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:	TLC City West
Name of provider:	Cubedale Limited
Address of centre:	Cooldown Commons, Fortunestown Lane, Citywest, Dublin 24
Type of inspection:	Unannounced
Date of inspection:	21 February 2022
Centre ID:	OSV-0000692
Fieldwork ID:	MON-0036258

About the designated centre

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

TLC City West is a purpose-built nursing home which can accommodate 139 male and female residents over the age of 18. There are 83 en-suite single rooms and 28 en-suite double rooms in the centre over four floors: Ground, 1st, 2nd & 3rd Floor. The building is T shaped which is divided into left, right and middle wing. The details of rooms, sizes and facilities are available in the centres statement of purpose. Each bedroom is fully furnished and has a television and a phone provided.

The centre is designed to meet the individual needs of the older person in pleasant surroundings, whilst facilitating freedom and independence. TLC Citywest is ideally located close to the Red Luas line, Citywest Hotel, Citywest shopping centre and Saggart village. It is just off the N7 or the N81 in the other direction and within close proximity to Tallaght Hospital.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	113

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
Monday 21 February 2022	08:35hrs to 19:10hrs	Niamh Moore	Lead
Monday 21 February 2022	08:35hrs to 19:10hrs	Margaret Keaveney	Support
Monday 21 February 2022	08:35hrs to 19:10hrs	Margo O'Neill	Support

What residents told us and what inspectors observed

The general feedback from residents was that they were happy with the care and services provided in the centre. Residents told inspectors that the staff were very caring and attentive. However, inspectors found that there were gaps in oversight arrangements in a number of areas in the centre. These findings are discussed under the relevant regulations in this report.

On arrival at the centre, inspectors were met by reception staff who guided them through the infection prevention and control measures necessary on entering the designated centre. This included the wearing of personal protective equipment (PPE) such as a face mask, a foot bath, temperature checking and hand hygiene prior to starting the inspection.

Following a short introductory meeting, inspectors completed a walkabout of the premises with the person in charge who highlighted some improvements made to the residents' environment since the last inspection, such as the replacement of carpet with vinyl flooring.

Throughout the day of the inspection, inspectors met with many of the residents in the centre and spoke in more detail with 12 residents and five visitors, in order to establish the residents' experiences of living in TLC CIty West. Residents were observed to spend time in the various communal areas and in their bedrooms. The hairdresser was available to residents on the day of the inspection, and inspectors saw that many residents availed of this service.

The centre is a large building set out over five floors with access to each floor by stairs or lift. Residents' bedrooms were located on the ground, first, second and third floors, and comprised of 83 single occupancy and 28 twin occupancy bedrooms, all of which were ensuite. Residents' bedrooms were seen to be comfortable, warm and personalised with their personal possessions which included included furniture, personal photographs and ornaments.. Inspectors observed that the personal floor space and storage facilities for residents in shared bedrooms required review which will be further discussed within this report. Each floor had dining and day spaces available to the residents' of that floor. There was also a number of communal bathrooms and one hydrotherapy bathroom in the centre.

Communal areas were bright and of sufficient size to meet resident's needs. However, inspectors observed that some areas required improved oversight of maintenance and cleaning, paintwork was seen to be chipped and resident chairs in one communal room were seen to be stained and worn. Residents were seen to spend the majority of their days in the seating areas around the nurses station on each floor where staff also spent the majority of their time. Although there were additional communal areas on each floor, inspectors were told that these rooms were not routinely used by residents. Inspectors found that some of these communal areas were located at a distance from the nurses station and on the day

of the inspection, staff and residents were not seen to spend time within these areas. The layout of furniture of two of these communal rooms was no conducive to a homely environment as couches and arm chairs were placed against the wall with dining tables and chairs placed in front of them.

The layout of the centre promoted resident's independence. There was clear written directional signage to orientate residents to communal areas, and unobstructed handrails along all corridors. Large notice boards displayed in both writing and pictures the activities on offer to residents for the week, and other services available to residents. Residents had easy access to a landscaped garden, which some residents told inspectors they enjoyed walking in when the weather allowed.

Residents told inspectors that the staff were nice, however a number of residents and visitors spoken with said that they felt there was inappropriate staffing levels within the designated centre. Inspectors saw many occasions where residents were not engaged in any activity and were seen snoozing during the daytime in communal areas.

Inspectors observed that staff knocked on residents' bedroom doors and ensured they had privacy during personal care activities. Staff who spoke with inspectors were knowledgeable about residents and their needs. Most residents who spoke with inspectors said that they were content within the centre. One resident told inspectors that they enjoyed their daily routine of receiving their newspaper and attending a different floor to meet their friend each day.

Residents were able to choose where they wished to have their meals. Inspectors observed the lunchtime meal across three different floors within the designated centre. The menu was displayed outside the dining rooms and on each table. Inspectors could see residents being offered a choice for their main meal and dessert and meals looked well-presented. Tables were organised for residents to sit in groups of two and three. Most residents spoken with were satisfied with the food on offer. However, one resident said they are not offered additional portions and inspectors were told that meal-times were too close together. Inspectors also observed that one resident who required assistance was not provided with timely support during the lunchtime meal. In the main, staff were seen to support residents and to move at the residents' pace, however this was completed in a very task orientated manner and inspectors did not observe any chat or friendly engagement taking place.

The next two sections of this report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

The registered provider needed to improve the overall governance and management structures in place to ensure effective oversight and that the service provided was safe. There was little evidence that the registered provider had sufficient oversight of this designated centre, this was further evidenced by the repeat findings of the May 2021 inspection found within this inspection. Inspectors found there was gaps in management systems particularly in the areas of staff resources, staff training and supervision, auditing and governance systems.

Cubedale Limited is the registered provider for TLC City West. The governance structure within the designated centre changed since the last inspection. This centre is part of the Orpea Care Ireland group. The governance structure in place included the Chief Operating Officer and a Regional Director, whom the person in charge reported to. The designated centre also had the support of additional resources through the provider group such as a Quality team. Despite this clearly defined management structure, the provider's governance and management arrangements had failed to substantively address key areas of concern found on the day of the inspection. Inspectors were told that immediate action was taken by the provider group the following day of the inspection to address some of these failings.

The person in charge was responsible for the day to day operations of the centre and was supported in their role by a housekeeping and catering manager, two assistant directors of nursing and five clinical nurse managers (CNMs). Other staff members included nurses, senior healthcare assistants, healthcare assistants, activity coordinators, housekeeping, catering and maintenance.

Inspectors were told that the designated centre had a number of staff vacancies which they were covering with agency staff. Inspectors were told that agency use had to be pre-approved by the Regional Director. However inspectors were told that short-term cover could be authorised by the local management team if required, however this was not seen to occur on the day of the inspection. Inspectors were told that staffing retention had also been an issue and the registered provider had reviewed incentives to retain staff and attract new employees to fill these vacancies.

Inspectors found that the centre was not appropriately resourced. Inspectors saw evidence where there was insufficient staffing levels to provide supervision to all communal areas of the building and that there was gaps in sourcing cover for activity personnel on the day of the inspection. In addition, the centre's statement of purpose outlined there was a physiotherapist available full-time, however this role had been vacant from November 2021 and had only recently been filled with part-time hours.

On the day of the inspection, there were no residents confirmed with COVID-19. There had been an outbreak which had not yet been declared over by public health. Inspectors viewed records and saw evidence that the person in charge and their staff team worked hard to meet the needs of the residents during the recent COVID-19 outbreak. Regular communication was seen with public health officials within outbreak control meeting minutes. The provider was in the process of reviewing the outbreak and any learning from it.

There was insufficient oversight of training within the designated centre. Inspectors were provided with a training graph on the day of the inspection, however inspectors were told by management that they were not assured this graph was accurate and they provided additional information the day following the inspection. There were gaps in staff accessing up-to-date training on safeguarding, fire and infection control. The provider confirmed there were plans in place to address these gaps.

Supervision and oversight of staff practice was required to ensure the national standards for infection control were adhered to. Furthermore, inspectors were told that there was an induction programme in place for agency staff members, however this was not in place for a member of staff on the day of the inspection. Inspectors were not assured this staff member had been appropriately introduced to the policies and procedures in the centre or the care and needs of residents in their care.

Inspectors reviewed records of management meetings within the centre. There was a variety of meeting forums which met on a regular basis, such as governance meetings and COVID-19 meetings. Meeting minutes were seen with agenda items of human resources, maintenance, infection control, quality and safety where resident information, audits and incidents, and complaints. In addition, a daily report was completed and issued to the registered provider. Information within this daily report recorded resident numbers, COVID-19, complaints, incidents, and staffing. However, despite these measures in place, inspectors were not assured that the current systems ensured that the service provided was safe and effectively monitored. Staffing vacancy numbers remained the same as discussed at the monthly clinical governance meeting in November 2021, December 2021 and January 2022 and the physiotherapy replacement was also discussed at all three meetings with insufficient action to ensure these areas were satisfactorily addressed. In addition, provider oversight failed to identify gaps in staffing levels, care planning, the management of responsive behaviours, premises and infection control findings found by inspectors.

Inspectors found that due to limited resources, improvements which had been identified by the registered provider had failed to be addressed. For example, following a gastroenteritis outbreak review, an action plan was developed to facilitate bowel training management for staff nurses. Inspectors were told that while this had been on the training calendar, it had to be cancelled due to insufficient staffing. Inspectors found evidence on the day of the inspection where best practice in relation to bowel management was not in place.

Some audits seen did not drive quality improvements within the centre. For example, an audit on key performance indicators was seen to take place on resident records and care plans throughout 2021 with compliance of 82% found. Inspectors found that numerous actions identified within this audit due to be complete by November 2021 remained outstanding. This reflected the poor oversight of care planning seen on the day of the inspection. In addition, this audit tool did not recognise incidents relating to responsive behaviours and safeguarding. Thus

inspectors found there was insufficient oversight of assessments and care plans in place to address the safeguarding needs of these residents.

A complaints policy and procedure was in place and visible within the reception area of the designated centre, however these required review to record the correct personnel involved in the management of complaints. Inspectors reviewed a sample of complaints and found they were well managed.

Regulation 15: Staffing

On the day of the inspection, inspectors found that there was an insufficient number and skill mix of staff for the assessed needs of residents and the size and layout of the designated centre. For example:

- Inspectors saw a resident was in a communal area on their own. Inspectors were told by this resident that they had been with a group of other residents' but these residents' had left the room and there was no staff available to assist them back to their room. Inspectors sought the attention of staff to respond to this resident's needs.
- Feedback from residents, staff and visitors was that there were insufficient staffing levels. Two residents' told inspectors there were occasions where they had to wait for staff assistance including access to drinks in their bedrooms.
- There were gaps in recreational assessments and inspectors were told this was due to insufficient staffing to complete them.
- While there were three activity staff employed by the centre, there was one activity staff member rostered on the day of inspection. Inspectors were told that a second staff member's leave had not been covered by management. Therefore there was insufficient staff to provide residents with sufficient recreation and activities.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors were not assured that all staff had access to mandatory and relevant training. Gaps were evident on the training matrix supplied for safeguarding, fire safety and infection prevention and control.

Improved supervision of staff was required to guide and support staff. For example, a staff member designated to one area of the designated centre had not been inducted and given access to the computerised system of resident records by 13:00

on the day of the inspection. In addition, there was gaps in oversight of staff PPE which will be further discussed under Regulation 27: Infection Control.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that the provider needed to increase the overall governance and management systems in the centre in order to ensure effective oversight and the sustainability of the safe delivery of care. For example:

- There was insufficient oversight of training. The training matrix provided to inspectors on the day of the inspection was incorrect.
- While the registered provider had identified some areas which required improvement, inspectors found there was insufficient action to address these required improvements. For example, care planning was identified as a gap to inspectors at the start of the inspection but no action was seen to respond to this.
- Trending was being completed on responsive behaviours, however this trending did not ensure that the root cause analysis of behaviours had been discussed or reviewed.
- Despite a recent large outbreak of COVID-19, the provider failed to have sufficient oversight with regard to infection control measures within the designated centre. For example, staff were wearing incorrect PPE and monitoring records for both residents and staff were not in line with guidance 'Public Health & Infection Prevention & Control Guidelines on the Prevention and Management of Cases and Outbreaks of COVID-19, Influenza & other Respiratory Infections in Residential Care Facilities V1.3 17.02.2022'.
- Audits seen were not driving improvements. For example, the environment audit completed in December 2021 identified flooring in shared bathrooms was damaged with rust visible, however this item had been recorded as complete. This rust was observed on the day of the inspection.
- Inspectors found that the provider had failed to take the action within the compliance plan of the last inspection. Repeat findings were seen in regulations 23 Governance and Management, 5 Individual Assessment and Care Plan, 9 Residents' Rights.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints procedure and policy dated July 2021 which identified the person in charge as the complaints officer for the centre. However, both documents

had not been reviewed in light of the new management structures within the designated centre. Therefore the contact details for the person responsible to review and oversee complaints and the person responsible for appeals were not up to date.

Judgment: Substantially compliant

Quality and safety

The findings on the day of inspection were that overall, the provider was delivering good clinical care to residents with most residents seen to have good access to healthcare. Residents were seen to have choice in how they spent their days. However, this inspection identified that action was required to meet the regulations for care planning, restrictive practices and managing responsive behaviours, protection, residents' rights, the dining experience for residents, the premises and infection control.

Inspectors reviewed a sample of residents' records and noted that pre-admission assessments of residents' needs were completed. Following their admission to the designated centre, staff used a variety of accredited tools to complete assessments on resident's needs. However, the inspectors observed that effective care plans to meet some of the assessed needs of residents had not been developed. Incomplete care plans did not provide clear guidance to staff on how to deliver safe and appropriate care to residents. This is a repeat finding from the previous inspection in May 2021 and is further discussed under regulation 5 below. The person in charge had identified that there were issues with care plans and informed inspectors that they were developing an action plan to improve care planning in the centre.

Residents had good access to medical and to most allied health care services. General practitioners visited the centre daily to review residents and completed a full review of residents under their care, with the senior nursing team and pharmacist, on a three monthly basis. The residents had access to a dietitian and speech and language therapist via a referral process. However, inspectors were not assured that the provider was adequately resourcing the centre with physiotherapy services. On the day of the inspection, the physiotherapist was attending the centre two days per week instead of the previous five days, and there was evidence that the reduced service had impacted on residents. This is further discussed under regulation 6 below.

Inspectors saw that for some residents, with a restraint in place, there were incomplete care planning records to evidence their use and to guide and support staff. Incomplete documentation on the use of restraint also prevented the management team adequately monitoring its use within the centre. Although resident records showed that the use of restraint had been discussed with residents, or where appropriate their families, there was no documented evidence that explicit consent on the use of restraint had been obtained. Also in the sample of resident

records reviewed for residents displaying behaviours that challenge, inspectors saw that appropriate supports were not in place for the residents. This is further discussed under regulation 7.

There was a safeguarding policy available in the centre which had been updated recently. The provider had completed three investigations on safeguarding incidents that had occurred in the designated centre since the previous inspection. All three had been investigated fully and responded to appropriately. However, from a review of resident records and observations throughout the inspection, inspectors were not assured that residents were appropriately protected and safe from all forms of abuse. This is further discussed under regulation 8 below.

There was one person responsible for the delivery of activities on the day of the inspection and inspectors found that there was limited planned group activities seen to take place. An activity schedule was available on each floor, however inspectors observed one group activity planned to take place did not take place on the day of the inspection. In addition, the activity care plans and records reviewed did not provide assurances that residents had sufficient opportunities to participate in activities in accordance with their interests and capacities. The centre's management team assured inspectors that this matter was under review and that a new software package was being purchased in order to assist staff when completing these assessments and activity care plans.

Inspectors received repeat feedback from resident's from the May 2021 inspector where they felt the meal times were too close together with lunch and the tea time meal served four hours apart. Inspectors found that there was insufficient action taken following the last inspection to respond to resident's feedback.

Inspectors observed many visitors on the day of the inspection. Residents and their visitors confirmed to inspectors that they had good access and no restrictions to their loved ones.

The registered provider acted as a pension agent for 11 residents. Inspectors observed that records were transparent and well maintained. There was also a system in place to ensure that residents had timely access to their money should they request it. Each resident had a lockable space in their rooms to store their valuables.

The person in charge had arrangements in place to ensure that residents' clothing and linen was laundered regularly and returned to their possession in a timely fashion. Residents who spoke to inspectors were satisfied with the laundry service. However, a review of storage within the multi-occupancy bedrooms was required as inspectors observed residents' clothes on the floor of wardrobes due to insufficient hanging space for some items and some wardrobes contained other residents' belongings.

Resident had end-of-life care plans with information regarding their wishes and preferences. There was evidence that where appropriate, resident's families were

involved. Inspectors requested that the location of residents' end of life preferences be reviewed as this was not easily accessible to staff in the event of an emergency.

While some flooring within the designated centre had been replaced, ongoing improvements were required to ensure the premises conformed with Schedule 6 of the Care and Welfare of Residents in Designated Centres for Older People Regulations 2013. For example, inappropriate storage was observed, wear and tear was visible on paintwork throughout the designated centre and some items of furniture and equipment required repair or replacement to ensure it could be effectively cleaned.

Inspectors were not assured that the observed design and layout of the multi-occupancy bedrooms within the designated centre afforded each resident a minimum of 7.4 square metres of floor space to include the space occupied by a bed, a chair and personal storage space for each resident, as per Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016 S.I. 293 which took effect on 1 January 2022. Inspectors observed that two residents' spaces measured between 4.8m2 and 5.3m2. In addition, the configuration of all of the multi-occupancy bedrooms did not allow the residents to access their personal belongings in private and out of sight of the other room occupant. Inspectors requested that the registered provider review these arrangements for all multi-occupancy rooms within the centre, and take action to come in to compliance.

Inspectors observed kind interactions between staff and residents however, assistance provided by staff to residents at meal times was overall task based in nature and required review. For example, one staff member was observed assisting residents to put on clothes protectors before their meals however the staff member did not ask or speak to the residents who they were assisting. In addition, inspectors had to request staff to provide a drink to a resident with their meal. Inspectors observed offerings of hot drinks throughout the day. However, further action was required as while residents were seen to have jugs of fresh water, inspectors observed that not all residents had a glass. Inspectors noted that there were appropriate arrangements in place to ensure that residents had timely access to Speech and Language Therapists and Dietitians as required.

Inspectors reviewed three resident records and found that when a resident was temporarily discharged from the designated centre, all relevant information about the resident was provided to the receiving facility to ensure the safe transition of the resident. Records viewed also showed that when the resident returned to the designated centre, relevant information about the resident was obtained from the facility and any advised follow up care was provided to the resident. The provider had developed a centre-specific policy to provide guidance to staff on safely temporarily discharging a resident.

Inspectors observed that residents were prompted and assisted with hand hygiene at the start of meal-time. However, inspectors were told that residents were not monitored for signs and symptoms of infection. Staff were also not monitoring their temperate twice daily and there were inconsistencies in the use of PPE by staff

during the inspection. Further fundamental gaps in infection control within the centre will be discussed under Regulation 27: Infection Control.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. The person in charge confirmed to inspectors that visiting was normalising in line with the most recent guidance published by the Health Protection Surveillance Centre. Resident's visitors were observed attending the different floors of the centre throughout the day.

Judgment: Compliant

Regulation 12: Personal possessions

Inspectors found that storage within multi-occupancy rooms required review. Inspectors viewed a sample of wardrobes and observed that two residents shared a single wardrobe which did not allow for the separation of belongings and some residents did not have sufficient space to store their personal possessions. For example, items of residents' clothing were seen stored at the bottom of wardrobes due to insufficient hanging or drawer space and some wardrobes had more than one resident's belongings stored within them.

Judgment: Substantially compliant

Regulation 13: End of life

Staff assessed residents to establish their end of life care preferences and this information was used to inform an end of life care plan. Nursing notes showed that these were implemented in practice and that there was regular communication with resident's families. Where decisions had been made to generate advanced healthcare directives, these were completed in conjunction with the resident's general practitioner so that residents made informed choices.

There were private single rooms for residents at end of life and facilities available for residents' families.

Judgment: Compliant

Regulation 17: Premises

Action was required to ensure the registered provider was compliant with SI 293 which came into effect on 01 January 2022. A sample of multi-occupancy bedrooms were viewed by inspectors and found that they did not comply with the requirements of 7.4m2 floor space which area shall include the space occupied by a bed, a chair and personal storage space, for each resident of that bedroom. Some of these rooms were seen to only have the residents' bed and bedside locker within their private space. Access to their wardrobe and chair was outside of this area.

A number of areas of the premises did not conform to the matters set out in Schedule 6 of the regulations. For example:

Inappropriate storage was observed:

- Resident's medicine was seen stored in a communal room.
- A sluice room had five bins and two linen trolleys stored within this room which prevented access to the bed pan washer and the hand hygiene sink.
- There was inappropriate storage of cleaning chemicals. For example, a floor cleaning chemical was stored in an unlocked room and chemicals and bin bags were seen stored on sink areas in sluice rooms.
- Inspectors observed that staff stored personal items in an equipment store room.

Equipment and areas of poor repair were observed:

- The flooring in some areas of the centre were stained or damaged. For example, carpeting in communal dining rooms was badly stained, there was rust visible on the floor tiles in four shared bathrooms and tiling was damaged in two clinical rooms seen.
- The floor drain was ill-fitted in one store room on the ground floor.
- The lock to the clinical room on the second floor required repair to ensure it would open safely and easily.
- Resident chairs in one communal room were worn and stained.
- Paint work was chipped on numerous walls, skirting boards and door frames.

Judgment: Not compliant

Regulation 18: Food and nutrition

Supervision and assistance was required to ensure that residents who required assistance were supported to take adequate quantities of food and drink at meal times. For example, inspectors observed a resident who was sitting with their meal

in front of them who was calling out for over five minutes, before staff came to assist them.

Furthermore the system in place for serving drinks and supporting residents to drink needed improvement. Inspectors observed that although there was water jugs in the majority of residents' rooms, three residents were noted as not having any glass or cup to drink from. Inspectors also noted that a resident struggled to use the utensils and glassware provided.

Residents were assessed to identify their risk from malnutrition and care plans were formulated to inform staff regarding each residents' needs. Gaps were noted by inspectors in the sample of care records looked at.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Inspectors saw evidence that residents were temporarily discharged from the designated centre in a planned and safe manner, with all relevant about the resident provided to and obtained from the receiving facility.

Judgment: Compliant

Regulation 27: Infection control

Improvements were required to ensure the registered provider was in compliance with the National Standards for Infection Prevention and Control in Community Services 2018. For example:

- Staff were not wearing FFP2 face masks as per Public Health and Infection Prevention and Control guidelines on the Prevention and Management of Cases and Outbreaks of COVID-19, Influenza and other Respiratory Infections in Residential Care Facilities.
- There were gaps seen in monitoring logs to identify signs and symptoms of COVID-19 for staff members and there was no routine monitoring of residents taking place.
- Storage of items created a cross-contamination risk. Open unused incontinence wear was seen on a carer's trolley stored in a store room, this created a risk of cross contamination.
- A review of single-use items was required:
    - Resident's personal hygiene products were not labelled in multi-occupancy bedrooms which created a risk that items were not single use.

- There was evidence of storing opened sterile dressings which were to be re-used. While staff spoken with were aware of the single use sign, these supplies had not been discarded after use.

- Gaps were seen in cleaning schedules and processes:
  - The hygiene of shared bathrooms, sluice rooms and clinical rooms required action. There was areas of poor hygiene around handle rails in shared bathrooms. In addition, equipment within some clinical rooms was unclean, this included trolleys and IV trays. There was also gaps in cleaning records for these areas.
  - One sitting room on the first floor required attention to enhance residents' enjoyment of the room, the walls were marked and furniture in the room was scraped and worn.
  - A room signed off as 'terminally cleaned' was not clean. The bathroom had inappropriate storage, resident belongings and the toilet, sink and a pair of gloves had bodily fluid on them.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was needed to improve the quality of care plans as the following gaps were identified during the inspection:

- The pre-admission assessment information for two residents was not translated into care plans. This included information regarding manual handling, the use of a hoist and medicine management.
- The care plans of two residents who had fallen in the centre, had not been appropriately updated following the falls. For example, fall dates were not recorded or the guidance for staff did not change following multiple falls.
- The skin integrity care plan for one resident had not been updated to reflect the most recent advice from the tissue viability nurse and the actual care being delivered. This could result in the incorrect care being delivered to the resident.
- Inspectors were told that the skin integrity for one resident was checked daily during personal care. However, this was not documented in any care plan and therefore lead to inadequate monitoring of the residents' skin.

Judgment: Not compliant

Regulation 6: Health care

Inspectors were not assured that residents had adequate access to physiotherapy services in the centre. For example, a mobility care plan which recommended

regular physiotherapy reviews had not been followed. The records showed that the resident was last reviewed by the physiotherapist in August 2021. Inspectors spoke with the resident who confirmed that they would like to avail of physiotherapy services more often in order to improve their ability to mobilise independently.

Inspectors also spoke with a visitor to the centre who stated that they were not satisfied with the access that their family member had to physiotherapy services in the centre, following a recent fall.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Inspectors were not assured that staff had up to date knowledge to respond to and manage residents' behaviour that was challenging. For example:

- Inspectors noted that, following occasions where two residents had displayed behaviours that challenge, records on the triggers and management of their behaviours were not completed.
- For two other residents who displayed behaviours that challenge, there were no care plans in place to guide staff on how to support these residents when they displayed such behaviours.
- For one residents who wore a security bracelet, there were no care plan developed to guide staff on its use.
- During the inspection, inspectors observed occasions where residents in communal areas displayed behaviours that challenge and that staff did not did not appropriately respond to such behaviours.

When requested during the inspection, inspectors were not provided with evidence that residents, or where appropriate their families, had provided signed consent on the use of restraint.

Judgment: Not compliant

Regulation 8: Protection

Inspectors found that there were no appropriate safeguarding plans in place for three residents involved in incidents of abuse, which would guide staff on how to proactively protect those residents from such abuse.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Inspectors were not assured that all residents were provided with adequate opportunities to participate in activities in accordance with their interests and capabilities. Although inspectors observed one small group of six residents enjoying painting in the centre's activity room, most residents spent prolonged periods of time sitting in their rooms or in sitting areas near the nurses' stations on each floor.

Inspectors followed up on the compliance plan from the last inspection and found that the action plan to review and improve residents' psychosocial assessments and care plans had not been completed. Inspectors noted that psychosocial assessments contained no information regarding residents' interests and activity preferences and no care plans had been developed to guide and inform staff. Activity records did not inform staff of residents' level of participation or enjoyment from partaking in activities, therefore it could not inform ongoing quality improvement or refinement of the activity programme.

Inspectors found that residents were consulted with in the organisation of the designated centre. However action was required to ensure that this consultation led to improvements. For example, at the previous inspection resident's spoke with inspectors about the timing of meals within the designated centre and inspectors were told there were plans to respond to this feedback. Inspectors found that this had not taken place.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for TLC City West OSV-0000692

Inspection ID: MON-0036258

Date of inspection: 21/02/2022

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: • A full-time activity coordinator commenced employment on the 1st of February 2022. From 12th of April 2022, a new activity team lead role will commence. In addition to daily feedback to activity staff, residents were last consulted during the resident's council meeting of 7th March 2022 about their preferred activities and all suggestions are used to inform the activity timetable going forward. The activity timetable will be audited as part of Quarterly KPI Resident Audits from June 2022 and kept under ongoing review by the PIC. • Two members of our activity team are booked to attend a DSIDC Life stories activity course to enable them to complete the recreation assessments. For completion by June 2022. • As the activity team is now in place, we do not foresee any gaps. However, in the event of gaps arising, we have a number of HCA's who can fill the role of the activity coordinator on a relief basis and a process is place should a gap in the activity roster arise. Completed and reviewed on an ongoing basis by the PIC. • Staffing levels are kept under ongoing review and are revised to reflect changes in occupancy and the assessed needs of residents and to ensure coherence with the SOP. A dedicated recruitment and retention programme is ongoing within the centre to maintain staffing levels across all grades. This recruitment programme is reviewed monthly at governance meetings by the PIC, the Regional Director (RD) and HR manager to ensure it is fully responsive to the needs of the centre. Complete and ongoing.	
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• The current approach to the provision of training within the centre has been reviewed and revised. A monthly training calendar is now displayed on all floors. From 24th February 2022, the Practice Development Nurse (PDN) has been allocated additional protected time for training. Furthermore, an ADON has dedicated responsibility in relation to the oversight of training within the centre. Both will be supported by HR and the administration team and progress will be reviewed monthly by the PIC. All outstanding training will be completed by 30th May 2022.
• Newly recruited / agency staff are now inducted by a CNM who ensures access, as appropriate to the centre's electronic record management system. This has been completed and is under ongoing review by the ADON.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• An additional ADON will be recruited to support the governance and management of the centre. Active recruitment is on-going and is at interview stage currently. Recruitment expected to be concluded by June 2022.
• A weekly internal governance meeting commenced on 23rd February 2022 with membership comprising CNM/ADON/HR/Housekeeping and Catering (HK&C) Manager & PIC to discuss current events, all clinical indicators in the centre and to close off all actions arising within the week. All outstanding actions will be followed up from the preceding week to ensure actions are completed in a timely manner. This forum also ensures that for example, updated national guidance including the use of PPE and symptom monitoring is cascaded to staff and implemented in a timely manner. A dedicated centre-specific plan is now in place that captures all outstanding actions and is used to inform all weekly and monthly governance and management team meetings. Completed and ongoing.
• An ADON has been allocated with dedicated responsibility in relation to the oversight of training and to ensure the training matrix is up to date. This person will be supported in the role by HR and administration teams and will be reviewed monthly by the PIC at clinical governance meetings. Completed and ongoing.
• The PDN has commenced updated care plan training for nurses on a 1:1 basis to enhance the level of person-centered information available with each plan. This will be kept under ongoing reviewed by the CNMs & ADONs. The PIC will review monthly to ensure compliance. Completed and ongoing.
• Immediately following the inspection, the tiling in the communal toilet area (stained from previous metal bin located there) was addressed and a new bin acquired. Completed.
• The Group Quality Team will visit the centre by end of June 2022 and review KPI audits

and carry out an external evaluation of the implementation of actions contained within this compliance plan.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The Complaint Policy and procedure has been updated and a copy is available at the reception area and throughout the home. Completed.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• Work has commenced by our facilities team on improving the levels of personal storage for each resident including the acquisition of additional sets of wardrobes and chests of drawers as required in shared rooms to replace existing furniture. It is anticipated that this work will be concluded by 31st July 2022.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• All medications within the centred are stored appropriately and the lock in the clinical room has been fixed. Completed
• Staff personal items have been removed from the equipment room and stored appropriately in the staff room. This is checked daily by the HK&C Manager. Completed.
• TLC Citywest has 28 twin full ensuite bedrooms on the ground (8), first (10) and second floor (10). Following the most recent inspection and in response to the issues raised during the provider meeting on 25 April, 2022, a full and comprehensive review was undertaken to determine compliance with S.I. No. 293/2016 – Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People)(Amendment) Regulations 2016. From the review, we can confirm all TLC Citywest resident rooms are in compliance with S.I. No. 293/2016 – Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People)(Amendment) Regulations 2016. Furniture items

identified during the inspection have been addressed and all necessary items have been put on order. Timeframe for expected delivery is 30 days
• Storage has been reviewed on the ground floor and additional storage is now available in in the basement. Completed.
• All chemicals are stored in a locked room and bin bags kept in a cupboard. This is monitored daily by a member of the Senior Management Team (SNT). Completed.
• A review of all furniture has been completed, and all worn and damaged furniture has now been removed. New leather chairs for the rooms are included in the CAPEX funding for 2022. A list of equipment to be replaced has been collated and submitted for purchase. Communal Dining Room carpets will be replaced with linoleum flooring as part of the next phase of refurbishment, which will commence shortly. Due to be completed by August 2022.
• As a result of the ongoing building works, paint work was chipped on numerous walls, skirting boards, and doorframes. A full audit of the work to be undertaken to remedy these matters has been completed and works are to be completed by end of August 2022.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• Mealtime audits are now completed by the HK&C Manager twice a month. All actions arising are reviewed during weekly and where required monthly governance and management meetings. Completed.
• A member of the SMT (PIC/ADONs/CNMS/HK&CM) completes daily observations during mealtimes to ensure that each residents' needs including those in relation to hydration and nutrition are fully addressed and that the utensils and glassware available are appropriate for each resident. Completed and ongoing.
• Immediately following the inspection, catering staff were instructed to ensure that all residents received a jug and a glass of water together. Completed and monitored daily by care staff.
• The PDN has provided updated care plan training for nurses on a 1:1 basis to enhance the level of person-centered information available with each plan including the risk from malnutrition. This will be kept under ongoing review by the CNMs & ADONs. The PIC will review monthly to ensure compliance. Completed and ongoing.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• A weekly internal governance meeting commenced on 23rd February 2022 with membership comprising CNM/ADON/HR/Housekeeping and Catering (HK&C) Manager & PIC. Among other actions, this forum also ensures that for example, updated national guidance including the use of PPE and symptom monitoring is cascaded to staff and implemented in a timely manner. Completed and ongoing.
• All personal hygiene products are now appropriately labelled in multiple occupancy rooms and staff have been educated on the appropriate storage of continence wear.
• Nurses have received update training on the discarding of all single-use dressings once opened. This has been added to the infection control audit to ensure full compliance from April 2022 onwards and is monitored daily by PIC/ADONs/CNMs. Completed.
• A revised detailed cleaning schedule is in place for nurses to ensure that the clinical room equipment is cleaned. Completed 29th March 2022 and monitored weekly by the ADON's.
• An SOP is in place for the cleaning of sluice rooms outlining the responsibility of clinical and non-clinical staff. Completed 22nd February 2022 and monitored daily by ADON's/CNM's with oversight by the PIC.
• First floor sitting room redecorated and all furniture where relevant to be replaced by 30th August 2022
• An updated process is now in place to deep clean rooms. This will be checked daily by the cleaning staff and randomly checked by a member of the SMT. Completed
• An antibiotic stewardship initiative commenced in the centre from 29th of March 2022 and going forward will be reviewed by the PIC/ADON in monthly governance meetings. Completed and ongoing.

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:
• From 24th February 2022, the Practice Development Nurse (PDN) has been allocated additional protected time for training to include care planning and the triangulation of incidents and accidents. CNMs ensure that nurses have updated their care plans, and this will be reviewed by PIC/ADON prior to closing off any incident. Ongoing since 9th March 2022.
• In addition to the regular review and in-house audit of care plans by the SMT, an external audit is to be carried out by the Group Quality Team by end of June 2022.
An information template for nurses is now being used to guide them with assessments and care planning for residents. The PDN is overseeing this action. Completed 28th March 2022. Completed.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• A new physiotherapist commenced in the centre on the 4th of February 2022, initially for two days per week. This has subsequently been increased to 3 days per week and is kept under regular review to ensure that resident's care needs are fully met. Completed and ongoing.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• Training on responsive behaviours has been scheduled monthly from March 2022 onwards and all staff are facilitated to attend the training. The training includes the reporting and recording of all responsive behaviours. The PIC will audit training to ensure full compliance by June 2022.
• An activity lead is due to commence on 12th of April 2022. This will ensure that the range of activities provided in the centre are commensurate with resident's wishes. This review will also include feedback from the resident's committee. In addition, the group are also setting up an activity strategy team to look at activities within all centres which will usefully guide provision within the centre.
• A trend analysis including a root cause analysis of all incidents has been completed and an action plan implemented. This will be discussed at the health care governance and quality safety committee meetings from April 2022 onwards. Responsibility of compliance is with the PIC. Completed.
• All assessments in relation to the use of restraint are discussed and agreed with the resident and/or their family member and relevant documentation is completed as appropriate. To be completed by 30th April 2022, overall responsibility with PIC. A restraint audit has been scheduled for week commencing 18th April 2022 by the PDN to ensure full compliance. Action plan will be discussed with PIC and placed on our overall action plan and discussed weekly and monthly. To be completed by June 2022.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• A trend analysis including a root cause analysis of all incidents has been completed and an action plan implemented. This will be discussed at the health care governance and quality safety committee meetings from April 2022 onwards. Responsibility of compliance is with the PIC. Completed.
• A safeguarding care plan is in place for all relevant safeguarding issues. An ADON has been assigned the oversight of care plans for such incidents from March 2022 onwards. Completed and reviewed monthly by the PIC. This will be further reviewed and discussed in the weekly governance meeting and lessons learned will be discussed in the healthcare governance and quality safety monthly meeting. Completed and ongoing.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A full-time activity coordinator commenced employment on the 1st of February 2022. From 12th of April 2022, a new activity team lead role will be commencing. Residents were consulted during the resident's council meeting on 7th of March 2022 about their preferred activities and activity staff are advised to ask for suggestions regularly. These suggestions will be included in the timetable going forward. This will then be audited as part of Quarterly KPI audit on resident's experiences from June 2022. To be reviewed by the PIC end of June 2022.
• Two activity staff are booked to attend a DSIDC Life stories activity course to enhance their skills and competencies in the completion of recreation assessments. For completion by June 2022.
• A new 'Happiness' programme has been introduced as part of the activity to spark laughter and happiness for everyone living with dementia and cognitive impairment. Training has taken place for activity staff to implement this programme and it is anticipated that this will be fully rolled out during May 2022. The activity lead will have responsibility to introduce the programme once appointed. To be reviewed by the PIC/ADON.
• As the activity team is now in place, we do not foresee any gaps. However, in the event of gaps arising, we have a number of HCA's who can fill the role of the activity coordinator on a relief basis and a process is place should a gap in the activity roster arise. Completed and reviewed on an ongoing basis by the PIC.
• A dedicated one hour is allocated to the nurses to complete their care plans and assessments including the psychosocial assessment and care plan, this will be supported by the activity team. A 'Key to Me' assessment for all residents was introduced on 21st of March 2022 and will be completed for all the residents by 30th of May 2022. This assessment will record resident's interests and preferences. Overall responsibility for compliance will be with the PIC.
• Timings of meals was discussed during the resident council meeting on the 7th March 2022. Delayed dining times have been trialled on the ground floor and feedback will be sought from residents during the April council meeting. This feedback will be used to inform next steps. The PIC has responsibility for taking forward this action.
• A nurse computer has been discretely relocated to one of the sitting rooms to facilitate enhanced supervision of the residents. Completed by the 30th April 2022.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	30/06/2022
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has	Substantially Compliant	Yellow	31/07/2022

	adequate space to store and maintain his or her clothes and other personal possessions.			
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	30/06/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/05/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	01/03/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/08/2022
Regulation 18(1)(a)	The person in charge shall ensure that each resident has access to a safe supply of fresh drinking water at all times.	Substantially Compliant	Yellow	23/02/2022

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.	Not Compliant	Orange	23/02/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/08/2022
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Substantially Compliant	Yellow	21/03/2022
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in	Substantially Compliant	Yellow	21/03/2022

	paragraph (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	28/03/2022
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/06/2022
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	24/02/2022

Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	30/06/2022
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	30/06/2022
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	30/06/2022
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	30/04/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to	Not Compliant	Orange	23/02/2022

	participate in activities in accordance with their interests and capacities.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	30/06/2022