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 Carton
Name of provider:	TLC Spectrum Limited
Address of centre:	Tonlegee Road, Raheny, Dublin 5
Type of inspection:	Unannounced
Date of inspection:	04 December 2023
Centre ID:	OSV-0005800
Fieldwork ID:	MON-0041901

About the designated centre

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

TLC Carton is a purpose-built nursing home designed to meet the individual needs of the older person, while facilitating freedom and independence for the more active. TLC Carton is located off the Malahide Road and close to Beaumont Hospital, and can accommodate up to 163 male and female residents over 18 years of age. The building has three storeys consisting of 135 single bedrooms and 14 double/twin bedrooms. Each bedroom has full en-suite facilities, and furniture which includes a television, call bells and a phone. Each floor is serviced by stairwells and passenger lifts and access to outdoors spaces are available on the ground and first floor.
TLC Carton provides long term, respite care and stepdown care to meet the health and social needs of people with low, medium, high and maximum dependencies. The centre provides 24-hour nursing care. The provider's aim is to ensure freedom of choice, promote dignity and respect within a safe, friendly and homely environment that respects the individuality of each resident who chooses to reside in TLC Carton.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	153

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 4 December 2023	08:10hrs to 18:25hrs	Niamh Moore	Lead
Monday 4 December 2023	08:10hrs to 18:25hrs	Karen McMahon	Support

What residents told us and what inspectors observed

This inspection took place in TLC Carton in Raheny, North Dublin over the course of a day during which time inspectors spent time observing and speaking to residents, visitors and staff. Overall feedback from residents and visitors was positive relating to the care their loved ones received.

Upon entering the designated centre, inspectors were met by a member of the administration team and completed the signing-in process. Following an introductory meeting with a member of management, inspectors were guided on a tour of the building. The centre is laid out over three floors, with lifts and stairs to facilitate movement between all floors, referred to as the ground, first and second floor. Bedroom accommodation was laid out across all three floors and comprised of 135 single bedrooms and 14 twin rooms, all with en-suite toilet and shower facilities. Residents were supported to personalise their bedrooms, with items such as photographs, artwork, bed linen, personal belongings and furniture. Bedrooms were seen to be clean and residents reported to be happy with their bedroom accommodation.

Residents had access to a number of communal day spaces and a dining room on each floor. There was additional communal spaces such as an oratory, activity room and enclosed garden on the ground floor. Many seasonal Christmas decorations were on display for residents to enjoy. Overall the premises was found to be maintained to a good standard with the exception of a small number of areas that were identified as requiring some attention, namely ensuring the designated smoking areas had appropriate call bells. There was some wear and tear seen to paintwork and furniture and this required oversight to ensure these areas could be effectively cleaned.

Residents could attend the dining room on each floor or were supported to have their meals in their bedroom as per their preferences. A daily written menu was available and displayed outside each dining room with choices seen for breakfast, lunch and dinner servings which included both cold and hot servings. In the morning time, inspectors observed many residents enjoying a hot breakfast. Residents reported that they enjoyed their breakfast meal and they were particularly fond of the eggs. Inspectors observed the lunch time sitting and received mixed feedback from resident's relating to their dining experience. Some residents said the taste was "okay", others felt the portions were too big and the mealtime was too early in the day. Inspectors observed that some residents chose to not eat their main meal at lunch time and moved on to the dessert option. The music playing in the background during the mealtime on one floor was not appropriate. In addition, inspectors saw that one resident who required a modified consistency diet was not offered their choice or the required modified soft diet. Meal time options and the dining experience will be further discussed within this report.

Residents had access to advocacy services. Residents had opportunities to meet with visitors and there were numerous private spaces throughout the building for these visits to occur. Group activities occurred within the centre and were facilitated by dedicated activity staff. Activity schedules were displayed on noticeboards. Inspectors were told that the centre had recently held a market where items were sold and profits raised would be spent on activities for residents. Activity staff were in the process of organising additional activities for the festive Christmas period to include musicians.

Inspectors observed numerous interactions where staff were gentle, patient and kind to residents. Residents told inspectors that the staff were "lovely" and "great". Residents' had the opportunity to provide feedback on the service they received through resident council meetings. Records showed that overall residents reported to be happy within these meetings. However, some residents reported that they were unhappy when other residents entering their bedrooms. Residents were overall happy with staffing levels. However, throughout the inspection day inspectors noted at times residents sat together in groups at nurse's stations with limited activity. Inspectors saw evidence in management documentation that further opportunities to engage residents with smaller group activities or 1:1 was to be developed.

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 impact on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013). This inspection also followed up on the compliance plan from the last inspection in March 2023 and reviewed solicited and unsolicited information received since this inspection. Inspectors found that overall the registered provider had safe systems in place to oversee the quality of the service, however some of these systems required strengthening to ensure that all residents received a service that was safe, appropriate, consistent and effectively monitored.

This designated centre is operated by TLC Spectrum Limited which is part of the Orpea Care Ireland group. The Chief Operating Officer is the person delegated by the provider with responsibility for senior management oversight of the service. The designated centre has a Regional Manager from the group who provides additional oversight to the person in charge.

On the day of the inspection, inspectors found that there was sufficient staffing levels in place. Inspectors were told that the registered provider had identified a need for additional supervision on some floors in the evening time. Additional staff were put in place for the second floor at the time of the inspection, with a review

ongoing to include different shift patterns to allow for the additional supervision required.

The person in charge works full time and was supported in their role by a deputy director of nursing and two assistant directors of nursing. In addition, they were supported by 4 clinical nurse managers, a practice development nurse, a physiotherapist and administration staff. Nursing staff were supported by senior health care assistants, health care assistants, activity staff, household, laundry and catering staff. Recruitment was ongoing for some posts. Inspectors were told that any staff vacancies were covered short term by the registered provider's own agency staff.

There was an ongoing mandatory training programme in the centre. The training matrix provided to inspectors recorded overall high levels of attendance at mandatory training such as infection control and safeguarding. Training records for fire safety and manual handling had a compliance level of 84%, and training dates were scheduled for the same week of the inspection. While inspectors were told that additional in-house safeguarding training was being facilitated. Inspectors found evidence of one safeguarding incident which had occurred over the weekend prior to the inspection that had not been identified by any staff member or reported to management in line with the safeguarding policy. This will be further discussed under Regulation 8. There was evidence that staff were supported in their professional development through an induction programme for new starters, and performance reviews.

The registered provider had ensured that the records set out in schedule 2 of the Care and Welfare of Residents in Designated Centres for Older People Regulations 2013 were made available to inspectors. Inspectors reviewed evidence that the registered provider was in the process of renewing current staff vetting disclosures in accordance with the National Vetting Bureau Act 2012 and there were records available of current registration details for staff nurses.

The registered provider had a current certificate of insurance which indicated that cover was in place against injury to residents.

There were clear roles and responsibilities identified by a stable management team within the designated centre. Overall inspectors found there were some good management systems and oversight within the designated centre. There were regular monthly data gathered on residents' such as medication incidents, falls, restraints, weight loss and infections. Monthly clinical and corporate meetings occurred to discuss the gathered data in addition to other agenda items such as human resources, finance, housekeeping, maintenance and catering. There was an audit schedule in place and regular auditing was seen to occur, through this the registered provider identified areas for quality improvements such as the introduction of a pressure ulcer prevention programme and additional on-site training in safeguarding. However further discussed within this report highlights that some audits were not always leading to quality improvements. In addition, there was an active risk register in operation for the designated centre, however not all

risks had been identified and recorded on this risk register. This is further discussed under Regulation 23: Governance and Management.

An annual review of the quality and safety of care delivered to residents had been completed for 2022 in consultation with residents. It also identified actions for 2023.

There was a complaints procedure in place which was displayed in communal areas, however this procedure required review to ensure it complied with the updated regulatory requirements. Residents and visitors spoken with confirmed they were aware of who to make a complaint to and for those that had made complaints, were assured appropriate action had been taken to respond to their concerns.

Regulation 15: Staffing

There was a sufficient number and skill mix of staff available on the day of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors saw evidence that staff had access to appropriate training and supervision.

Judgment: Compliant

Regulation 21: Records

Inspectors reviewed a sample of four staff files and found that they were kept in accordance with schedule 2.

Judgment: Compliant

Regulation 22: Insurance

There was an appropriate contract of insurance in place that met the regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

Gaps were identified in the management systems in place in the following areas:

- while a review of safeguarding incidents occurring within the designated was seen to be complete, this data had not led to quality improvements. For example:
    - the Chief Inspector was notified of a high level of safeguarding incidents since the registered provider's last inspection of 29 March 2023. Despite the registered provider's awareness that a high level of safeguarding incidents were occurring within the designated centre, safeguarding was not on the centre's risk register
    - the learning outcomes from safeguarding incidents were found to be repetitive and had no evaluation or oversight for their effectiveness in clinical practice, despite some resident's being involved in multiple safeguarding incidents
    - inspectors were not assured that all resident's placed on additional supervision such as every 30 minutes had these checks completed. Some staff members were unclear of the resident's who had additional supervision and who was responsible to complete these checks. In addition, inspectors saw that there was gaps seen in some records of the 30 minute supervision checks
- auditing was not always leading to quality improvements. Recent audits in October found high compliance in care planning and nutrition and hydration which did not correlate to findings of the inspection. In addition, inspectors were told the registered provider had similar findings from a recent audit on the dining experience to what inspectors observed on the day of the inspection, for example, inappropriate music was played during the lunch-time meal on one floor.
- the oversight of the action plan devised for 2023 required review. For example, improvements identified included further development of the investigation and close off of safeguarding incidents and the requirement for management presence and supervision during mealtimes. These were items that inspectors found remained in place on the day of the inspection
- the oversight of medication management required review. On the day of the inspection eye drops, for current residents, with dispense dates dating back to March 2023 were found in medication stores. The provider could not provide assurances that residents were receiving their eye drops daily, as prescribed and had no explanation for the storage of these eye drops.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors reviewed the complaints log from 2023 and saw that there were four open complaints on the system which were being reviewed in line with the centre's policy. Inspectors reviewed a sample of some closed complaints and found that overall there was evidence of investigation and conclusion to complaints. However, two complaints reviewed had been closed without the provision of a written response informing the complainant whether or not their complaint had been upheld, the reason for that decision, any improvements recommended and details of the review process.

Judgment: Substantially compliant

Quality and safety

Overall residents appeared happy living in the centre and had good access to health care services. However some improvements were required to ensure a safe and good quality service for residents, particularly in the areas of care planning, safeguarding and nutrition.

A selection of care plans were reviewed on the day of inspection. A pre assessment was carried out prior to admission to the designated centre and a comprehensive assessment was carried out within 48 hours of admission to the centre. Care plans were individualised and many clearly reflected the health and social needs of the residents. However, inspectors found that where changes had occurred, the corresponding care plans had not been updated to guide staff on how to manage the resident's changing needs. This was particularly identified in nutritional and responsive behaviour care plans. This is further discussed under regulation 5.

Residents had good access to medical and health and social care professionals. A general practitioner (GP) visited the centre twice a week and was contactable by phone outside of their twice weekly visits.There was good access to specialist health professionals seen within residents' records such as dietitians, speech and language therapy and tissue viability nursing. Residents also had access to local community services such as opticians, dentistry and chiropody.

There was a low level of restraint in use in the centre, with on-going review and evaluation in an effort to reduce use further. Inspectors reviewed three care plans in relation to physical restraints. Care records showed that when residents had a restrictive practice in place such as bed rails, there was a risk assessment in place for its use. All residents had a signed consent in place. Staff had relevant training in management of responsive behaviours (how people with dementia or other

conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

For residents who required it, staff were available to provide assistance with their meals. Inspectors observed that some staff discreetly provided assistance and spoke with resident's regarding their daily lives, however, some staff were observed to be standing over the residents when assisting them and talking to other staff members instead of interacting with residents. This was seen to occur at the breakfast meal and at lunch time servings. In addition, despite the menu displaying that a choice of meal was available, this was not the case for all residents who required a modified diet. For example, a resident recorded their preference for the lasagne option but was provided with the turkey and ham option. Inspectors were told that this was due to the turkey and ham being softer than the lasagne option. There was no additional softening provided to this meal. In addition, inspectors were told that residents who required a pureed or minced and moist diet had options available, however for the soft diet, this was only available as puree.

Inspectors followed up on documentation relating to recent notifications submitted to the Chief Inspector relating to allegations of abuse. Inspectors were not assured that all reasonable measures were in place to protect residents from abuse. This is further discussed under Regulation 8: Protection.

The layout of the premises promoted a good quality of life for residents. The centre was well maintained overall by maintenance and housekeeping staff with oversight provided by a housekeeping supervisor. One storage room was seen to have inappropriate storage and the storage of oxygen cylinders required review. The registered provider had installed clinical hand wash facilities since the last inspection and these were seen to be in use by staff throughout the inspection. In addition, items of resident equipment such as hoists and chair scales had stickers which detailed to staff when these items had been cleaned. However, inspectors noted that there some areas of wear and tear and staining visible on items of flooring, tiling, paintwork and furniture which had the opportunity to detract from the homeliness of the centre and may impact on cleaning.

Regulation 11: Visits

There were no restrictions around visiting and there was ample suitable communal spaces for residents in which to receive their visitors.

Judgment: Compliant

Regulation 17: Premises

Overall the premises conformed to the matters set out in Schedule 6 of the regulations.

Judgment: Compliant

Regulation 18: Food and nutrition

Findings relating to a number of care plans which had not been updated to reflect the dietary needs of the individual residents, based on nutritional assessment are recorded under Regulation 5.

On the day of the inspection, inspectors found the following areas required improvement:

- some residents were not offered choice during their main meal at lunch time
- as there was no appropriate soft diet option available to those residents who required it, a regular dinner was served which was not as prescribed by healthcare and dietetic staff and posed a risk to the residents concerned

Judgment: Substantially compliant

Regulation 27: Infection control

There were issues fundamental to good infection prevention and control practices which required improvement. For example:

- the oversight of cleaning the external areas required review. The external garden was noted to have multiple cigarette butts discarded around the ground and there were also empty cigarette boxes and tissues scattered around the garden. The patio area on the first floor was visibly unclean
- some items were seen to be in a poor state of repair. For example, tiling was chipped and carpet and some resident chairs in communal areas were badly stained. This may impact on the effective cleaning of those surfaces
- there was inappropriate storage of bin bags under the drying racks in sluice rooms and one sluice room contained a charging point for a hoist which presented a risk for cross contamination.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The registered provider had failed to ensure care plans were reflective of the resident's current care needs. For example:

- two residents who had recently been seen by a dietitian due to significant weight loss, did not have the recommendations for care as made by the dietitian updated in their individualised care plans
- another resident had a substantial weight loss recorded in their weekly weight chart, however this had not been reflected or actioned in the resident's care plan
- three residents who displayed responsive behaviours did not have relevant care plans in place to identify their needs and guide staff.

Judgment: Not compliant

Regulation 6: Health care

There were good standards of evidence based healthcare provided within this centre, with twice weekly oversight by a general practitioner and referrals made to specialist health and social care professionals as required. The inspector was told that eligible residents were facilitated to access the services of the national screening programme.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a low level of restraint in the centre. Restraints were used in line with national policy. Staff had access to relevant training on managing behaviour that is challenging.

Judgment: Compliant

Regulation 8: Protection

The oversight of safeguarding is further discussed under Regulation 23. However, inspectors found the registered provider had failed to take all reasonable measures to protect residents from abuse. For example:

- inspectors were not assured that care plans in place were being followed by staff, with gaps in records of supervision and safety checks

- some care plans seen were generic, the alleged victims identified in abuse notifications had control measures in place similar to those of the alleged individuals causing the abuse. For example, one resident was on 30 minute supervision due to another resident entering their bedroom as was the resident who entered their room
- staff had failed to recognise a serious episode of abuse as an incident of abuse and had not reported it to the relevant manager
- furthermore, the registered provider was not operating in line with its safeguarding policy with regard to pension agent arrangements. As per local policy only the director of nursing could act as the named pension agent. However, a review of residents' files, for whom the registered provider acted as a pension agent, did not name the director of nursing as the pension agent.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for TLC Carton OSV-0005800

Inspection ID: MON-0041901

Date of inspection: 04/12/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The PIC has added safeguarding to the Centre's risk register. This action was completed by 31 December 2023.

• The PIC has implemented a more rigorous process for analysing safeguarding incidents to identify patterns, trends and potential risk factors. From 1 January 2024, a designated safeguarding officer in the Centre will review safeguarding incidents and action plans implemented to ensure effectiveness of action plans for each resident. This analysis will be used to inform the development of targeted interventions and prevention strategies.

• From 1 January 2024, staff allocation sheets will clearly identify who is responsible for completing the safety checks. The Clinical Nurse Managers along with RGN's will monitor records of supervision daily and address gaps or inconsistencies in a timely manner. Additionally, the ADONs will have direct oversight and audit the above process on a weekly basis.

• The PIC and local management team conduct a suite of monthly audits. Auditors have been advised to be rigorous to identify areas for improvement. All audits are reviewed and additional actions discusses as required during monthly clinical governance meetings with the Regional Director. (Complete).

• All nurses, CNMs and ADONs supervise residents during meal times. The PIC ensure this is done routinely. (Complete).

• CNMs complete a monthly medication stock review and audit. This is reviewed by the PIC or designate and discussed with the Regional Director at monthly governance meetings as required. (Complete).

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• From 1 January 2024, the PIC ensures all complaints are responded to appropriately including if the complaint was upheld, the rationale behind the decision and recommendations for improvement along with review process. The Regional Director review all complaints at monthly governance meetings to ensure the above information is included when complaints are closed.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• Immediately following the inspection, the PIC in conjunction with the Catering and Housekeeping Supervisor, introduced updated menu record sheets and provided updated training for staff which ensures all residents are provided with a menu selection fully reflective of their assessed needs and wishes. Ongoing monitoring by the Household & Catering Manager and senior nurse management ensures adherence to choices (Complete).

• The PIC ensures residents who are in receipt of modified consistency diet receive variety and choice in menu. This has been discussed with the chefs and adherence to the menu is monitored by Household & Catering Manager and senior nursing management. (Complete)

• All nurses, CNMs and ADONs supervise residents during mealtimes to ensure all residents receive appropriate diets and are offered choice in line with their prescribed diet. The PIC or designate monitors adequacy of supervision during mealtimes. (Complete)

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• From 01 January 20024, a dedicated repair, replacement & refurbishment programme overseen by the Head of Facilities and implemented by local maintenance ensures that surfaces and items of equipment are suitably maintained and can be appropriately cleaned. (Ongoing).

• The maintenance cleaning schedule for external areas within the Centre has been reviewed and robust oversight put in place. The schedule to power wash the patio area has been developed. (Complete)

• All nurses, CNMs and ADONs supervise residents during meal times. The PIC or designate monitors adequacy of supervision during mealtimes. (Complete and ongoing)

• Inappropriate items stored under the drying racking in sluice room have been relocated to an alternate storage location. (Complete)

• The charging point in the sluice room is not used and will be removed from the sluice room by the maintenance team by 31 January 2024.

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:
• A monthly weight loss report completed by the PIC and local management team ensures recommendations following dietitian reviews have been incorporated into residents' care plans. This report is discussed at monthly clinical governance meeting with the Regional Director.

• Residents' care plans are audited each month. Staff nurses receive ongoing training on care planning and named nurses are allocated to complete care plans in accordance with regulations and best practice. (Complete).

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC has implemented a more rigorous process for analyzing safeguarding incidents to identify patterns, trends and potential risk factors. This analysis will be used to inform the development of targeted interventions and prevention strategies.

• Dedicated training by Quality Manager and Practice Development Nurse has been provided to nurses on how to develop individualised safeguarding care plans. The contents of the plans is audited by the Regional Director and Quality Manager to ensure they sufficiently guide staff on how to safeguard a resident. Audit findings are used to reinforce learning and as required to identify areas of further development.

• From 1 January 2024, a designated safeguarding officer in the Centre will review safeguarding incidents and action plans implemented to ensure effectiveness for each resident.

• By 29 February 2024, refresher training on recognizing, responding and reporting abuse will have been provided to all staff by the Practice Development Nurse and PPIM. These issues are also revisited during staff handovers and other meetings.

• From 1 January 2024, the staff allocation sheet clearly identifies who is responsible for completing safety checks. CNMs along with RGNs monitor records of supervision daily and address gaps or inconsistencies in a timely manner. Additionally, ADONs have direct oversight and audit the above process on a weekly basis.

• The Residents Property Policy governing the pension agent arrangement is currently under review and should be completed by end of June 2024. The local process has been amended to add DONs as pension agent. (Complete)

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 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	31/12/2023
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Substantially Compliant	Yellow	31/12/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	01/01/2024

	place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
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.	Substantially Compliant	Yellow	31/01/2024
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	01/01/2024
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	Not Compliant	Orange	31/01/2024

	necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	01/01/2024