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:	Claremount Nursing Home
Name of provider:	Claremount Nursing Home Limited
Address of centre:	Claremount, Claremorris, Mayo
Type of inspection:	Unannounced
Date of inspection:	02 February 2022
Centre ID:	OSV-0000329
Fieldwork ID:	MON-0033407

About the designated centre

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

Claremount Nursing home is a purpose-built, two-storey centre which provides 24-hour nursing care for up to 70 residents requiring continuing care, convalescence, respite, dementia and palliative care. The centre is well laid out. All residents' bedrooms, communal areas and sanitary facilities are situated on the ground floor. Bedroom accommodation comprises 30 spacious single and 20 twin bedrooms. All bedrooms have accessible en-suite toilet and showering facilities. There is a choice of different communal areas for residents to relax and a dedicated visitors' room, physiotherapy room and oratory are available. The centre is located approximately 1km outside the town of Claremorris in County Mayo. It has a large accessible internal garden for residents and is set in landscaped grounds.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	45

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 2 February 2022	10:00hrs to 19:30hrs	Leanne Crowe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection of Claremount Nursing Home to review ongoing compliance with the regulations. On arrival at the centre, the inspector was met by a staff member who guided them through the infection prevention and control measures necessary on entering the designated centre. This included a temperature check, completing hand hygiene and ensuring that the inspector was wearing Personal Protective Equipment (PPE) such as a face mask prior to entering the centre.

An opening meeting was held, and the person in charge accompanied the inspector on a tour of the premises.

The inspector spoke with 13 residents on the day of the inspection. Residents spoke positively about their rooms and the premises in general. They also praised staff, stating that "they're great", "they give us good attention" and "they're kind but efficient also". A small number of residents noted that sometimes staff can take "too long" to answer a call bell.

In relation to activities, residents' feedback was mixed. A number of residents felt that they had enough to occupy them during the day, including playing ball games and attending live music and mass in the centre. However, others felt improvements were required, stating "there isn't enough to do", "we just sit here" and "we have to do our own thing". While there was an activity co-ordinator on duty on the day of the inspection, an additional staff member usually rostered to support them with activities was not available. The inspector observed two day rooms throughout the inspection and on a number of occasions, found that there was little to occupy residents. When the activity co-ordinator was not in one of these rooms, staff members assigned to supervise residents were observed completing paperwork or providing drinks to residents, rather than using the opportunity to have more meaningful engagement with residents. Later in the evening, in the large day room, the inspector observed one television playing a film and while a number of residents appeared to be watching this, this TV was muted as music was being played through a second TV on another wall.

There were a number of secure courtyards available for residents. The inspector was told these areas allowed for residents to enjoy fresh air and engage in outdoor walks. However, the inspector noted that access to these areas were through designated fire doors only, and therefore residents could not enter the courtyards without staff accompanying them as keycodes were required to disarm the doors.

The inspector observed two sittings of residents' mealtimes. Residents who spoke with the inspector praised the quality and quantity of the food served and confirmed that their personal preferences were catered to, as well as their dietary requirements. The food served on the day of the inspection was well presented and residents appeared to enjoy it. However, the inspector's observations indicated that

the mealtime experience could be improved upon. For example, while there were sufficient staff available to support residents to eat and drink, a number of staff were observed providing "task orientated" care to residents. This included failing to speak or interact with the residents they were assisting and interrupting a resident during their meal to momentarily attend to another task. One staff member was also observed placing a folder on a surface in front of a resident in order to complete some nursing notes without acknowledging the resident. These observations were raised with the person in charge during the inspection and an observation of a later mealtime demonstrated a more sociable atmosphere.

The next two sections of the 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 findings of this inspection were that the registered provider had not sufficiently ensured that an effective and safe service was continuously provided for residents living in the designated centre.

Claremount Nursing Home Limited is the registered provider for this designated centre. The established governance structure in place includes a company director that represents the registered provider and to whom the person in charge reports. The nursing management team consists of the person in charge and an assistant director of nursing. They oversee the work of a team of nurses, healthcare assistants, a physiotherapist, activity co-ordinators and housekeeping, catering and administrative staff.

While the centre was appropriately resourced and the nursing management team worked hard to meet the needs of residents, enhanced oversight and monitoring of the service was required to ensure safe delivery of care at all times. While the management team had previously met regularly to discuss topics relevant to service delivery including COVID-19, admissions, staffing and audits, the most recent meeting records were from August 2021.

A sample of the audits carried out in the centre were reviewed by the inspector and were seen to cover clinical and non-clinical areas. The inspector found that while information was collected, it was not always sufficiently analysed to develop clear quality improvement plans with appropriate time frames and allocated to appropriate personnel. For example, a medication management audit had identified areas of improvement in relation to administration records in December 2021. Appropriate action was taken and a follow up audit was completed which identified a significant increase in compliance. However, by contrast, the centre's monthly falls audit gathered relevant information but did not sufficiently analyse the data to identify any trends or patterns in relation to the incidents and did not identify a clear improvement plan. Additionally, an environmental audit completed in April 2021 had

identified areas of improvement but no follow up audit had been completed to assess progress with the action plan and the impact of the changes for residents.

The inspector was assured that there was enough nursing staff and healthcare assistants on duty to meet the health care needs of residents. Recruitment was ongoing at the time of the inspection for additional healthcare staff but the person in charge confirmed that existing staff were effectively covering the rostered care hours. However, on the day of the inspection, this had resulted in a staff member being unavailable to support the activity co-ordinator in their duties. Instead, another staff member was assigned to supervise residents in one of the day rooms.

Staff had good access to ongoing training and consequently were up-to-date with training in fire safety, moving and handling practices and infection prevention and control. However, some staff required updated safeguarding training.

The inspector reviewed a sample of staff files and found that these contained all of the information required by Schedule 2 of the regulations.

A policy relating to the management of complaints was available in the centre. An action from the previous inspection had been addressed; a large-print summary of the process was displayed throughout the building. The person in charge was the centre's complaints officer and maintained a record of complaints received. The inspector noted that the recording of the response to complaints required additional detail to ensure that they were appropriately dealt with.

A directory of residents was maintained in line with the regulations.

An annual review regarding the standard of services delivered throughout 2020 was completed and the review for 2021 was in development at the time of the inspection.

Regulation 15: Staffing

The inspector found that the number of nursing and care staff on duty was appropriate with regard to the assessed needs of the 45 residents in the centre. However, on the day of the inspection, there was insufficient staff dedicated to providing activities, due to a short-notice staff absence. One activity co-ordinator was on duty, and while they would usually be supported by an additional care staff member, the absence resulted in another staff member being allocated to supervise residents in one of the centre's day rooms, who was not responsible for providing activities. An action relating to this is featured under regulation 9, Residents' Rights.

Judgment: Compliant

Regulation 16: Training and staff development

There was an induction programme in place for staff, as well as a varied programme of training that supported skill development.

The inspector observed two incidents on the day of the inspection that indicated that systems for supervision of infection prevention and control practices required strengthening. Additionally, supervision of staff needed improvement, particularly when staff were supporting residents at mealtimes and when supporting residents as they mobilised.

Judgment: Substantially compliant

Regulation 19: Directory of residents

All of the information required by Schedule 3 of the regulations was set out in the centre's directory of residents.

Judgment: Compliant

Regulation 23: Governance and management

The inspector identified a number of deficits in relation to governance and management systems in the centre:

- The quality of audits completed was inconsistent. Data being gathered was not always analysed or used to identify potential areas requiring improvement
- Records indicated that formal management team meetings were not occurring regularly, with the most recent occurring in August 2021 and only discussed visiting. As a result the inspector was not assured that clinical governance issues relevant to the care and services provided for residents were adequately discussed by the management and communicated to staff, in line with good governance practice
- Some documentation and information sought on inspection could only be accessed by a particular member of staff. For example, a summary of staff training records was only accessible to a administrator and correspondence in relation to a complaint could only be accessed by a director of the provider entity. This posed a risk in terms of information governance as this prevented the person in charge from accessing information that may be needed on a day-to-day basis
- A complaint received regarding poor quality of care of a resident had not been investigated as a safeguarding concern, in line with the centre's own

policy.

Judgment: Not compliant

Regulation 34: Complaints procedure

A complaints log was maintained, one complaint had been recorded in November 2021 and remained open at the time of the inspection. Records relating to this complaint did not demonstrate that it had been appropriately investigated or responded to. While the nursing management team verbally outlined what action was taken in response to the complaint, including additional training staff for and revising practices regarding a nursing assessment tool, this was not detailed in the records relating to the complaint.

Judgment: Substantially compliant

Quality and safety

Residents were provided with good standards of nursing care and timely health care to meet their needs. Residents' care plans were detailed and reflective of their individual preferences and wishes regarding their care and supports. Residents had access to a general practitioner (GP) of their choice and a GP visited them regularly in the centre. A physiotherapist was based in the centre 5 days per week. A variety of allied health care professionals were available to residents on a referral basis.

Records showed that there was a good standard of care planning in the centre. Residents' needs were comprehensively assessed using validated assessment tools at regular intervals and when changes were noted to a resident's condition.

The centre had infection prevention and control policies which covered aspects of standard precautions, transmission-based precautions and guidance in relation to COVID-19. Staff received training in infection prevention and control practices. For the most part, the environment was observed to be clean and tidy. However, a number of findings in relation to poor infection prevention and control are outlined under Regulation 27.

Residents were supported to choose how they lived their lives within the designated centre. A programme of activities had been developed for residents, however staffing issues on the day of the inspection impacted on the provision of these activities. This is discussed under Regulation 9. The activity co-ordinator stated that residents who preferred to spend time in their bedrooms had opportunities to join group activities that interested them or to participate in one-to-one activities as they wished. Residents were supported to provide feedback on the quality of the service

and this feedback was incorporated into the centre's annual quality and safety review. Residents' representatives were invited to submit feedback on behalf of those who were unable to communicate.

While residents' outings hadn't occurred within the last 12 months due to COVID-19 guidelines, external services providers were attending the centre. For example, live music and mass was performed in the centre on a regular basis.

Residents were supported to continue to practice their religious faiths and had access to newspapers, radios and televisions.

While there were measures in place to protect residents from the risk of abuse, an incident that occurred during the inspection and was observed by the inspector, and a complaint submitted to the centre, required notification to the chief inspector regarding allegations or suspicions of abuse. This is discussed under Regulation 8, protection.

Residents were supported to safely meet with their visitors in line with public health guidance.

All staff had up-to-date training in fire safety. The fire procedure and evacuation plans were prominently displayed in the centre. The centre had monitoring systems in place to ensure that fire safety equipment was regularly assessed and serviced. Fire exits were free from obstruction. Although fire drills had been conducted up until May 2021, records indicated that none had been carried out after this date. The inspector sought assurances that the centre's largest compartments could be evacuated in a timely manner with minimal staffing levels available during the night. These assurances were provided following the inspection.

The nutritional status of residents was assessed regularly using a validated nutritional screening tool. A variety of meals, drinks and snacks were served to residents throughout the inspection, in line with their personal preferences and dietary needs. Some improvements were required to ensure that meal times were a pleasant social experience for the residents, especially for those residents who needed staff to support them at meal times.

Regulation 11: Visits

The inspector was satisfied that visiting arrangements were in line with current guidelines set out by the HPSC (Health Protection and Surveillance Centre).

Judgment: Compliant

Regulation 12: Personal possessions

Residents had sufficient space to store their personal belongings and the inspector observed that many residents had decorated their rooms with ornaments, photographs and furniture of their choosing.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents' hydration and nutrition needs were assessed and appropriately monitored. There was sufficient staff available to support residents who needed assistance with drinking fluids and with eating their meals. Residents with assessed risk of dehydration, malnutrition or with swallowing difficulties were referred for dietitian and speech and language therapy assessment and their recommendations were implemented. Residents requiring modified and fortified diets were provided with meals and snacks prepared as recommended.

Judgment: Compliant

Regulation 27: Infection control

The inspector identified issues throughout the course of the inspection, which did not comply with the National Standards for Infection Prevention and Control in Community Services 2018. These findings did not assure the inspector that there was sufficient supervision of infection prevention and control practices. For example:

- A number of staff observed by the inspector failed to follow appropriate hand hygiene practices
- While residents' equipment were included in the weekly cleaning schedule, they were not decontaminated between each use
- Cleaning records for "high-touch" areas such as handrails and door handles were signed on a weekly basis, which did not assure the inspector that they were being cleaned as frequently as needed
- While residents requiring the use of a hoist had their own sling, hoists were being stored with various slings draped over them. It could not be ensured that these slings had been appropriately laundered or did not pose a risk to cross-contamination
- Alcohol hand gel was not available on a trolley used for serving of residents' food and serving utensils were observed being used by a number of staff throughout mealtimes
- The system in place for mopping floors did not reflect best practice and posed a risk of contamination between rooms
- Although the inspector was informed that the cleaning trolley was included

within the cleaning schedule, it was visibly dirty at the time of the inspection
- The centre's treatment room and a number of storage areas were cluttered and therefore the floors of these rooms could not be effectively cleaned
- While an audit of hand hygiene had been completed in October 2021, there was no evidence that audits to monitor other aspects of infection prevention and control had been carried out since April 2021.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire drill records indicated that the most recent fire drill was completed in May 2021. Records of fire drills reviewed by the inspector indicated that between nine and 17 staff participated in these exercises. Fire drills simulating night time staffing levels had not been completed since 2020. A number of drills were conducted following the inspection that simulated night time staffing levels.

Personal emergency evacuation plans (PEEPs) for residents were available but required revision to ensure they included all of the information required to inform a safe evacuation. For example, the level of assistance required to safely move the resident, as well as their cognition was not outlined.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed a sample of the clinical care records including assessments and care plans in place to manage residents' care needs and found that assessments were completed on admission including nutrition and mobility. Care plans for any identified need were prepared within 48 hours of admission. Arrangements were in place to evaluate care plans at four monthly intervals.

Judgment: Compliant

Regulation 6: Health care

Suitable arrangements were in place to ensure each resident had access to a GP and other specialist medical professionals. All recommendations made by these specialists were integrated into the care given to residents.

Judgment: Compliant

Regulation 8: Protection

The systems in place to safeguard residents were not sufficiently robust.

The inspector observed an incident on the day of the inspection and also identified a complaint that had been received by the registered provider, both of which required notification to the Chief Inspector as allegations or suspicions of abuse.

The inspector observed an incident whereby a member of staff was not respectful in their interaction with a resident. When the inspector alerted the person in charge to the incident, this was followed up appropriately in line with the centre's safeguarding policy.

A review of the complaints log indicated that a concern that referred to unexplained bruising had been investigated and responded to appropriately, however this had not been identified as a potential safeguarding incident, nor had it been identified to the Chief Inspector.

Notification of these incidents were submitted following the inspection and assurances were provided in relation to the investigation and action taken on foot of both concerns.

Fifteen staff that had been recruited within the last four months had not yet received training in safeguarding. This was scheduled to take place within quarter two of 2022.

The registered provider was pension agent for a number of residents. While there were comprehensive records in place in relation to how this money was managed, the provider was not fully compliant with the Department of Social Protection requirements as the payments were not being lodged directly into the residents' account before any fees were charged to the residents.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector was not assured that residents had opportunities to participate in meaningful coordinated social activities that supported their interests and capabilities. Activities were not being provided in line with the schedule that was displayed in the centre, and residents feedback on the day of the inspection indicated that some were dissatisfied with the range and number of activities

available to them.

One activity co-ordinator was on duty during the inspection and while a care staff member would usually be allocated to provide support with activities, a short-notice staff absence resulted in the activity co-ordinator working alone. Instead, another staff member was allocated to supervise residents in one of the day rooms. While some activity occurred during the inspection in each day room, the inspector observed on a number of occasions that residents were not being meaningfully engaged with by staff.

While residents had access to a number of suitable external courtyards, they could only enter these areas via fire exits that required key codes to open them. Therefore, many residents could not independently access the courtyards and would need to be accompanied by staff.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	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	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Claremount Nursing Home OSV-0000329

Inspection ID: MON-0033407

Date of inspection: 02/02/2022

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff informed that they must sanitise hands before putting on their masks after break. Mealtime & staff interaction audits will be conducted on a weekly basis by ADON. Areas identified will be actioned immediately. Analysis of these audits will be relayed to the staff at the quarterly staff meetings. All staff have been instructed they must wear gloves when attending to cleaning of body fluids. Fifteen newly recruited staff members and any subsequent new staff members will have completed Safeguarding training by 31st May 2022. Infection, Prevention & Control training and refresher training is scheduled to be completed for all staff by 31st August 2022.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Audits have been reviewed for quality and changes have been made to improve data being gathered. Information gathered will be analysed by PIC and areas requiring improvement will be identified and discussed at weekly management meetings.	

Management meetings are now being held on a weekly basis and all areas of care and services for residents will be discussed and communicated to staff in staff meetings to be held on a quarterly basis.

Accurate record keeping and formal management meetings will be kept up to date for all occasions they occur.

All documentation and training records are now accessible to DON and ADON.

All complaints received will be investigated in line with our policy.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Going forward all complaints will be investigated, responded to and documented as per our policy.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Hand Hygiene Audit plan is in place. All staff will be monitored for hand hygiene on a monthly basis. Infection, Prevention & Control training and refresher training for all staff is scheduled for completion by 31st August 2022.

Wheelchairs and hydro tilt chairs - in addition to cleaning schedule all chairs are decontaminated after each use by the carer. Disinfectant wipes are provided in storage room. A carer is allocated on a daily basis to ensure that decontamination is completed. Any non-compliance will be brought to the attention of the PIC/ADON for immediate action.

High touch areas are cleaned twice daily and signed for by Housekeeping staff.
Slings draped over hoists have been removed and laundered and staff instructed not to leave slings draped over hoist. Each resident has own sling.

Housekeeping trolley was cleaned immediately and will be audited on a weekly basis by the PIC. New housekeeping trolley and mopping system is being sourced and will be

ordered by 30th June 2022.

PPE removed from linen room and treatment rooms.

Alcohol hand gel now accompanies dessert trolley for all staff.

Audits for all aspects of Infection, Prevention and Control are now in place and will be conducted on quarterly basis.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire drills for daytime and night time will be conducted regularly and recorded.
PEEPS have been amended to include number of staff required to evacuate each resident and cognitive status of each included.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Occasions where staff weren't respectful: The staff member was spoken to and instructed about the appropriate manner in which to speak to residents. Staff member completed Safeguarding refresher training to reinforce this.
Incident regarding bruising reported to Chief Inspector on 3rd February 2022 as a potential safeguarding incident. Staff training scheduled for completion on 31st May 2022, in order to avoid further instances arising.
Residents pension now paid directly to her own bank account after liaising with the vulnerable persons unit in her bank.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Activities are being revised, more meaningful and enjoyable activities to be provided, especially arts and crafts by a staff member who has displayed an enthusiasm for arts and crafts. This is extra to regular activities planned.

Staff are reminded they must engage with residents when supervising the dayrooms - not a time to do paperwork.
Two gardens have keypad access. Whilst a few residents are independently mobile enough to walk out unsupervised all bar one have cognitive impairment which poses a risk to them being outside unsupervised as they have little or no safety awareness.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	03/02/2022
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	07/02/2022
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	30/06/2022

Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	08/02/2022
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	03/02/2022
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken	Substantially Compliant	Yellow	03/02/2022

	on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	03/02/2022
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	31/05/2022
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	03/02/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/04/2022