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:	Killeline Nursing Home
Name of provider:	Killeline Nursing Home Limited
Address of centre:	Cork Road, Newcastle West, Limerick
Type of inspection:	Unannounced
Date of inspection:	05 April 2022
Centre ID:	OSV-0000423
Fieldwork ID:	MON-0036476

About the designated centre

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

Killeline Nursing Home is located in the town of Newcastle West on the Cork Road. The home was opened on the 14th December 2007, providing 63 beds. Most of the bedrooms are single bedrooms with an additional 8 double bedrooms. All bedrooms have en-suite bathrooms, with toilet and shower facilities; grab rails and cabinets for toiletries. We accommodate both female and male residents with the following care needs: general care, dementia specific care and acquired brain injury. There is also a dedicated wing for Alzheimer's and a secured unit for Acquired Brain Injury for people with challenging behaviour. Our ethos of care is to promote the dignity, individuality and independence of all those who enter our care and to assist our Residents in achieving and maintaining all their goals and objectives. There is 24 hour nursing care available. The majority of admissions to Killeline Nursing Home are pre-arranged. An admission pack is made available to all Residents on arrival, which includes information on the nursing home, contract of care, copy of the complaints procedure, and list of personal possessions form. A full assessment shall be completed within 24 hours of admission which will include any updated information and care needs identified to develop appropriate care plans. The care plans will be completed within the 48 hour time frame and additional information can be added appropriately. A Contract of Care will be issued to every resident within one week of their admission to the Nursing Home. The contract provides a legally binding commitment to terms and conditions. We operate an open visiting policy within Killeline Nursing Home. Facilities provided are: quiet room, Polly tunnel, hairdressing, dietitians, chiropodist, speech and language therapists, etc. the following recreational activities are available at Killeline Nursing Home on a weekly basis: arts and crafts, live music twice weekly, bingo, pet therapy, outdoor walks, etc. There is a bus available to ferry residents on outings of interest planned by activity therapist. Mass is celebrated each Wednesday morning. Provision is also made for any Resident wishing to avail of alternative religious services. If a Resident wishes to attend an off-site religious service, we make the necessary arrangements to facilitate this.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	61

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
Tuesday 5 April 2022	17:00hrs to 22:00hrs	Sean Ryan	Lead
Wednesday 6 April 2022	09:00hrs to 18:30hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Overall, residents gave positive feedback with regard to their lived experience in the centre. Residents told the inspector that they were care for by a team of staff who were dedicated to ensuring that they were supported in all aspects of their daily life. Residents told the inspector that the staff, including the management team, made them feel safe, respected and supported.

The inspector was guided through the centres infection prevention and control measures in place on arrival. Following an opening meeting, the inspector walked around the centre with the person in charge and observed residents and staff during the evening time.

The centre provides long term care to male and female adults with a range of dependencies and needs. It is a two-storey premises providing general care, dementia care and acquired brain injury care in three distinct units. The inspector spent time in each of the three units meeting residents and speaking with staff during the two-day inspection.

As the inspector walked through the premises, residents were observed playing card games, chatting with one another and watching the evening news. Staff were observed engaging with residents in the communal dayrooms and serving snacks and refreshments. Residents appeared content and relaxed in the company of staff. On day one of the inspection, the inspector had the opportunity to observe resident's during the evening and early night time. Staff were observed to be very busy answering call bells and assisting residents to bed while supervising residents in communal dayrooms. Residents were observed waiting long periods of time to go to bed following their request for assistance from staff. The inspector observed occasions where residents at risk of falls and residents with complex care needs were left unsupervised when staff were assisting other residents on each unit. Nursing staff were observed by the inspector to attend to residents care needs and answer call bells during their medication round.

On day two of the inspection, residents were observed enjoying their breakfast in the dining room and in their bedrooms with the assistance and supervision of staff. The atmosphere was observed to be calm and relaxed. Staff were observed assisting residents with their morning care needs and the inspector observed staff and resident interactions that were kind, polite and unhurried.

The residents bedrooms were clean and bright and furnished with personal items of significance to each residents such as photographs, ornaments and furniture from home. Residents that spoke to the inspector were happy with their rooms. There was sufficient space for residents to live comfortably including adequate storage for personal belongings in wardrobes and bedside lockers. The inspector observed that

not all bedrooms had a call bell for residents in the acquired brain injury unit as they had been disconnected by residents but had not been replaced.

The inspector spent time listening to the residents and relatives experience of living through the COVID-19 pandemic and the challenges this presented when restrictions were in place. Both residents and relatives were complimentary of the management and staff in their efforts to protect residents during the pandemic and outbreaks in the centre. The inspector acknowledged that the pandemic had been difficult on residents and staff.

The inspector observed residents receiving visitors during the inspection. Visitors completed COVID -19 health checks when they arrived and wore face coverings before entering the building. Residents were able to meet their friends and family in the privacy of a visitors room or in their bedrooms, where appropriate. The inspector spoke with a small number of visitors. They said that they were happy with the care their relatives received.

The lunch-time experience was observed by the inspector. Food was freshly prepared and specific to residents individual nutritional requirements. Staff were available to provide assistance and support to residents in the dining room and residents who choose to have their meals in their bedroom.

The design and layout of the premises was suitable for its stated purpose and the centre was found to be clean throughout. The inspector observed that the provider had made improvements to the premises which addressed some of the issues highlighted in the previous inspection such as refurbishment of communal toilets. Similar to previous inspection findings, the inspector observed areas of the premises where floors, walls and doors were chipped, damaged and in need of maintenance and repair. The dementia care unit was brightly decorated and bedroom doors were decorated to resemble front doors. Throughout the day, residents were observed moving independently around the centre with the support of handrails placed throughout the centre. The centre had numerous communal areas for residents to relax in and they were appropriately furnished to create a homely environment. Residents had access to secure enclosed outdoor space that was maintained to a satisfactory standard.

A reminiscence/memory box was placed beside residents' bedrooms and contained a variety of objects and photos directly associated with each individual. This meant that staff were facilitated to engage in a meaningful and personal way with residents. A large activities board was displayed in the units communal dayroom and a variety of activities were scheduled that included hand massage, SONAS and baking. The inspector observed the activities staff member providing activities in various areas of the building throughout the inspection. The activities staff were observed to divide their time between each of the three areas. Activities included bringing residents outside for walks and to the local shops. The person in charge told the inspector that healthcare staff were responsible for supporting the activities staff with implementing the activities plan on each of the three units. However, the inspector found that some residents had limited opportunities for social engagement

on the units when activities were taking place in other areas of the centre. These residents spent long periods of time with no social engagement.

The next two sections of this report present the findings of this inspection in relation to the governance and management of the centre and how these arrangements impact on the quality and safety of the service provided to residents.

Capacity and capability

This was an unannounced risk inspection carried out over two days to;

- monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).
- review the actions taken by the provider to address issues of non-compliance found on the last inspection in September 2020.
- follow up on notifications and unsolicited information received by the office of the Chief Inspector.

Overall, the findings of this inspection were that there was a satisfactory level of compliance with the regulations. This was reflected in the quality of care experienced and described by the residents. However, Regulation 15: Staffing and Regulation 5: Individual assessment and care planning were found to be not compliant and action was also required to ensure compliance under the following regulations

- Regulation 23, Governance and Management
- Regulation 16, Training and Development
- Regulation 17, Premises

The systems to monitor, evaluate and improve the quality and safety of the service required strengthening to ensure a safe, consistent and quality service was provided to residents. The inspector found that while action had been taken to address some of the substantial compliances found on the previous inspection, there continued to be repeated non-compliance with Regulation 15, Staffing.

Unsolicited information received by the Chief Inspector was reviewed and found to be partially substantiated with regard to insufficient levels of staff.

The registered provider of the centre is Killeline Nursing Home Limited. The management team consisted of a representative of the company directors, a quality manager and the person in charge. The clinical management structure had been strengthened since the previous inspection with the appointment of two assistant directors of nursing who supported the person in charge to discharge her duties and regulatory responsibilities in a supervisory capacity.

The provider had systems in place to ensure there was oversight of the quality and safety of the service provided to residents. Audits were used to monitor, evaluate and improve the quality of the service and informed the development of actions plans to address areas for improvement. Trending and analyses of complaints, incidents and resident feedback were also used to inform service improvements. This information was effectively communicated to staff to ensure the identified actions were implemented.

The inspector reviewed a sample of completed clinical audits and found that some audit tools were not effective in supporting the management team to identify risks. For example, audits of falls had not identified that falls were not consistently managed in line with the centres own policy and therefore a corresponding quality improvement plan could not be developed.

There were regular meetings taking place between senior management to discuss all aspects of the quality and safety of the service and the outcome of those meetings were effectively communicated to staff during regular staff meetings. There were systems in place to monitor and respond to risk that may impact on the safety and welfare of residents. This included a risk register that contained centre specific and organisational risks and the controls in place to mitigate the risk of harm to residents, visitors and staff. The inspector followed up on incidents notified to the office of the Chief Inspector as required by the regulations. Incidents were appropriately recorded, reviewed and actions implemented to prevent recurrence or harm to residents.

A review of COVID-19 outbreak in the centre had been completed and the management team had acted to implement the learning from those reviews to prevent and prepare for possible future outbreaks in the centre. The annual review of the quality and safety of the service for 2021 had been completed and a quality improvement plan was developed for the year ahead.

Records and documentation required by Schedule 2, 3 and 4 of the regulations were made available for the inspector to review and were maintained effectively.

The inspector found that there was insufficient staff on duty to meet the needs of residents taking into account the size and layout of the building to ensure resident safety. The staffing levels committed to by the provider in the compliance plan following the previous inspection had been withdrawn and there was no assessment of risk or audit to underpin this decision. This is discussed further under Regulation 15, Staffing.

Staff were supported and facilitated to attend training appropriate to their role and to ensure they had the required competencies and skills. Staff who spoke with the inspector were knowledgeable regarding safeguarding of vulnerable people, infection prevention and control, fire safety and complaints management. Arrangements were in place to ensure staff were appropriately supervised by the clinical management team. There was a comprehensive induction programme in place for staff. However, fire safety training had not been completed by all staff. The

person in charge confirmed that the training was scheduled for staff to attend in the weeks following the inspection.

A centre specific complaints policy detailed the procedure in relation to making a complaint and set out the time-line for complaints to be response to, and the personnel involved in complaints management. The complaints procedure was prominently displayed throughout the centre and the inspector was satisfied that complaints were appropriately documented and managed in line with regulatory requirements.

Regulation 15: Staffing

There was insufficient levels of staff on duty for the size and layout of the building to ensure residents safety. This was evidenced by:

- insufficient numbers of staff on duty to meet the assessed supervision needs of residents.
- residents with complex care needs and at high risk of falls were not adequately supervised by staff in communal rooms.
- two residents were observed waiting a long period of time for assistance from staff to go bed following their request. The residents had to wait until another staff member could assist them from another area of the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

A review of staff training records indicated that a number of staff had yet to complete fire safety training. The inspector was informed that these were predominantly staff that had recently been recruited and training was scheduled for those staff in the weeks following the inspection.

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 supervision of staff to implement the activities programme for residents.
- staff were not wearing the correct face coverings when providing care to residents as recommended under the guidance issues by the Health Protection Surveillance centre.

Judgment: Substantially compliant

Regulation 21: Records

Record-keeping and file-management systems ensured that records were securely store, appropriately maintained and accessible.

Records were maintain in respect of the daily health and social care provided to residents in addition to reviews carried out by health and social care professionals.

A sample of staff personnel files were reviewed by the inspector and were found to contain the information as required by Schedule 2 of the regulations including evidence of a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the governance and management systems were not in line with regulatory requirements. For example:

- there was inadequate staffing levels to meet the supervision and care needs of residents. This is a repeated non-complianace from previous inspections in December 2019 and September 2020.
- the information collected from some of the clinical audits reviewed did not identify areas of risk. For example, medication audits had not identified medication management practices that were not consistent with the centres own policy, and therefore, no quality improvement plan could be developed.
- the systems of risk identification had not identified, for example, the fire risk associated with unsuitable furnishings in the area designated for resident to smoke.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifications were submitted in a timely manner and a review of the accident and incident log indicated that notifiable events were notified to the Chief Inspector as required by the regulation. The inspector followed up on notifications submitted and these were adequately managed to support the care, welfare and safeguarding of residents.

Judgment: Compliant

Regulation 34: Complaints procedure

A review of the complaints log indicated that complaints were recorded, investigated and required improvements, if any, were put in place in response to complaints. There was an up to date complaints policy that identified the person in charge as the complaints officer. The policy included an independent appeals process. The procedure for making a complaint was on display. Residents told the inspector that if they had any complaints or concerns they would inform the person in charge and residents were confident that their concerns would be addressed promptly.

Judgment: Compliant

Quality and safety

Overall, resident's health and welfare was maintained by a satisfactory standard of evidence-based care and support. Residents were content living in the centre and said they felt safe. The inspector found that further action was required to ensure compliance with assessment and care planning, and the premises.

While all residents had an assessment and care plan in place, a review of the documented care plans found that they did not consistently reflect the up to date assessed needs of the residents. The inspector noted that some improvement had been made since the last inspection, however, further action was required to ensure compliance with Regulation 5, individual assessment and care plans.

Residents were provided with timely access to a general practitioner (GP) of their choosing and there was a referral system in place to ensure residents could access health and social care professionals, for additional support and expertise, such as a physiotherapy, dietetics, and speech and language therapy.

There were appropriate arrangements in place to monitor for the risk of COVID-19. On the day of inspection, the centre was nearing the end of a COVID-19 outbreak that had affected both residents and staff. Staff and residents were monitored for signs and symptoms of COVID-19 twice daily. There was signage displayed throughout the centre reminding staff, residents and visitors of the protocols to follow such as hand hygiene and symptom monitoring. A colour-coded, single use, mop and cloth system was in place and staff provided a demonstration of the cleaning procedure and cleaning agents used. The centre was found to be cleaned to a satisfactory standard throughout and was subject to frequent auditing to ensure standards were maintained.

The premises was spacious and decorated to a satisfactory standard throughout. The communal space available to the residents was unchanged since the last inspection. Residents had access to secure enclosed gardens that were appropriately furnished. Although the premises was generally clean and tidy, there were areas identified by the inspectors that required maintenance and repair. The inspector observed that there was limited storage facilities in the centre which resulted in the inappropriate storage of residents equipment in corridors and bedrooms.

The centre had a risk management policy that met the requirements of the regulation. The risk policies addressed specific issues such as the unexplained absence of a resident, self-harm, aggression and violence, safeguarding and the prevention of abuse. There was a risk register in the centre which covered a range of risks and appropriate controls for those risks.

Residents had access to television, radios, daily newspapers, telephone and WiFi. Residents were consulted about the quality of the service through monthly resident forum meeting. Residents and relatives feedback surveys completed in 2021 indicated an overall satisfaction with the quality of the service. Residents under the age of 65 were supported to access additional external support from personal assistants, community nurses and social workers. The management team were in the process of identifying further supports for residents under the age of 65. Independent advocacy services were available to residents and details of the service were prominently displayed for residents and relatives. Residents had the opportunity to attended fire safety training in the centre in March 2022. While there was a programme of activities that included group and one-to-one sessions, some residents were observed to spend long periods of time without appropriate occupation or activity. This is further discussed under Regulation 9.

Regulation 11: Visits

The registered provider had ensured that visiting arrangements were in place in line with the current Health Protection Surveillance centre (HPSC) guidance and public health advice. Visits were encouraged and residents could meet their relatives or friends in a designated visitor room or in their bedroom if they wished.

Judgment: Compliant

Regulation 17: Premises

Action was required to ensure compliance with regulation 17. This was evidenced by;

- There was inadequate storage for equipment. For example, residents equipment such as hoists were stored along corridors or in residents

bedrooms, and there were examples where commodes were stored in residents en-suites bathrooms.
- The centre did not have a dedicated room for the storage or preparation of cleaning chemicals. Cleaning equipment was inappropriately stored in the dirty utility.
- The laundry was not of an adequate size and layout to support a dirty to clean flow of linen to ensure contamination did not occur. The staff member working in the laundry did not have an area to sort cloths adequately.
- Some resident equipment, such as commodes, were rusted.
- A number of maintenance issues were identified in each of the centre's units including items of furniture that were visibly scuffed, chipped paintwork on the walls, doors visibly damaged and plasterwork was in need of repair.
- Some bedrooms did not have a call bell lead for residents occupying those rooms.
- The central heating system flues were located outside the dayroom window in the dementia unit which made it unsafe for residents to open those windows. This issue had been identified by the person in charge but a date to rectify the issue had not been established.
- There was insufficient dedicated hand hygiene sinks in the centre.
- Furnishings in the residents designated smoking area were not suitable and not maintained in a satisfactory state of repair.

Judgment: Substantially compliant

Regulation 26: Risk management

The centre had a risk management policy that contained actions and measures to control specified risks and which met the criteria set out in regulation 26. The centre's risk register contained information about active risks and control measures to mitigate these risks.

Arrangements were in place for the identification, recording, investigation and learning from serious incidents. For example, the person in charge had completed a review of the COVID-19 outbreak in the centre which identified lessons learnt to prepare the centre in the event of a future outbreak.

Judgment: Compliant

Regulation 27: Infection control

The centre had procedures in place for the prevention and control of healthcare associated infections. All staff in the centre had completed infection prevention and control training. The inspector observed that there was appropriate signage

throughout the centre reminding staff, residents and visitors of symptoms of COVID-19 and prompting hand hygiene. The premises and equipment used by residents was visibly clean on inspection.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A number of care plans had not been reviewed following a change in a resident's health status or assessed need as required under regulation 5. This was evidenced by;

- A resident's falls risk assessment and care plan had not been reviewed or updated following a number of falls in line with the centres own falls management policy to inform decision making with regard to a referral for further clinical assessment.
- A resident's mobility and dependency needs were not accurately described within the assessment of the resident's dependency.
- One care plan gave conflicting information with regard to the supervision needs of a resident at risk of absconding.
- Care plans did not consistently reflect if consultation with the residents and, where appropriate, their relatives had taken place during the care planning process or when a change in care needs was identified.

Judgment: Not compliant

Regulation 6: Health care

The inspector found that residents had access to appropriate medical and health and social care support to meet their needs. Residents had a choice of general practitioners (GP). A physiotherapist visited the centre on a weekly basis to review residents where necessary. Wound care was observed to be of a satisfactory standard and the centre benefited from the expertise of a member of staff in tissue viability. Services such speech and language therapy and dietetics were available when required. The inspector found that recommendations given was integrated into the residents care plan which resulted in good outcomes for residents.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a low incidence of bedrails used in the centre. Where necessary, alternatives to bedrails were trialled, the appropriate assessment of risk was completed with the resident and multi-disciplinary team and resident consent was obtained.

Arrangements were in place to support residents who experienced episodes of responsive behaviours and staff provided care and support to meet residents physical, psychological and social care needs. Interactions were observed to be non-restrictive.

Judgment: Compliant

Regulation 8: Protection

Residents spoken with stated that they felt safe in the centre and confirmed that staff were caring and kind. All interactions by staff with residents on the day of the inspection were seen to be respectful.

The centre was pension agent for nine residents and adequate arrangements were in place for the management of residents' finances. All staff had attended training on safeguarding residents on abuse and were knowledgeable with regard to recognising and responding to abuse. Residents had access to the services of an advocate and contact details were on prominent display in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Residents reported that staff made them feel at home in the centre and that they were treated with dignity and respect. Resident felt supported and could exercise choice in how they spend their day.

Residents were provided with daily newspapers and could watch television in either the communal dayrooms or in their bedrooms. Resident detailed how they maintained contact with their friends and families during restrictions such as telephone and video calls and they were satisfied that Mass had continued in the centre.

A comprehensive programme of activities had been developed in consultation with the residents and this programme was delivered by the activities staff with the support of healthcare staff. However, while residents were supervised by staff in the communal dayrooms, there was limited social engagement and activities observed.

The allocation and supervision of staff to provide meaningful activities is actioned under Regulation 16: Training and staff development.
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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Killeline Nursing Home OSV-0000423

Inspection ID: MON-0036476

Date of inspection: 06/04/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. Rosters were revised to ensure sufficient staff on duty to meet the assessed supervision needs of the current residents 2. Daily staff allocations reviewed by the PIC/APIC to ensure adequate supervision for residents with complex needs, in the communal areas has been introduced 3. Night duty care hours increased to ensure the care needs of the residents are met in the evening time. An extra 12 care hours nightly, was implemented from Monday night 11/04/2022.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. Current scheduled training completed, Training matrix reviewed and training schedule updated to include fire safety training, which was completed on 20th and 21st April 2022. The PIC, with the Nursing Management team and the Activities Coordinator, review the roster daily and ensure staff on duty are allocated to implement the activities programme for residents each day. This is overseen by the ADON/CNM on duty on the day 2. The use of FFP2 face masks by staff reimplemented with immediate effect as recommended under the guidance issued by the Health Protection Surveillance Centre	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The staff roster was revised by the PIC and the Director of Quality & Safety, and the staff complement increased to ensure adequate staffing levels to meet the supervision and care needs of current residents.
2. The Clinical Audit tools have been revised and updated by the PIC, and the Nursing Management team and reviewed by the Director of Quality & Safety, to ensure they identify areas of risk, support the development of a quality improvement plan and ensure triangulation.
3. The management team have reviewed their risk assessment tools to ensure that risks, as they arise are identified and acted on accordingly

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Engineer engaged to review the findings of the inspection report. Meeting on site with the PIC and RPR scheduled for Wednesday 15/06/2022 to address the following issues: storage areas for equipment, a preparation and storage area for cleaning chemicals and equipment, the laundry flow and work area, the central heating system flues, and handwash sinks.
2. An audit of all resident equipment is being completed, and obsolete equipment removed
3. Repairs to the building identified on the day of the inspection have been added to the maintenance schedule and are in progress and painting is ongoing.
4. A call bell audit was completed, and any damaged or missing call bells are replaced. Due to the complexity of some resident's conditions, it is inappropriate to have call bell equipment in their rooms. This audit has been added to the Master Audit Schedule for 2022 to be completed monthly.
5. Suitable furnishings for the residents smoking area are being sourced and added to the maintenance schedule to be checked, to ensure they are well maintained.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
1. PIC met with nursing management and staff to discuss the inspector's findings on the care plans
2. An audit of all Resident's care plans will be completed by the PIC/APIC/CNMs by the 31/05/2022, updated and an action plan agreed to ensure compliance with Regulation 5. going forward.
3. All residents at risk of falls, had their falls risk assessment and care plan reviewed to ensure compliance with Centre's Falls Management policy
4. All resident's dependency assessments reviewed and updated
5. Resident at risk of absconding, care plan reviewed to ensure correct supervision requirement identified and implemented.
6. All care plans will be reviewed and updated 4 monthly in consultation with the residents and their families. Residents will be continuously monitored, and individual care plans will be audited more frequently where necessary for any additions/amendments that are required.

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	Orange	11/04/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	21/04/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	07/04/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Substantially Compliant	Yellow	30/09/2022

	provide premises which conform to the matters set out in Schedule 6.			
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.	Substantially Compliant	Yellow	11/04/2022
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.	Substantially Compliant	Yellow	31/05/2022
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	31/05/2022