plans for a number of these residents and found evidence of good practices, including weekly weights, regular turning to promote skin integrity, reviews by the dietetic team and charting of oral nutritional supplements. Falls were managed well with multidisciplinary input.

A physiotherapist visited the centre on a weekly basis. In addition and to support residents' physical recovery, twice-weekly sessions with Siel Bleu had been introduced, providing gentle group exercises as part of the activity programme. The general practitioner (GP) was visiting the centre on a regular basis, and records showed that residents had good access to.

A team had been established to address concerns of abuse when they arose within the designated centre. Good links had been established with the safeguarding team and the local Gardaí.

The inspectors reviewed the restraint register. The use of the restraint in the centre was low, and there was evidence that alternative, less restrictive interventions were offered and trialled and risk assessed. Additionally, records showed that the residents were involved in the decision-making process.

Regulation 11: Visits

The centre had an up-to-date visiting policy in place and was in the process of implementing the most recent Health Protection Surveillance Centre (HPSC) visiting guidance while at the same time complying with infection prevention and control advice. The centre had a booking system for visiting in place which was reflected in the local policy. Relatives and friends visiting the centre had symptom and temperature checks and screening questions to determine their risk of exposure to COVID-19.

Judgment: Compliant

Regulation 18: Food and nutrition

Inspectors saw that residents' nutritional needs were assessed by a dietitian and speech and language therapist and specialist advice was communicated effectively to the chef and catering staff. However, inspectors observed at least two instances where residents were provided with a modified diet that was not in line with their assessed needs. This posed an immediate risk of choking and as a result an immediate action plan was issued to the provider to address this identified need in respect of regulation 16: Training and staff development and to ensure residents' safety was safeguarded.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Copies of information provided when a resident was transferred out of the service to another service or back to the centre were retained in the centre.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspectors found that medication management practices in the centre were not based on the best available evidence and in line with local policy for the protection of the residents. The medicine systems in place for prescribing, dispensing, administration and storage required full review. For example:

- Ensuring that allergy drug status was appropriately and consistently documented in care records and medication administration records.
- Ensuring that prescriptions were accurate, completed in full and that the 10 rights of medication administration were consistently implemented at the administration phase.
- Ensuring that each medication to be administered in 'crushed' format was individually prescribed and dispensed in a suitable alternative format after consultation with a pharmacist.
- Storage of medication required review as residents' items were observed stored in the lockable press for the controlled drugs.
- Ensuring that medical equipment such as nebulising masks were disposed of in line with best practice, maintained clean and replaced when visually dirty or at regular intervals.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Overall, care plans were very detailed and comprehensive but not effective at providing clear guidance in respect of the plan of care for an individual resident. Although care plans were evaluated on a timely basis, they included a lot of historical information, which was conflicting with the new information that was added in a list format. For example:

- The same care plan of a resident who, as per the latest assessment, should not receive anything via the oral route made reference to the fact that the resident was on a soft diet and grade 1 fluids, on grade 4 fluid and level 4 type of diet, and nil PO (per oral).
- Care plans were not discontinued when no longer relevant. For example, one resident still had an active care plan for a urinary tract infection even though it had been treated more than a month previously; another resident still had an active care plan for bedrails, although the resident was assessed as not suitable for the use of bedrails.

Judgment: Not compliant

Regulation 6: Health care

Although residents had good access to a range of healthcare supports, improvements were required in order to ensure residents were provided with safe, effective care and a high standard of evidence-based practice. For example:

- The most recent national guidance contained in 'Interim Public Health and Infection Prevention and Control Guidelines on the Prevention and Management of Covid-19 Cases and Outbreaks in Residential Centres' issued by the Health Protection Surveillance Centre was not consistently implemented. For example that residents displaying signs and symptoms of COVID-19 should restrict their movement until a negative PCR swab test was obtained.
- An active surveillance programme of monitoring the residents for signs and symptoms of COVID-19, which included at a minimum twice daily temperature checks, was not consistently implemented, and nursing staff who communicated with the inspectors were not aware of this requirement. This was not in line with centre's own contingency plan, local policy or best available guidance as issued by Health Protection Surveillance Centre.
- Residents' risk assessments or specialist advice and recommendations from relevant healthcare professionals did not always inform the plan of care for residents, and it was unclear whether all care interventions were evidence-based.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

There was a very low level of responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and staff knew the residents really well. Inspectors examined documentation, including care plans for residents identified as displaying responsive behaviours. Alternative interventions and de-escalation techniques to minimise the impact of the behaviour were outlined to be trialled prior to administering medication.

Judgment: Compliant

Regulation 8: Protection

There was a safeguarding policy in place, and staff had participated in the training. Staff had completed training in the safeguarding of vulnerable adults and demonstrated an awareness of how to respond to an incident of suspected or actual abuse.

Judgment: Compliant

Regulation 10: Communication difficulties

The communication needs of residents were described clearly in care documentation, and staff were observed to take time ensuring that residents understood what was said to them. A number of residents were using communication aids to enable them to communicate effectively. Staff were observed facilitating residents to use these aids during the inspection. A sample of communication care plans reviewed documented person-centred interventions to support the resident in meeting their needs.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 10: Communication difficulties	Compliant

Compliance Plan for Ratoath Manor Nursing Home OSV-0000152

Inspection ID: MON-0034406

Date of inspection: 24/11/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance the PIC will have the following in place and implemented and actioned as required: • The PIC has introduced and formailised a supervision daily allocation for the senior nurses on staff to provide oversight and supervision to the staff. This allocation is based on the needs identified within the home using the information gathered at report times, incident tracker, staff skill mix, Allied healthcare visits, care plan reviews, medication rounds, meal times and resident needs. This plan is reviewed 3 times per day 9am post home review, 2pm post morning care and 6.45pm post afternoon care and preparation for night duty. The Night staff meet at 8.15pm and both Nurses and HCAs work in a team together. The allocation sheet is sent to the Compliance and Governance team on a weekly basis to review and ensure any issues identified are addressed and learnt from. • All Care staff have completed online and in person training on Dysphagia. • The registered provider has introduced an independent IPC COVID preparedness audit review to ensure all staff follow the training that has been provided. The findings of this audit have been communicated to the PIC and staff and actions to be addressed by the PIC have been completed.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To ensure compliance the registered provider will have the following in place and	

implemented and actioned as required:
• A dedicated staff supervision allocation plan is in place on a daily basis to ensure oversight and improve staff performance. This is led by the homes PIC, ADON and CNMs.
• All Staff have been educated in the homes IPC policies and COVID preparedness plans. The evidence of which can be determined and confirmed by the independent IPC COVID preparedness audit introduced by the registered provider and review of the sign off by staff of their understanding.
• All Care staff have completed online and in person training on Dysphagia. HCA Staff will be supervised by the staff nurses when attending to residents identified with dysphagia needs. Any non- compliances will be recorded in the homes incident tracking system and issues can then be addressed immediately by the PIC/Compliance and Governance team.
• The audit process for reviewing and assessing residents care plans is based on a 3 monthly review cycle, and in addition a review takes place following each incident, change in condition, GP or allied health care review. On a weekly basis the PIC will inform the Compliance and Governance team of the residents care plans reviewed and these will be verified by the compliance and Governance team. To ensure all care plans reflect the needs of the current residents an audit plan is now in place in which the homes PIC/ADON /Clinical Governance and Compliance. This audit will involve a full review of all care plans in place and will be completed and verified.
• The wound and weight loss monitoring audit now includes a clearly identified improvement and learning plan.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
To ensure compliance the registered provider will have the following in place and implemented and actioned as required:
• The PIC has begun information and training sessions for staff in the schedule 5 policies. The staff will sign off that they understand and will follow the policies. To verify the senior staff on duty will assess care given as per the policies.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
To ensure compliance the person in charge will have the following in place and implemented and actioned as required:

• All care staff have completed have completed on line and in person training in Dysphagia and modified diets. • The senior staff on daily will supervise meal times to ensure compliance. Any non-compliance found will be reported via the homes incident reporting process which informs the PIC and Clinical Governance and compliance team so immediate support and action is given.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
To ensure compliance the person in charge will have the following in place and implemented and actioned as required:
• The PIC with the residents GP has reviewed all prescriptions and residents kardex's to ensure that the allergy drug status is appropriately and consistently documented in the residents care records and medication administration records.
• The PIC with the residents GP has reviewed all prescriptions to ensure they are accurate, completed in full.
• Medication audits are taking place on a regular basis both by internal staff and by the external pharmacist to ensure the 10 rights of medication administration are consistently implemented at the administration phase.
• The PIC and residents GP have reviewed and documented all residents Kardex and medication administration records where a medicine is to be crushed. The pharmacy advice and dispense a suitable alternative as required.
• The PIC has reviewed all controlled drug presses and all now storing controlled meds. A review of the controlled drug press is now included in the medication audits.
• All nebulizer masks when changed are to be dated and signed by staff nurse on duty.

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:
To ensure compliance the registered provider and the person in charge will have the following in place and implemented and actioned as required:
• A full and comprehensive review of all care plans is under way. The homes PIC and ADON and the Clinical Governance team are reviewing all the residents care plans to ensure they correctly reflect the care required and been given. Once all care plans

completed they will be verified by the compliance team. Care plans will ensure a safe, effective and high standard of evidenced based care is delivered.
• All care plans is set a review date, this information is visible on the computerized care planning system Fusion. Fusion alerts staff to review care plans by using the traffic light system (green in date, orange due and red out of date) the staff have also the ability to archive care plans once they are no longer required.
This process will be reviewed by the compliance team.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• All staff have received education and learnings assessed in the homes COVID preparedness plan. The reviewed COVID preparedness plan has been audited to ensure staff are aware of its contents and in how to deliver the plan in the event of a resident or staff member displaying signs of COVID.
• The home now as agreed set times for completing the twice daily symptom checks across the 3 units in the home.
• Allied healthcare visits will be reviewed weekly to ensure actions required are recorded correctly into the residents care plan. This information is now included in the Weekly care report completed by the PC and submitted to clinical governance.

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.	Not Compliant	Orange	14/02/2022
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.	Substantially Compliant	Yellow	31/01/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure	Not Compliant	Orange	28/02/2022

	that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	10/01/2022
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	31/01/2022
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	28/02/2022
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have	Not Compliant	Yellow	31/03/2022

	been assessed in accordance with paragraph (2).			
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	28/02/2022