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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:	Droimnin Nursing Home
Name of provider:	Droimnin Nursing Home Limited
Address of centre:	Brockley Park, Stradbally, Laois
Type of inspection:	Unannounced
Date of inspection:	06 September 2023
Centre ID:	OSV-0000702
Fieldwork ID:	MON-0041131

About the designated centre

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

Droimnin Nursing Home is a designated centre for older people. The centre has two buildings that are purpose built. The centre provides accommodation for a maximum of 70 male and female residents, over 18 years of age. Residents are admitted on a long-term residential, respite and convalescence basis. The centre is located at the end of a short avenue in from the road and within walking distance to Stradbally, Co Laois. A variety of communal rooms are provided for residents' use including sitting, dining and recreational facilities. Each resident's dependency needs is assessed to ensure their care needs are met.The provider employs a staff team in the centre to meet residents' needs consisting of registered nurses, care assistants, activity, administration, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	57

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 6 September 2023	15:00hrs to 19:30hrs	John Greaney	Lead
Thursday 7 September 2023	08:00hrs to 18:00hrs	John Greaney	Lead
Wednesday 6 September 2023	15:00hrs to 19:30hrs	Brid McGoldrick	Support
Thursday 7 September 2023	08:00hrs to 18:00hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Overall, residents living in Droimnin Nursing Home gave positive feedback with regard to their experience of living in the centre. Residents told inspectors that they received a satisfactory level of care from staff that were responsive to their needs. Residents did however comment on the frequent changes in staff working in the centre.

Inspectors arrived unannounced at the centre in afternoon on the first day of the inspection and were met by the recently appointed person in charge. The new person in charge was previously a regional manager and was appointed following the unplanned absence of the previous person in charge. Following a brief introductory meeting with the person in charge, inspectors walked through the centre with the clinical nurse manager (CNM) and spent time talking to residents and staff, and observing the care provided to residents, and the care environment.

Droimnin Nursing Home is located close to the town of Stradbally, Co. Laois and is registered to accommodate 70 residents. It is a two storey building situated on spacious grounds that contain a number of other private dwellings that were originally designed for independent living purposes. The provider has no involvement in these dwellings. All of the bedrooms are single occupancy and are en- suite with shower, toilet and wash hand basin.

The ground floor of the centre is called Dunamaise and accommodates 29 residents. Communal space on this floor comprises a large reception area with a variety of comfortable seating and also contains a table and chairs. Adjacent to the reception area is a secure outdoor space that is landscaped to a good standard with plant beds and also has suitable garden furniture. It is readily accessible to residents from different parts of the centre. This area was seen to be used by residents to sit and read and also by residents that smoked, as this was the designated smoking area. Since the last inspection, a fire extinguisher and fire blanket that were previously located within the centre were now in an enclosed cabinet immediately adjacent to the area in which residents smoked. Due to a plastic key in the lock of the cabinet, accessing the fire extinguisher could be delayed in the event of an emergency. This was rectified by maintenance on the day of the inspection. Despite a commitment following the previous inspection, a call bell was still not in place in the smoking area. A large number of cigarette ends were seen in the gravel at the smoking area. While there were ash trays in the vicinity, the provider was requested to review the location of ash trays to make them more conveniently located for residents.

The first floor is called Tursalla and accommodates 41 residents. This area is accessible by stairs and a lift. Communal space here comprises a reception area, where most residents spend their day. There are also two day rooms, two dining rooms and an activity room. There is an outdoor area that has been closed to residents since an inspection conducted in January 2023 when it was found that the decking had an algae like coating that made it slippery and unsafe for residents. The

provider has committed to renovating this area by April 2024. In the interim, residents on the first floor that wish to avail of outdoor space will have to go to the ground floor.

Staff were observed to be attending to residents requests for assistance throughout the centre. Residents were observed to be comfortable in the variety of communal areas available to them, both on the ground and first floors. Some residents were seated in the comfortable seating located in the reception area. Inspectors observed that residents in the ground floor sitting room were unsupervised when they visited this area on a number of occasions over the course of the two days of the inspection. Some of these residents were unable to mobilise independently and had minimal meaningful interactions with staff, other than at mealtimes or when they were taken to group activities.

Inspectors spent time talking with residents in their bedrooms and in the communal dayrooms. While overall residents were complimentary in their feedback about the staff, who they described as 'very helpful', inspectors were concerned about one resident that informed inspectors that they would like a visit from their general practitioner (GP). Despite management being informed of this request and it being evident that a medical review may be warranted, it was not actioned in a timely manner and inspectors had to make a second request for this to be done.

Some residents did note that there were a lot of staff leaving and new staff starting and wondered what the reason was for high staff turnover. Other residents talked about the programme of activities that included bingo, baking, exercise classes and music sessions. Residents also talked about excursions to the community. The centre is located close to the site of a large music festival, Electric Picnic, which took place on the weekend prior to this inspection. Residents were taken on a bus tour of the venue in the days immediately preceding the event and then went to a local restaurant for beverages and snacks. There was also a steam rally held in the local town at the beginning of August and staff had organized for some of the vintage vehicles to visit the centre. There was a BBQ scheduled to take place in the week following this inspection that would include a visit by an ice cream van.

Inspectors viewed the medical records store room and noted improvements since the previous inspection. The room was now solely used for medical records and not for general storage. It was also secured from general access by staff. Inspectors did, however, note that a door adjacent to the room was being used by staff to come and go to an external storage area. The door was alarmed and even though staff used the keypad to exit, it alarmed each time the door was opened. The frequent sounding of the alarm had the potential to desensitise staff to the alarm, risking a delayed response in the event that a resident absconded from the centre through a door connected to an alarm.

The premises was warm, bright, spacious, and appropriately decorated for residents. Residents' bedrooms were generally personalised with items such as family photographs, colour coordinated soft furnishings, and ornaments. In general, residents were satisfied with their bedrooms and comfortable furnishings. Inspectors observed that for the most part, residents were socially engaged during the

inspection. Residents attended group activities in the main activities room on the ground floor. Group activities were also facilitated in the dayrooms of each wing. Activities staff were present to provide meaningful social engagement, and assist residents with snacks and refreshments. However, staff reported that some residents could not attend activities as a consequence of their increased supervision and safety needs.

Some of the maintenance issues identified at the last inspection were addressed, however, some were not, including the larger issues such as cracks within the structure of the building. On the previous inspection the physiotherapist room was locked with a key controlled pad lock and management were unable to provide a satisfactory explanation for using a pad lock to secure the room. On this inspection the key controlled lock was replaced with a coded lock. This did not remedy the concerns of the inspectors of the potential for a resident or staff member to be unable to leave the room should it be locked from the outside. Signage had been replaced on ancillary rooms, such as housekeeping rooms and sluice rooms that had not been in place at the last inspection.

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

This unannounced risk inspection was carried out over two days by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended). Inspectors also followed up on the actions taken by the provider to address significant issues of non-compliance found on previous inspections, conducted in August 2022, January 2023 and May 2023, particularly with regard to the governance and clinical oversight of the service and the provision of healthcare. Since the previous inspection there has been escalatory engagement with the provider. Also on this inspection, the inspectors reviewed actions taken by the provider following monitoring notifications submitted to the Chief Inspector relating to the unexplained absence of a resident from the designated centre. The findings of this inspection were that the provider had failed to take the required action to address significant non-compliances in relation to governance and management that had been identified on previous inspections. Urgent action was required with regard to the safety of residents at risk of leaving the centre unaccompanied. While a recruitment process was underway to enhance nursing management, inspectors found that gaps in the management structure and frequent changes in management personnel negatively impacted on the quality and safety of care provided to the residents living in the centre.

Droimnin Nursing Home Limited, a company comprising three directors, is the registered provider of Droimnin Nursing Home. While the provider is not involved in the operation of any other nursing homes, the company directors are involved in the operation of four other nursing homes throughout the country under the umbrella of Brookhaven Healthcare. None of the company directors attended the centre in person or remotely on the days of inspection or for the feedback meeting at the end of the inspection.

Similar to the findings of previous inspections, new governance and management arrangements were in the process of being established for the oversight of this and the four other designated centres in which the directors of Droimnin Nursing Home Limited are involved. A new clinical operations director had been appointed on 21 August 2023, just over two weeks prior to this inspection. The person in charge had been appointed on 28 August 2023 to replace the previous person in charge ,having only been in post for approximately six months. This is the seventh person to hold the post of person in charge of the centre in approximately four and a half years. The new person in charge was previously the regional manager and is an interim appointment until a new person in charge is appointed, which is anticipated to be in October 2023. The position of assistant director of nursing was found to be vacant on the three previous inspections and remained vacant on this inspection. The provider was aware of the deficits in the staffing resources, and had continued to admit new residents to the centre in the absence of stable and safe staffing levels. The impact of inadequate staffing levels is discussed further under Regulation 15: Staffing.

While there were systems in place intended to provide oversight of the quality and safety of care, the systems were not adequately robust to capture deficits in care delivery. For example:

- a detailed falls audit reviewed the incidence of falls as an opportunity for learning and included details such as the location of falls, times falls took place and the frequency of falls for individual residents. However, the audit did not capture the care of residents following falls and whether or not care was delivered in accordance with the centre's own policy or was based on evidence-based nursing practice
- there were not adequate root cause analysis of accidents and incidents involving residents to minimise the risk of re-occurrence
- there was inadequate oversight of the supervision of a resident identified as at risk of absconding. The supervision arrangements in place did not comply with the centre's own policy for the level of risk identified. An immediate action plan was issued to the provider on the day of the inspection to increase the level of supervision for this resident. Following a review of the resident's behaviour pattern to identify times of increased risk, the provider put in place enhanced supervision arrangements.

The policies and procedures, as required by Schedule 5 of the regulations, were reviewed by the inspectors. The policies had been reviewed by the provider at intervals not exceeding three years and were made available to staff. However, the

registered provider had failed to ensure that some policies and procedures were implemented.

Regulation 14: Persons in charge

The person in charge was a recent appointment, having commenced in the role on 28 August 2023. It is intended to be an interim appointment until a new person has completed the recruitment process. It is planned that the current person in charge will revert to their previous role as regional manager when the new person is appointed.

The person in charge is an experienced nurse and manager and meets the requirements of the regulations in terms of experience and qualifications.

Judgment: Compliant

Regulation 15: Staffing

Since the previous inspection, reliance on agency staff has lessened. There were adequate numbers of nursing staff to meet the needs of the roster and agency healthcare assistants were only occasionally used. However, frequent changes to person in charge, the ongoing vacant assistant director of nursing position, and on boarding of new staff resulted in clinical nurse manager having to complete a number of functions in addition to their primary role. This impacted on overall monitoring and supervision of staff, and the supervision of the quality of care provided to residents. It was also evidenced by poor oversight of nursing documentation. This will dealt with under regulation 23(a).

Judgment: Compliant

Regulation 16: Training and staff development

The induction record for new staff did not identify that the person had demonstrated competence in the provision of care in accordance with the centre's policies and procedures and relevant to their role.

Management did not ensure that all nursing staff were appropriately supervised so that residents were receiving a safe level of care that was in accordance with each resident's needs and with relevant policies. For example, a resident that displayed signs and symptoms of deterioration did not have appropriate clinical monitoring in place despite it being brought to the attention of management on the first evening

of inspection that the resident appeared to be clinically unwell and had requested medical attention.

The findings of this inspection were that, while staff had completed mandatory training in areas such as fire safety and responsive behaviour, additional training was required to meet the assessed needs of residents living in the centre, specifically in respect of clinical areas where deficits in care for residents have been identified throughout the report in relation to the following:

- assessment, monitoring and treatment of residents following falls to ensure that care was provided in accordance with evidence based practice and the centre's own policy to support the early recognition of injuries as inspectors found that this was not followed on a number of occasions.
- assessment and monitoring of residents to recognise and respond to clinical deterioration. For example, staff had not identified that a resident was deteriorating and had not taken the appropriate action
- care of residents with a diagnosis of epilepsy to ensure that all staff were aware of the emergency treatment required in the event of a seizure
- implementation of a protocol for residents with bruising.

Judgment: Not compliant

Regulation 21: Records

The duty roster did not reflect all persons working in the centre. For example, the person in charge or the clinical facilitator were not included on the roster.The duty roster was not comprehensive as it did not reflect when staff were on annual leave or planned days off.

The nursing record for resident's health and treatment given, following an incident in which a resident suffered harm was poorly documented, and investigated. There was no documented evidence that appropriate assessment, treatment and care was delivered to a resident following a serious fall.

Nursing records were not completed in line with the requirements of Schedule 3(4)(c).

Judgment: Not compliant

Regulation 23: Governance and management

The management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), were not sufficiently robust. Inspectors found repeated failings in the

governance arrangements and ineffective management systems to ensure a safe, monitored and consistent service was provided to residents. For example:

- while a recruitment process was underway to enhance nursing management, the governance and management structures in the centre were not in line with the governance structure as outlined in the statement of purpose and were not implemented in practice. The registered provider has failed to address this issue over the course of inspections carried out in August 2022, January 2023 and May 2023
- frequent changes to person in charge, the ongoing vacant assistant director of nursing position, and on boarding of new staff resulted in clinical nurse manager having to complete a number of functions in addition to their primary role. This impacted on overall monitoring and supervision of staff, and the supervision of the quality of care provided to residents. This was also evidenced by poor oversight of nursing documentation
- commitments outlined in compliance plans submitted following previous inspections have not been fully implemented and there have been repeated non-compliances over the course of a number of inspections. The inspectors found repeated and ongoing non compliance in the areas of Regulation 16; Regulation 23; Regulation 17; Regulation 28; Regulation 05; Regulation 06
- there was poor oversight of clinical care and monitoring systems in place did not capture deficits in care that was not delivered in accordance with evidence-based nursing practice or relevant policies. This is evidenced under regulation 31 Notifications; Regulation 05 Individual assessment and care planning and Regulation 06 Healthcare
- the induction process for new staff was not sufficiently robust to provide assurances that staff were competent to carry out the role for which they were recruited
- there was not adequate managerial oversight of the care provided to residents to provide assurance that accidents and incidents were appropriately investigated to support the identification of safeguarding concerns; and to ensure the supervision arrangements for a resident at risk of absconding were implemented in accordance with the centre's own policy and were based on the level of risk identified in the resident's care plan. This is further outlined under Regulation 8: Protection

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The contract of care did not detail the services to be provided for the weekly additional service charge.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A review of the duty rosters found that staffing resources and structures were not in line with those outlined in the centres statement of purpose. Staff vacancies included an assistant director of nursing and three carers.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifications were not submitted in accordance with the requirements of the regulations. For example, in instances where residents sustained bruising of unknown origin, this was not notified as possible abuse.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Action was required in relation to the procedure for managing complaint. For example:

- when describing the complaints process, the complaints policy made reference to another designated centre
- the complaints procedure made reference to a role within the organisation to act as the review officer, however, this role was not listed in the organisational structure. It was therefore unclear as to who was responsible for reviewing complaints, should the complainant be dissatisfied with the outcome of the complaints process.
- training had not been provided as required under regulation 34(7)(a).

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Policies and procedures in accordance with Schedule 5 of the regulations were in place and were reviewed regularly. Adequate systems, however, were not in place to ensure that these were implemented in practice. These include the procedure for

monitoring residents following an un-witnessed fall and the supervision of residents that may be at risk of absconding.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors found that residents were not in receipt of a high standard of nursing care. Frequent changes in key roles in the governance and management of the centre was negatively impacting on the quality and safety of care in key areas such as healthcare, training and development, fire safety and the submission of notifications.

Most residents, primarily long-term residents, were under the care of one general practitioner (GP). Respite and other short-stay residents remained under the care of their own GP. Routine medical reviews predominantly took place late on a Friday evening, when there were no nursing management on duty. This was a busy time with reduced staffing and when night nurses would be carrying out their initial assessments of residents. Inspectors found that there was not adequate clinical oversight or monitoring or residents' health status. For example, adequate monitoring had not taken place of a resident that had been prescribed antibiotic therapy, to ascertain if the treatment was effective. Nursing staff failed to recognise when further medical review was warranted and routine observations were not recorded to support the early recognition of a resident that may be clinically deteriorating. Management were slow to respond, even when informed by inspectors that further medical review was warranted. Adequate clinical observations were also not recorded in residents that may have sustained a head injury following a fall, particularly for residents that may have had an un-witnessed fall. An opportunity for the early identification of deterioration in these residents was lost when the centre's own policy was not followed.

Adequate measures were not in place for the investigation of incidents involving residents to provide assurances that any safeguarding concerns would be identified. The investigations were not sufficiently robust and did not take account of the full details of each incident. This is discussed in more detail under Regulation 8 of this report.

A system of electronic care planning and documentation was used by staff. This was in the process of being introduced at the last inspection and was now in place for all residents. Residents were assessed using validated clinical assessment tools and these were reviewed at a minimum of every four months or in response to changes in a resident's status. The inspectors did note that for one resident the malnutrition risk assessment did not accurately reflect the actual risk, based on the resident's weight lost in the previous three to six months. This was corrected when it was pointed out to staff and management undertook to investigate the reason for the

miscalculation. While improvements were noted in care planning, further action was required to ensure that adequate detail was contained in care plans to guide care delivery. This is particularly important as there is a high turnover of staff and some new staff members may not be as familiar with residents care needs as others. Required improvements in relation to assessment and care planning are discussed in more detail under regulation 5 of this report.

Residents spoken with were generally complimentary of the care provided by staff. Consultation with residents about the running of the centre was through residents' meetings and satisfaction surveys. Minutes of residents' meetings reviewed by the inspector showed that relevant topics were discussed including mealtimes, staffing, and activities. The minutes of the meetings were analysed by a member of management to ensure that issues raised by residents were addressed. The agenda of each meeting also included a review of the previous meeting to to ensure issues raised at that meeting were addressed to the satisfaction of the residents. There were two staff assigned to oversee the programme of activities. At least one member of staff was on duty each day over seven days a week and there were two members of staff on duty for two days each week. The programme of activities was varied and included outings to places of interest in the community. Some residents reflected on the programme of activities with inspectors and spoke positively about what was provided. There was a traditional Irish music session facilitated by external musicians on the second day of the inspection and a large number of residents were observed to be enjoying the performance. Inspectors did, however, note that over the course of the two days of the inspection a number of residents in the ground floor sitting room were frequently left unsupervised and with minimal stimulation. Residents stated that they could exercise choice over many aspects of their day, such as when to get up, where to have their meals and in what activities they would like to participate. Inspectors did note that on the first evening of the inspection some residents were watching the television while others were participating in an activity. There was music playing loudly to support the activity, however, staff did not seem to recognise the impact the music had on residents trying to watch the television.

The provider had introduced a tagging system to identify equipment that had been cleaned. However this system had not been consistently implemented at the time of inspection. For example, several items of shared equipment had not been tagged after cleaning. Inspectors observed that there were cleaning checklists in place, however, improved oversight was required as evidenced by findings which are detailed under regulation 27.

While there were some fire safety works completed since the previous inspection for example fire evacuation chairs had been purchased and were available in the centre, and personal evacuation plans had been updated, the main areas for attention highlighted in their own fire safety risk report, such as emergency lighting, fire stopping had not been actioned. The inspectors acknowledge that some delay related to contractor availability. In addition a fire door audit and report had been completed, there were a large number of doors requiring attention. Deficits in fire doors impacted on their ability to contain fire and smoke in the event of a fire. An action plan was not available to identify if the required remedial works would be

completed in accordance with risk level and associated timescale identified in the audit.

Regulation 17: Premises

Action was required to ensure compliance with Regulation 17 and Schedule 6:

- there were a number of cracks within the structure of the building. Some had been filled but not painted. Assurance was required that the cracks did not impact the structural integrity of the building
- the flooring in the treatment room was damaged under the clinical handwash sink
- the plasterboard at the base of a service shaft in a sluice room was damaged from a former leak and not repaired
- ceiling tiles in a number of areas were either stained, damaged or missing
- the physiotherapy room was locked with a padlock on the corridor side which looked unsightly and also had implications for the means of escape from this room
- externally, there was no call bell available for residents to summon help, including the outdoor smoking area
- the first floor outdoor area was not suitable for use and as a result the area was locked and not available for use by residents; the timber deck had an algae surface creating a slip hazard and there were sharp edges to the area surrounding a light shaft from the floor below.

Judgment: Not compliant

Regulation 18: Food and nutrition

The information contained on a white board in the kitchen in relation to modified consistency diets did not correlate with the dietary information contained on nursing handover sheets. This increased the risk to residents that were assessed as having swallowing difficulties. It also meant that some residents may be getting food that was modified beyond what was required and potentially detract from the dining experience.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

A review of a sample of transfer records indicated that relevant information about the resident was shared with the admitting hospital.

Judgment: Compliant

Regulation 27: Infection control

As found on the last inspection, a review was required of hand washing facilities in the centre. Required actions identified at the last inspection had not been addressed, such as:

- while preparatory plumbing had been completed in the treatment room for the installation of a wash hand basin, this had not yet been installed
- there was no wash hand basin in the housekeeping room on the ground floor
- the wash hand basin in the sluice room on the ground floor did not have hands free taps

While there were checklists and procedures for cleaning and decontamination further oversight was required as evidenced by:

- The system to identify that shared equipment had been cleaned after use had not been consistently implemented at the time of inspection.
- Some items were not included in the checklist such as fans which were found to be unclean
- Rooms signed off as having been clean were not.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had failed to meet the regulatory requirements in relation to fire precautions and had not ensured that residents were adequately protected from the risk of fire. For example:

- a fire safety risk assessment conducted in May 2023 had not been fully actioned and many of the required actions were identified as ongoing. The action plan did not identify when the works would be complete
- a fire door audit had identified that there were deficits in a large number of fire doors impacting on their ability to contain fire and smoke in the event of a fire. An action plan was not available to identify if the required remedial works would be completed in accordance with risk level and associated timescale identified in the audit. The previous compliance plan committed to

discussing fire safety and to remind staff re fire doors, inspectors attended handover and found that fire safety was not discussed.
- the provider was requested to get advice from a competent person in relation to the suitability of storage of communication equipment under a fire escape stairwell as it did not appear to be enclosed in fire rated construction.
- An immediate action was issued to the provider to address the inappropriate storage of paint close to the generator.
- action was required in relation to the designated smoking area. As found on the last inspection, there were not call bell facilities in the external smoking area. Additionally, the arrangements for disposing of used cigarette ends was inadequate resulting in a large number of cigarette ends being disposed of in the gravel in the external courtyard.
- Candles continued to be used in the centre
- Oxygen was found unsecured in the first floor nursing office

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure that care plans were reviewed and updated at regular intervals, when there was a change in the resident's condition and following a review by healthcare professionals. For example:

- care plans were not always updated to reflect advice given by physiotherapy to guide staff in the care of residents that had a fall. This advice may result in the avoidance of potential injury to a resident should they have further falls
- adequate detail was not contained in the care plan of a resident that may experience seizures. In the context of staff that may not know residents well, this detail would assist them in providing immediate and urgent care to a resident that may limit seizure activity.

Judgment: Not compliant

Regulation 6: Health care

The registered provider did not ensure that a high standard of evidence-based nursing care was provided for all residents. A review of a sample of residents' care records identified the following:

- residents were not adequately monitored following accidents and incidents to support the early detection and prompt treatment of injuries that were not immediately obvious, for example, following a fall

- adequate arrangements were not in place to detect deterioration in residents' clinical status, such as following the initiation of treatment for a known infection. It was also found that further medical review was not requested in a timely manner for residents that may not be responding to the current treatment regimen

Judgment: Not compliant

Regulation 8: Protection

Inspectors found that three potential safeguarding incidents were not recognised or investigated, and adequate protective measures were not put in place to protect the residents and the staff members involved in the incidents from further re-occurrences, for example:

- the investigation of an incident in which a resident sustained an injury during the delivery of personal care did not take account of there being only one member of staff present when the injury was sustained, even though the resident's care plan identified that there should be two members of staff present. The investigation was not sufficiently robust to be considered a root cause analysis
- the investigation into unexplained bruising by a resident was investigated under the complaints policy rather than under the safeguarding policy. Detailed statements were not taken from all staff involved in the resident's care to support the assertion that the injury was related to the use of manual handling equipment
- a complaint had identified that a staff member responded inappropriately when a resident requested their mobility aid, was not investigated as a safeguarding issue

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors observed that residents in the ground floor sitting room were unsupervised when they visited this area on a number of occasions over the course of the two days of the inspection. Some of these residents were unable to mobilise independently and had minimal meaningful interactions with staff, other than at mealtimes or when they were taken to group activities.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
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	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Droimnin Nursing Home OSV-0000702

Inspection ID: MON-0041131

Date of inspection: 07/09/2023

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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• A formal competency assessment of staff is currently under development by the senior clinical management team & group HR Manager as an additional document to the induction form. This will be rolled out no later than 30/11/2023 and all nursing staff will have completed by 04/02/2024.

• Since early September when the onsite clinical persons overseeing standard of care delivery included: PiC, clinical skills facilitator, Quality Consultant and CNM full time, the RPR has secured the centers current onsite clinical management team which includes PIC, ADON & CNM. The CNM also has 20 supernumerary hours per week providing enhanced oversight of clinical care in the center by the onsite team. The role of the onsite clinical management team is to oversee the standard of care delivered and the clinical KPI's will continue to be overseen by the regional manager weekly, reported to the clinical operations director and discussed at the monthly G&M meetings as part of identifying, developing and implementing quality improvement plans.

• Falls Management and protocol of required care post incident has been circulated again to all nursing staff since inspection and the application of this policy by the nursing team will be overseen by the Clinical Management team.

• The PiC & RPR held meetings with the nursing team on 6th & 13th of October 2023, where the NMBI roles and responsibilities including guidance on care of the older person has been circulated. Ongoing meetings with the nursing team will take place at a minimum monthly to provide oversight and receive feedback on their nursing practice and their acknowledgement of providing effective care to the residents.

• The PiC and ADON will review all incidents on Mon, Wed & Fri as part of effective monitoring and oversight. Any concerns will be escalated to the Regional Manager

• All incidents will have an RCA completed with any identified actions followed up and review completed by the PiC.

• All bruises will continue to be recorded and relevant RCA completed to ensure any unexplained bruising is notified to the regulator.

• Following review of the monthly KPI's the Governance and Management team will identify if any specific training is required for the staff and this training will be completed as required.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• The duty roster has been reviewed and now reflects all persons working solely in the center. Visits by the clinical senior management team are recorded in the visitor book.

• The PiC manages the duty roster which now reflects staff on leave etc. This will ensure an accurate duty roster is available at all times.

• The clinical management team have reviewed the actions taken by the nursing team post incidents to ensure that neurological observations are completed as per protocol and the nursing team have received further direction on documenting appropriate assessment, treatment and care delivered following a fall. Oversight of incidents and actions is being completed by the DON & ADON minimum 3 times per week and continue to form part of the agenda on the weekly and monthly G&M meetings.

• Further training is being provided to the nursing team to ensure that nursing records are reflective of the residents health, condition and treatment given. The records will continue to be completed on a daily basis. Evidence based Assessment tool PINCHME now forms part of the nurses assessment in the resident progress notes and the PIC checks post falls to ensure that neuro observations are completed for the appropriate duration in line with policy.

Regulation 23: Governance and management	Not Compliant

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

• The statement of purpose has been updated to reflect the commencement of new ADON on 25/09/23 and PiC on 01/10/2023 and this is accessible in the home.

• The presence of a committed and experienced clinical management team with support from the regional manager will ensure increased oversight of clinical practices are continued. Weekly and monthly reports will ensure monitoring of safe effective services in the center.

• Compliance plans will be discussed at monthly G&M meetings where RPR, Operations Director, Clinical Operations Director, Group HR Manager and Regional Manager will discuss with onsite clinical management team relevant action plans to ensure progressive action is completed where practically possible.

• Oversight of compliance to regulation will be monitored via the weekly DON report and the monthly KPI reports that form part of the monthly G&M analysis.
The Group HR Manager and Clinical Operations Director are finalizing a support competency document to the induction process to provide assurance on the competency of staff. This will be rolled out during December 2023.

The center will continue to review policy and adhere to relevant risk assessment on care of residents who are at risk of elopement.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
• The contents of the contract of care is currently being reviewed and revised to ensure that it has all necessary information about other potential cost which may occur.

• The contract of care will be reissued upon changes and updated with residents appropriately by 30/11/2023.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Statement of Purpose has been reviewed to reflect the new management structure and updated structures where the Regional Manager has returned to their position.

• ADON commenced in the center on 25-09-23 and DON commenced on 01-11-23. There is a full clinical management team onsite which is reflected on the SOP.

• Recruitment is ongoing and the WTE vacancies in the center is currently HCA's X4. Ongoing onboarding is in place to enhance the number of available care assistants in the home and the duty rosters are meeting the needs for the SOP.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All incidents and accidents continue to be recorded in the center, including any sustained bruising and these are being investigated. RCA's will be completed to determine if any bruising is unexplained and requires notification to the regulator.

• The PiC is aware of the Statutory Notification Guidance HIQA document and the information presented at the Stakeholder events in late September 2023 to include that going forward any allegation or incident of unexplained bruising will be submitted to the regulator.

• The PIC will continue to submit notification for any serious injury as per the HIQA guidance document.

• Notifications submitted will be trended monthly as part of the G&M meetings.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The complaints process has been reviewed and reference to another center removed.

• There is now a clear complaints procedure in place outlining who the complaints officer if for the center and the complaints review officer is clearly identified.

The PiC and ADON have completed training on complaints management via the HSELand and the complaints review officer is attending one day training on 26/10/2023.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

• The contents of policies and procedures in the center are being relayed as refreshers to staff during safety pause and staff meetings. This practice will continue with all new staff.

• A supporting document on the management of a resident post fall has been circulated as a reminder to nursing team to include the process of recording neurological observations. Adherence to this policy is being monitored and improvement has been noted by the PIC & ADON.

• The centers policy on the management of resident elopement outlines "8.3 Residents deemed to be at high risk for elopement will be commenced on a scheduled observation record, recording the time, date and location of the resident. The nurse on duty must assess the level of supervision required, and should consider that there may be times when the resident requires continuous supervision. The nurse on duty is responsible for delegating healthcare assistants (or specify other appropriate members of staff) to be responsible for these scheduled observations duty during the shift and ensuring that each observation is documented". The center will continue to risk assess the needs of residents with exit seeking behavior and then implement appropriate actions.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The RPR's commitment to the regulator in the compliance plan submitted post May 2023 inspection continues to include commitment to address the areas requiring repair within the center and dependent on contractor availability.

• A structural engineer is scheduled to attend before end of December 2023 due to the structural engineers availability. Once the report is received the RPR will address concerns in line with contractor availability and as per Capex Plan.

• The flooring in the treatment room is scheduled to be renewed and a flooring contractor appointed.

• The damaged area in the Sluice room will also be repaired when the contractor is onsite.

• The ceiling tiles have been replaced by inhouse maintenance team.

• Access and Egress to the physiotherapy room has been reviewed and the room has been risk assessed and is now unlocked, allowing freedom of movement and reduction of any potential risk.

• Placement of external call bell in the smoking area will be reviewed by the supplier to determine if works can be implemented. In the interim an alarm system has been implemented to assist residents and alert staff.

• The first floor outdoor area is currently out of use and inaccessible to reduce risk and ensure residents safety. Works identified for this area form part of the wider schedule of capex works required to be completed by 04/24. In the meantime residents are encouraged to assisted to and also move freely between the 2 floors in the center and join in all of the indoor and outdoor activities.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• The clinical management team have reviewed the system in place and updated the information in the catering department to ensure that all relevant information on resident's dietary needs contained in the nursing handover sheet is present and accurate on the white board in the kitchen.

• Accurate information is now in place on the white board in the kitchen and this will be monitored when a new resident comes to live in the centre and or if the dietician and SALT has recommendations for residents nutrition.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• The RPR continues to commit to completing the work as per the compliance plan submitted following the inspection in May 23 and commencement has begun as outlined in this report. The contractor is scheduled to be onsite to continue further works in December 2023 subject to their availability.

• The planned works include the installation of

· a wash hand basin in the treatment room,
· a wash hand basin in the housekeeping room on the ground floor
· changing the taps in the wash hand basin in the sluice room on the ground floor

• The PiC and ADON have reviewed the systems in place to now ensure that a clear process is in place for monitoring the completion of the housekeeping and clinical equipment cleaning schedules. All equipment is included in the cleaning schedule including fans.

• Further oversight is trended as part of the weekly checklist tracker which forms part of overall Governance and Management process to include reporting at the monthly Governance and Management onsite meeting.

When a resident is discharged or transferred to hospital the PiC and ADON will appoint a member of the housekeeping team to attend to the residents room within 24 hours.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The fire safety risk assessment conducted in May 2023 is being actioned and the RPR has committed to completing these works by 04/2024 as per the compliance plan post last inspection in May 2023. Although due to contractor availability this has proved challenging to secure action dates from the contractors, 53% of actions have been completed to date and outstanding actions will be completed by 04/04/2024.

• As part of the actions from the Fire Risk assessment, the management team in the home facilitated discussions on fire safety management regularly at handovers since May 2023 and this continues now on an intermittent basis and all relevant information will be provided to all new staff going forward.

• The Group Facilities manager and Regional Manager have attended the regulators training session on Fire safety management and as part of oversight will complete monitoring of storage to identify any associated risks. The generator area is now free from storage.

• Placement of external call bell in the smoking area will be reviewed by the supplier to determine what works can be implemented. In the interim an alarm system has been implemented to assist residents and alert staff to meet the needs of the residents.

• The center has reviewed the placement of cigarette ashtrays and there are 3 ashtrays located in the designated smoking area for residents who are encouraged to use them.

• The storage of the communication equipment has been assessed by the specialist IT engineer and the RPR awaits a quote for these proposed works. Once received the RPR

will liaise with the contractor to arrange a suitable start date.

• The center has a system in place to use battery fitted candles, all staff are aware that wax candles should not be used and this will continue to be monitored with reminders issued as part of safety pauses and monthly staff meetings.

• The oxygen storage has been reviewed

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:
• The onsite clinical management team continue to review the residents careplans to ensure that all information obtained on admission, post MDT review and resident care plan meetings is reflected in a person centered way and individualized within residents careplans.

• The PiC and ADON will regularly review care plans and provide direction to staff on the quality of the documentation including progress notes. A monthly audit is completed and training requirements will be identified and appropriate actions taken following monthly audit. The Standard of the completed actions will be reviewed by the PiC and ADON so as to ensure appropriate information is contained within.

• The nursing team have been provided with a detailed list of recognized nursing assessments which includes the details and description of the assessment and its relevance to residents care.

• Training with nursing staff on the care planning process remains ongoing on site to ensure nursing staff are fully aware of the standard required to meet residents' needs and compliance with regulation.

• Care plan review meetings will take place with the resident and/or their nominated person at a minimum 4 monthly.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

• Oversight of incidents and actions is being completed by the DON & ADON minimum 3 times per week and continue to form part of the agenda on the weekly and monthly G&M meetings.

• The clinical management team have reviewed the actions taken by the nursing team post incident to ensure that neurological observations are completed as per protocol and the nursing team have received further direction on documenting appropriate assessment, treatment and care delivered following a fall to ensure that residents are adequately monitored.

• Falls Management and protocol of required care post incident has been circulated again to all nursing staff since inspection.

• The process of monitoring residents with infection has been refreshed with nursing staff to include best practice of recording observations based on the residents diagnosis and presentation and or clinical assessment and GP recommendations. All staff have been directed to report any changes in resident condition at handover to senior nurse for action. The PiC and or ADON will attend daily handovers to monitor effectiveness and care provided.

• Residents have access to GP and MDT service. Resident may choose to retain their own GP once the GP is happy to attend the nursing home and or transfer to the GP who attends the nursing home regularly. Residents choice will be respected.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• All incidents and accidents will continue to be recorded in the center, including sustained bruising and these are being investigated either as part of the complaints or incident recording procedure.

• The PiC and ADON will continue to review all incidents on Mon, Wed & Fri as part of effective monitoring and oversight. Any concerns will be escalated to the Regional Manager

• All incidents will have a RCA completed with any identified actions followed up.

• All bruises will continue to be recorded and a relevant RCA completed to determine if bruising is unexplained. This will ensure any unexplained bruising is notified to the regulator.

• The PiC is aware of the Statutory Notification Guidance HIQA document and the information presented at the Stakeholder events in late September 2023 to include that going forward any allegation or incident of unexplained bruising will be submitted to the

regulator.

• The PIC will continue to submit notifications for any serious or unexplained injury as per the HIQA guidance document.

• Notifications submitted to HIQA will be trended monthly as part of the G&M meetings to cross reference incidents recorded and identify any non compliance.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The PIC assures the inspector that there are effective allocations in place to meet the residents needs, movement, rights and preferences.

• The activities schedule is on display and residents choose what type of activity they attend.

• All residents have Key to me Assessment completed and a Social recreational care plan in place outlining their preferences of activities.

• There are monthly residents committee meetings in place providing a forum for residents to voice their opinion and preferences.

Upon review of the residents availing of the quiet space in the sitting room the PiC has ensured that the interactions and engagement with these residents is being monitored throughout the day as part of comfort and safety checks

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)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	04/02/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	01/11/2023
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	04/04/2024
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared,	Substantially Compliant	Yellow	01/11/2023

	cooked and served.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	01/11/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	01/12/2023
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	Red	08/09/2023
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Substantially Compliant	Yellow	01/12/2023

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	30/01/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	23/10/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	04/04/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	04/04/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	04/04/2024

	reviewing fire precautions.			
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	Orange	01/12/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	01/11/2023
Regulation 28(2)(iii)	The registered provider shall make adequate arrangements for calling the fire service.	Substantially Compliant	Yellow	23/10/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	06/09/2023
Regulation 28(3)	The person in charge shall ensure that the procedures to be	Substantially Compliant	Yellow	10/12/2023

	followed in the event of fire are displayed in a prominent place in the designated centre.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	23/10/2023
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	23/10/2023
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).	Substantially Compliant	Yellow	23/10/2023
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal	Substantially Compliant	Yellow	27/10/2023

	with complaints in accordance with the designated centre's complaints procedures.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/01/2024
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	30/01/2024
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	30/11/2023
Regulation 8(3)	The person in charge shall investigate any incident or	Not Compliant	Orange	01/11/2023

	allegation of abuse.			
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	23/10/2023