Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Kilcolgan Nursing Home
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Kilcolgan, Galway
Type of inspection:	Unannounced
Date of inspection:	10 November 2021
Centre ID:	OSV-0000351
Fieldwork ID:	MON-0034429

About the designated centre

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

Kilcolgan Nursing Home is a purpose built facility located near Kilcolgan, Co Galway. The centre admits and provides care for residents of varying degrees of dependency from low to maximum. The nursing home is constructed on ground level. The centre is divided into two units. One unit has capacity for up to 30 residents. The dementia specific unit can accommodate up to 18 residents. All resident bedrooms are single occupancy and have ensuite, handwash basin, toilet and wheelchair accessible showering facilities. The provider employs a staff team consisting of registered nurses, social care workers, care assistants, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	38

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 10 November 2021	09:00hrs to 17:00hrs	Una Fitzgerald	Lead
Thursday 11 November 2021	09:30hrs to 16:30hrs	Una Fitzgerald	Lead

What residents told us and what inspectors observed

The inspector spoke with nine individual residents and spent periods of time observing staff and resident engagement in communal areas. Overall the feedback from residents was positive. Residents were aware that there had been a number of changes in the governance and management within the centre. One common concern voiced by residents was that staff were overstretched and that there were insufficient numbers on duty. When asked about satisfaction levels on the speed in which call bells were answered one resident stated that residents had "learnt to wait". Residents were quick to state that individual staff members were kind and supported them.

This was an unannounced inspection. On arrival, the person in charge guided the inspector through the infection prevention and control measures necessary on entering the designated centre. These processes included hand hygiene, face covering, and a temperature check.

Residents expressed gratitude that they had been kept safe throughout the pandemic. Residents reported that communication in the centre was good and that they had been kept up-to-date regarding the visiting restrictions and the COVID-19 pandemic. On the day of inspection, all residents that were eligible had been facilitated to receive the booster vaccine.

Resident were satisfied with the food served and the choice offered. The centre had completed a residents survey in June 2021, covering multiple aspects of the service. The survey had been completed by 21% of residents. Overall the responses from residents were positive.

Through walking around the centre, the inspector observed many residents had personalised their rooms and had their photographs and personal items displayed. Residents confirmed that their bedrooms were cleaned daily. Overall, the premises were found to be clean. The centre has two units. The memory care unit and the main unit. In the main unit, the communal area was open plan and is sub- divided into two separate areas by a partition wall. The inspector sat and observed staff and resident engagement. There was a radio playing country music and also a television on loud volume. The combination of both entertainments systems on at the same time was not conducive to a relaxed environment.

During conversations had with residents the inspector observed that items of clothing were heavily soiled, stained and in some cases presented in a poor state. Residents spoken with told the inspector they were satisfied with the laundry service provided.

The inspector was told that at the time of inspection, group activities were not being held in the centre due to the availability of staff. The inspector reviewed resident meetings held in February and September 2021. The records evidenced that

residents had requested that group activities be recommenced. Specific requests had been made for baking sessions, music sessions and to go outside for fresh air. At the time of inspection the responsibility for activities was delegated to the healthcare assistants (HCA). However, due to the availability of staff the person in charge confirmed that group activities were not occurring. The inspector spoke with healthcare staff about activities. Responses varied from having no knowledge that they had a role in activities to having very good insight into the need for meaningful activities for residents outside of the direct provision of care. Healthcare staff told the inspector that their focus was to ensure all residents were safe, provided with assistance with their direct care and answer all call bells.

The following sections of the report outline the inspection findings in relation to the governance and management in the centre and how this supports the quality and safety of the service been delivered.

Capacity and capability

Overall the inspector found that the provider needed to strengthen and stabilise the governance and management structure in the centre. Mowlam Healthcare Services Unlimited Company is the registered provider of Kilcolgan nursing home. The staffing numbers available for the direct provision of care and the support for the person in charge was not in line with the numbers outlined in the Statement of Purpose. The inspectors acknowledge that the centre has had a number of changes to the person in charge over a short period of time and that this change has had an impact on stability and the day to day running of the service. However, the inspector found that the current person in charge did not have sufficient numbers of staff available to deliver the care as per the assessed needs of the current number of residents.

The inspector found that the centre had moved away from full regulatory compliance found with the regulations reviewed on the last inspection in December 2019. This inspection evidenced there was insufficient resources and inadequate managerial oversight. The systems in place are not sufficiently robust enough. For example;

- Staffing - there were insufficient staff numbers on duty delivering the direct care. In addition, there was a period of weeks from October 2021 to the week of the inspection whereby there was no clinical nurse manager on site to support the person in charge. This was a shortage of thirty hours per week during this period whereby the person in charge did not have adequate support. This was impacting on their ability to ensure oversight and monitoring of the service delivered.
- While the Mowlan Auditing management system (MAMS) is in place at a group level, the person in charge was not accessing same. The only audit completed that was populated with detail and action plans that evidenced

monitoring of the service was in hand hygiene practices.

- Care plans were not completed in accordance with Regulation 5 requirements. The inspector found significant gaps in the completion of resident assessments. Assessment of residents are required to inform the direction of care and to enable registered nurses to develop individual person centered care plans. The risk register had identified the gaps in the completion of on-going resident assessments as high risk. In October 2021 there was sixty-three assesments overdue for completion. On the day of inspection this number had increased to ninty-two.
- Complaints made were not followed up and addressed as per the centres own policy. The detail is outlined below under Regulation 34 Complaints.

The inspector acknowledges that the provider has an active ongoing recruitment strategy in place. In addition, the inspector acknowledges that appointments had been made and that a newly appointed clinical nurse manager had commenced in the centre the week the inspection took place. Notwithstanding this positive progress, when the inspector queried the findings on the availability of staff and the shortfalls in the rotas the response from the management on duty was that all admissions were on hold untill staffing levels improved. When the inspector reviewed the records this information was not accurate. The centre currently has a service level agreement for upto five residents with an external provider. The inspector found that despite clear evidence that the centre did not have sufficient staffing numbers on duty admissions had occurred. For example; for two days in a row there was one registered nurse and one healthcare assistant looking after the direct care needs of 21 residents. The following day the centre admitted two new residents. While the inspector accepts that there was also one other staff member on a work placement, it must be highlighted that this staff member is not part of the staffing compliment and therefore supervision of their work was required at all times.

Mowlan Healthcare have a comprehensive mandatory training requirement in place for all staff. The training matrix was reviewed. While there were minor gaps the person in charge confirmed that training sessions to bridge the gaps were booked. The inspector also reviewed a sample of staff files. All nurse registration documentation was available. Vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021 were in place. The inspector acknowledges that once staff are recruited, there was procedures in place to support and induct new staff. An induction checklist was in place and had been commenced for all new staff files reviewed. While there were gaps in the completion of annual reviews and documented staff supervision and support meetings, the person in charge confirmed that once the clinical nurse manager hours are embedded into the rota these meetings with staff on supervision will recommence.

Regulation 15: Staffing

On the days of inspection, the assessed dependency care needs of the residents

were that the majority of residents required the assistance of two persons when receiving care. There were twenty residents with maximum care needs, ten residents with high dependency care needs, six residents with medium dependency care needs and two residents with low dependency care needs. The inspector reviewed the staffing rosters, and found that the number of staff available for the delivery of care was insufficient. Rotas reviewed evidenced that there was a consistent shortfall in the numbers of healthcare assistants on duty. In addition, there was insufficient clinical nurse management support on duty for the person in charge. For example;

- There were two days running whereby there was one registered nurse and one health care assistant responsible for the care needs of 21 residents.
- There was a shortfall of thirty hours per week in the availability of clinical nurse management hours to support the person in charge.
- Healthcare staff were temporarily assigned responsibility for meaningful activities for residents. Due to shortages in the staffing this was not consistently occurring. There were no group activities at the time of inspection despite a request from residents to recommence same.

Judgment: Not compliant

Regulation 16: Training and staff development

Mandatory training required by the regulations was in place. The training matrix reviewed identified that staff had received mandatory training in safeguarding vulnerable adults from abuse, fire safety, people moving and handling, infection prevention and control, hand hygiene and the management of responsive behaviours. Gaps were known to the management and a plan to address same was also in process.

The inspector was informed that annual appraisals had been occuring in the centre and that they will recommence now that additional management support is in place. The inspector reviewed a sample of a completed staff appraisal form that had been completed in the past and found it to be comprehensive. The non compliance with the ongoing supervision of staff, induction and appraisal systems are actioned under regulation 23 Governance and Management.

Judgment: Compliant

Regulation 23: Governance and management

The totality of the findings over the two days of this inspection evidenced that Mowlam Healthcare Services Unlimited Company did not have sufficient monitoring

and oversight of the service being delivered to residents. This was further compounded by the local management structure undergoing changes that now require time to become familiar with the systems in place. Review and improvements are required in the following;

- the staffing resources available to maintain consistent healthcare staffing levels on a daily basis.
- The MAMS auditing system that was in place at a group level was not known to the management on duty.
- The management and oversight of complaints requires a full review. Firstly, follow up on all open complaints logged and secondly, a review of the process to ensure that any future complaints are managed in line with the centres own policy.
- While there was a system in place to manage risk the inspector found insufficient oversight. The risk register required further review and analysis to ensure risks identified specific to the the centre are appropriately managed. For example, the provider continued to take new admissions into the centre despite having insufficient staffing numbers in place. The inspector acknowledges that staffing recruitment is a constant challenge and risk. However, the admission of two new residents into the centre with the knowledge that there are insufficient staffing numbers available is a direct risk to residents

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector reviewed documents that detailed an incident involving a resident that had not been notified to the Office of the Chief Inspector within 3 days as is required by the regulations.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The inspector reviewed the electronic complaints log. On the day of inspection there were a total of five open complaints. The detail of the complaints were logged. Outside of the detail of the complaint no other information was available. There was no evidence that complaints received had been acknowledged or progressed through the centres own complaints procedure. There was no evidence of follow up or actions taken to address the complaints.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the provision of quality care was negatively impacted upon and inconsistent due to the staff shortages. There were multiple gaps and oversight of care delivered and this was evidenced in the nursing documentation and through the voice of the residents. While Mowlam Healthcare services had systems in place such as the electronic care planning system, the oversight was not sufficient. Information requested specific to care needs was not readily available. For example; records on the frequency of showers and weight monitoring. The inspector found that care plans did not always contain the information required to guide the care. In addition, the provision of activities required resources to allow for the recommencement of group activities as per the residents requests.

The inspector reviewed a sample of residents' records, which evidenced gaps. Pre admission assessments were not available and therefore had not been made available to the nurses to inform their admission assessment. On admission, initial assessments of need were completed. The gaps identified on this inspection were specific to the reassessment of care needs when a residents overall condition changed or at intervals not exceeding every four months to inform the care plans. Improvements were required to ensure that each resident's care plan accurately reflected the assessment of their needs and were person centred in the detail.

The inspector found that the centre actively promoted a restraint free environment and on the day of inspection there was no use of bedrails in the centre.

Residents had access to general practitioners (GP) and health and social care professionals. Where residents require further allied health and specialist expertise, this was facilitated through a system of referral. For example, some residents were under the care of the dietetic services for ongoing monitoring of their weight and nutrition. Physiotherapy was available in the centre three days a week. There was evidence of recommendations from health and social care professionals being implemented. For example; the management of wounds was effective and records evidenced healing had occured.

There was a risk management policy in place that addressed the requirements of the regulation. A risk register was maintained as part of the centres risk management strategy. The risk register was updated as risks were identified and controls in place to mitigate risk. However, further development of the system was required as some risk found on the day of inspection had not been updated into the register.

The inspector walked the premises. Overall the premises were found to be clean. While there was staffing hours vacant in household services these hours were

covered by existing staff. As a result of the pandemic additional resources had been allocated to the cleaning of the centre. A deep cleaning schedule was in place. There was a colour coded cloth and mop system in place that utilises one cloth per room to ensure that each area is cleaned with a new cloth/mop on every occasion. The inspector spoke with staff who were very clear on the policy, procedures and practices in place. The supervision of the cleaning of resident individual equipment required attention. The inspector did observed examples were resident equipment that was in use was not cleaned appropriately. In addition, the system of transporting bags of rubbish and dirty laundry through the main unit was inappropriate. The inspector acknowledges this was addressed on the day of inspection.

Residents had access to information and news, a selection of newspapers and Wi-Fi were available. Independent advocacy services were also available. The inspector found that a review of the staffing allocation to enable all residents avail of activities or one to one sessions that meet their individual needs is required.

Regulation 11: Visits

Residents were supported to maintain personal relationships with family and friends. The centre was facilitating visiting in line with the current COVID-19 Health Protection and Surveillance Centre (HPSC) guidance on visits to long term residential care facilities.

Judgment: Compliant

Regulation 26: Risk management

The risk policy contained all of the requirements set out under Regulation 26(1). The system of risk identification and management required improvement and this is actioned under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 27: Infection control

Residents' lives had been significantly impacted by the COVID-19 pandemic and consequent restrictions. The inspector observed that staff adhered to guidance in relation to hand hygiene, maintaining social distance and in wearing PPE in line with the national guidelines. Staff reported that the training they had received had been of a good standard and they were able to implement it in practice. The management

team were committed to ensuring all reasonable measures were in place to prevent introducing the COVID-19 virus into the centre. This included:

- a temperature and COVID-19 symptom check on arrival to the centre
- alcohol hand sanitizers were available throughout the centre.
- appropriate signage was in place to prompt all staff, visitors and residents to perform frequent hand hygiene
- Individual resident slings for manual handling purposes

The laundry facilities and procedure were managed appropriately. Residents' laundry was managed on-site and each item of clothing was marked for identification.

Gaps found on the cleanliness of resident equipment and transportation of waste through the main unit were addressed on the day of inspection.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plans reviewed were not consistently updated and did not guide care. For example,

- residents with responsive behaviours observed by the inspector on the day of inspection did not have care plans to guide staff on the management of incidents of agitation and aggression.
- a resident with pain that was scored as severe on the 2/09/2021 had no further assessments completed. The care plan in place did not guide the care. The resident was receiving daily pain medication. No assessment was completed prior to or post the administration of pain medication. The records did not identify if pain medication administered was effective.
- in one file reviewed a care plan was not developed for six days following admission.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported to access health and social care professional services throughout the pandemic through a blend of face to face and remote consultations. A system of referral was in place for residents that required access to additional expertise such as Occupational Therapy, Speech & Language Therapy, Dietitian and Tissue Viability services. Residents had access to an on-site physiotherapist three days a week.

Judgment: Compliant

Regulation 9: Residents' rights

At the time of inspection, group activities were not occurring in the centre. The provider had failed to ensure that residents were facilitated to participate in activities in accordance with their interests and capacities.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Kilcolgan Nursing Home OSV-0000351

Inspection ID: MON-0034429

Date of inspection: 11/11/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
• The Person in Charge (PIC), supported by the Healthcare Manager ensures that there is a workforce plan in place to ensure that the staffing complement detailed in the Statement of Purpose is adhered to and that the care and service needs of all residents can always be met safely and effectively.
• Staff are supported to ensure that they have all the information they need about each resident to ensure the delivery of high-quality care.
• The PIC produces a staff roster which sets out the required staffing numbers and skill mix for each department. Rosters are produced in fortnightly cycles and are published in advance of the start date to ensure that staff are aware of their rostered shifts.
• The PIC and Clinical Nurse Manager (CNM) ensure that staff are appropriately deployed and that they are allocated appropriate duties commensurate with their skills, qualifications and abilities.
• If a staff member is unavailable for work, e.g., due to illness, the PIC or designated deputy will review the roster to arrange cover if possible. If it is not possible to arrange cover from within existing staff, an agency staff member will be booked to provide cover.
• A Clinical Nurse Manager commenced in post November 2021, as an additional support to the clinical management team.
• An Activities Coordinator (AC) has been hired and has commenced employment in November 2021. The AC will develop a varied activity schedule based on resident preferences that will include both individual and group activities.

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:
• There is a clearly defined management structure in the home. The PIC is supported by the regional Healthcare Manager and Director of Care Services, both of whom are PPIMs for the nursing home. The Healthcare Manager visits the home at least weekly and is always available for advice, discussion and consultation.
• The PIC and CNM supervise workflow and care practices to ensure that staff are facilitated to provide high quality, safe and effective care to all the residents.
• There is an active recruitment programme under way and several new staff have been appointed since the inspection, including Healthcare Assistants, Social Care Practitioners, an Activities Coordinator and a Kitchen Assistant.
• The MAMS auditing system is in place in the home and the PIC has been fully trained in its use and application.
• A comprehensive review of complaints management has taken place and all logged complaints will be reviewed by the PIC and HCM together, to ensure that the issues and concerns raised have been acknowledged, investigated, addressed and resolved satisfactorily.
• There is a comprehensive risk register in Kilcolgan that includes Staffing Risks.
• All admissions to the centre are pre-assessed by the PIC to ensure their needs can be met. The residents admitted as part of the agreement with an external provider are accommodated in the centre largely for reablement services such as Physiotherapy and O.T.

There are effective communications systems within the nursing home to foster an open culture and build a cohesive and effective team, who will work in accordance with the residents' care needs and expressed preferences in mind. These communications systems include, but are not limited to:

• An electronic care record, containing all relevant demographic, medical, nursing, allied health records, risk assessments, adverse events/incidents and progress updates.
• Handover reports at the beginning and end of shifts.
• Mid-shift updates (Safety Pause).
• Monthly management team meetings.
• Annual quality and safety review meetings.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC is aware of her requirement to notify any/all incidents within the required regulatory framework.
• A review has taken place of all recent incidents and notifications and the PIC will ensure that all notifications are submitted within the 3-day notice period.
• The Healthcare Manager will monitor compliance with the submission of required notifications to the Authority.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The PIC and CNM are always available to residents and relatives, meeting regularly with them to ensure that they have an opportunity to discuss any issues, concerns or suggestions. The management team will be supported and encouraged to foster a responsive attitude and an open and transparent culture in the home.
• We welcome suggestions and feedback from residents, relatives/representatives and visitors, as this provides an opportunity for experiential learning and drives continuous quality improvements.
• We will ensure that complainants are aware that all concerns and complaints are taken seriously and assure them of our commitment to investigate fully and respond to their concerns, taking corrective action where indicated.
• All complaints will be acknowledged, investigated and addressed in line with the Complaints Procedure in the nursing home.
• We will analyse the feedback from residents and their families, identify any common themes and trends, and implement quality improvements to prevent recurrence.
• We will monitor the satisfaction of complainants following the investigation and response to their complaint, and we will inform them of corrective actions and quality improvements implemented as a result so that they can be assured that their complaints have been taken seriously and that decisive action has been taken to prevent recurrence.
• The PIC and/or Healthcare Manager will arrange to meet complainants to review individual complaints, discuss strategies to prevent recurrence and provide reassurance that quality of care and service will be improved, and lessons learned from their feedback.
• We will ensure that complainants have access to an appeals process if they remain dissatisfied with the outcome of their complaint.

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:
• All residents in the nursing home are assessed prior to admission to ensure that their care needs can be safely met in the nursing home.
• A care plan will be prepared within 48 hours of each resident’s admission which will reflects the individual resident’s assessed care needs and preferences.

• Care plans are prepared in consultation with residents and/or their designated representative and a record of consultation is documented in the electronic care file.
• As part of the dependency assessment, each resident has a Barthel assessment conducted indicating the ability of the resident and the care interventions required.
• The PIC and CNM will provide clinical oversight to ensure that all residents' assessments and care plans have been completed and are individualised and person centred. They ensure that the assessment informs the plan of care and considers the resident's current medical, health and lifestyle status, including Behavioural & Psychological Symptoms of Dementia (BPSD) or responsive behaviours. If responsive behaviours are a presenting issue, an Antecedent, Behaviour & Consequence (ABC) chart will be completed for 3 days to assess the patterns of responsive behaviours, identify triggers and determine appropriate de-escalation techniques.
• We will ensure that the residents' level of pain is assessed where indicated, using the Abbey Pain Assessment tool, including an assessment of the effect of analgesia on the resident's level of pain.
• Care plans are reviewed at intervals not less than 4 monthly, or as indicated by the resident's condition or circumstances. These care plan reviews will consider all aspects of the residents' physical and mental wellbeing, personal and social care needs and any supports required to meet those needs, as identified by initial and ongoing assessment.
• The PIC will ensure that reviews are completed to monitor the effectiveness of the residents' support and treatment provision.
• The PIC will complete a weekly audit of clinical documentation to ensure that each resident's required care needs are addressed, that the care plan guides the delivery of care and that the care delivered is reviewed and evaluated appropriately and is in accordance with the resident's expressed preferences.
• Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The PIC will ensure that a varied and interesting activities schedule will be developed in consultation with residents, which will include group activities and one-to-one activities, in accordance with individual resident's preferences.
• A new Activities Coordinator has recently commenced employment in the home, and she will ensure that group activities are scheduled in accordance with residents' interests and capacities.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/01/2022
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	31/01/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure	Not Compliant	Orange	31/01/2022

	that the service provided is safe, appropriate, consistent and effectively monitored.			
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	31/12/2021
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Not Compliant	Orange	31/12/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the	Not Compliant	Orange	31/12/2021

	complaint and whether or not the resident was satisfied.			
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	31/12/2021
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/12/2021
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	31/12/2021