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:	Lakes Nursing Home
Name of provider:	Elder Nursing Homes Ltd
Address of centre:	Hill Road, Killaloe, Clare
Type of inspection:	Unannounced
Date of inspection:	18 May 2021
Centre ID:	OSV-0000447
Fieldwork ID:	MON-0032839

About the designated centre

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

Lakes Nursing Home is a two-storey purpose-built centre designed to provide care for residents requiring continuing and short stay care including respite and convalescence. As a provider of high quality nursing care, we welcome the 'National Standards for Residential Care Settings for Older People in Ireland'. These standards will help to consolidate existing good practice whilst also identifying areas for development. We are committed to enhancing the quality of life of all our residents by providing inclusive, high-quality, resident-focused 24-hour nursing care, catering, service and activities. Lakes Nursing Home can accommodate a maximum of 57 residents. there are 47 single rooms available with en-suite toilet facilities as well as five double rooms with en-suite toilet facilities. A number of shared shower rooms are available. there is stirs and lift access to the first floor. It is a mixed gender facility catering for dependent persons aged 18 years and over, providing long-term residential care, respite, convalescence, dementia and palliative care. Care for persons with learning, physical and psychological needs can also be met within the unit. Care is provided for people with a range of needs: low, medium, high and maximum dependency. We employ a professional staff consisting of registered nurses, care assistants, maintenance, and laundry, housekeeping and catering staff. Prior to admission, a pre-admission assessment shall be undertaken in the resident's home or transferring facility, by a member of the residential home's nursing staff. Care plans will be established and reviewed through inclusion of families and residents supported by the community services on referral. Resident records are stored on a secure computer system and also in filing cabinets. The activities coordinator meets new residents to plan an individual activities programme. Residents are encouraged to keep up their social/leisure interests after admission, for example, gardening, painting, knitting, quiz, music, media access, beauty and hair therapy. Day trips are also organised occasionally. Arrangements can be made for residents to go shopping or attend other activities outside the nursing home; these may incur some extra costs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	50

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
Tuesday 18 May 2021	10:15hrs to 19:00hrs	John Greaney	Lead

What residents told us and what inspectors observed

The inspector arrived to the centre unannounced on the morning of the inspection. On arrival to the centre, the inspector was met by the person in charge (PIC) who ensured that all necessary infection prevention and control measures, including hand hygiene and temperature checking were implemented prior to entering the centre. After an opening meeting with the PIC, the inspector was guided on a tour of the centre where he met and spoke with residents in their bedrooms and in communal areas.

This centre is a two storey, purpose-built nursing home, situated on the outskirts of the town of Killaloe. The centre is registered to accommodate fifty seven residents in forty seven single bedrooms and five twin rooms. There is bedroom accommodation for 24 residents on the ground floor and for 33 residents on the first floor. All of the bedrooms are in suite with toilet and wash hand basin. While the centre is purpose-built it was clearly evident on the walkaround that there is a significant shortage of storage space. As a result, equipment was inappropriately stored on corridors, in sluice rooms and in linen rooms.

Residents were facilitated to personalise their bedrooms with memorobila and photographs. There was adequate space in residents' bedrooms to store their personal possessions and clothing. Overall, the corridors and communal rooms were clean but some en suite bathrooms and communal bathrooms required attention. While parts of the centre had been redecorated recently, other areas required attention. An overall sense of homeliness was distinctly absent from the centre.

The inspector met and spoke with several residents during the inspection. Overall, the feedback from residents was that staff were kind and caring. All residents stated that staff were responsive to their needs, however, some residents stated that many staff were unfamiliar to them as they were not long working in the centre. The inspector observed residents having their meals in the different dining areas and in their bedrooms. There was mixed feedback from residents in relation to food, with some residents stating they were very happy with the food while others stated that the quality of food varied significantly throughout the week.

The inspector spent time observing resident and staff engagement. The inspector found that the residents interactions with staff were seen to be appropriate and respectful. Residents looked well-groomed and content and most residents that spoke with the inspector confirmed that they were happy living in the centre.

Visiting to the centre had resumed, was being monitored, and visitors were appropriately screened. The inspector observed a small number of visitors coming and going throughout the day of 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 was a one day unannounced risk inspection, which was conducted in response to the receipt of information by the Chief Inspector of Social Services from a number of sources in respect of staffing levels, quality of care, management of complaints, safeguarding residents from abuse and infection prevention and control. Since the last inspection in June 2020, there have been eight instances of unsolicited information received. In respect of the issues identified in earlier communications, assurances were received from the provider that all issues raised were satisfactorily addressed. These issues are also being followed up on this inspection in addition to any information received immediately prior to this inspection. The findings of this inspection are that, while there was a clearly defined management structure in place, management systems required strengthening to ensure that an effective and safe service was continuously provided for residents. Improvements were required in relation to the management of complaints, supervision of staff, the submission of notifications and compliance with the policy on investigating allegations of abuse.

The registered provider of this centre is Elder Nursing Homes Ltd, however, Complete Healthcare Services Ltd are responsible for the day to day operation of the centre. The directors of Complete Healthcare Ltd are involved in the operation of a number of nursing homes throughout the country. Care in Lakes Nursing Home is directed through the person in charge, who reports to a regional heathcare manager. From a clinical perspective the person in charge is supported by a clinical nurse manager (CNM) and a team of nurses, healthcare assistants, catering and household staff.

The previous inspection of this centre was conducted in June 2020 following a significant outbreak of COVID-19. Findings on that inspection were that there was evidence of good practice with respect to the care delivered to residents, however, improvements were required in management systems to ensure the quality and safety of care achieved regulatory compliance and that the centre was adequately prepared in the event of a further surge in the virus.

The findings of this inspection show that the provider was striving to deliver a high standard of care to the residents living there. The staffing number and skill mix on the day of inspection was appropriate to meet the care needs of the residents, and staff were observed to have the required competencies and experience to fulfil their roles and duties. However, despite managements' ongoing efforts to recruit and retain staff, there was a high staff turnover which impacted on staff's ability to consistently provide a high standard of quality care. This was reflected in the views of some residents that staff were unfamiliar to them. There was a comprehensive programme of training and all except recently recruited staff had completed mandatory training. Appropriate training had been provided in infection control,

application of personal protective equipment, the signs and the signs and symptoms of COVID-19.

There were systems in place to manage critical incidents and risk in the centre. Accidents and incidents were recorded, appropriate action was taken, and they were followed up on and reviewed. However, all incidents had not been notified to the Chief Inspector as per requirements of the legislation. Audits conducted by the person in charge identified deficits in the premises, such as the absence of a designated wash hand basin in the sluice room and inadequate storage space but there was no time bound plan associated with the audits to address these deficits.

There was a policy on the management of complaints and the complaints process was on display in the centre. A review of the complaints log indicated that there were only a small number of complaints recorded. The inspector reviewed a letter received by management that should have been considered a letter of complaint but the issues raised in the letter were not included in the complaints log. While records indicated that these issues were being addressed, the inspector was not satisfied that there was full adherence to the complaints process in the centre. This was also the case in instances where concerns were raised in relation to staff performance. There was not a full and thorough investigation to ascertain whether or not there was any basis to the allegations.

All records as requested during the inspection were made readily available to the inspector. Records were maintained in a neat and orderly manner and stored securely. However, there was a requirement for improvements in relation to staff recruitment particularly in relation to the requirement to have two verified references for each employee. While there was a process of induction, records of the induction were not always signed and dated by both staff involved in the induction process.

Regulation 15: Staffing

Based on the observations of the inspector and a review of the staff roster, there were adequate numbers and skill mix of residents to meet the needs of residents on the day of the inspection. All interactions by staff with residents observed by the inspector were respectful and caring.

Judgment: Compliant

Regulation 16: Training and staff development

There was a comprehensive programme of training and all but recently recruited staff had completed mandatory training. Dates were scheduled for new staff to

attend any training that was outstanding.

Judgment: Substantially compliant

Regulation 21: Records

Improvements required in relation to records included:

- there were not always two written employment references for all staff
- the inspector observed that the medication administration record was not always signed by a nurse at the time of administering medications
- while there was a programme of induction for new staff, the induction record was not always signed off by both staff participating in the induction process.

Judgment: Substantially compliant

Regulation 23: Governance and management

While there was a clearly defined management structure, management systems required review. This is supported by the findings that:

- there was a high turnover of staff. In the twelve months prior to this inspection thirty seven staff had commenced employment and forty nine staff had left. It is acknowledged that these records include some temporary staff recruited for the purpose of the COVID-19 pandemic and some staff that had left and returned, but the turnover of staff is still significant
- the management of complaints was not in keeping with the centre's own policy on the complaints process
- allegations of abuse were not investigated in accordance with the policy on investigating allegations of abuse
- where concerns were expressed in relation to the performance of staff, particularly on night duty, these were not adequately investigated
- there was not always a time bound action plan associated with all audits

Judgment: Not compliant

Regulation 31: Notification of incidents

Not all notifications were submitted as required, such as allegations of abuse.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

While there was a policy and procedure in place for the management of complaints, it was not always implemented in practice. For example:

- there were only a small number of complaints in the complaints logs
- issues brought to the attention of management were not always included in the complaints log
- adequate records were not available to indicate that all complaints were adequately investigated

Judgment: Not compliant

Quality and safety

Residents in the centre were generally satisfied with the quality of the service they received. Nonetheless, improvements were required in relation to residents' assessments and care plans, the design and layout of the premises, nutrition, infection control practices, and safeguarding.

The inspector acknowledges that COVID-19 restrictions posed a significant challenge to residents and staff. Staff were committed to providing quality care to residents. Residents' medical and health care needs were met to a good standard. The centre has good access to general practitioner (GP) services and a range of healthcare professionals such as dietetics, speech and language, occupational therapy and physiotherapy. There was a low incidence of pressure ulcer development and a low incidence in the use of bedrails. However, on review of documentation it was evident that care planning documentation required improvement as care being delivered in the centre was not always reflected in residents' care plans. This is discussed further under Regulation 5.

Staff members with whom the inspector spoke were knowledgeable about the steps to be taken in the event of any suspected or confirmed safeguarding concern. However, systems in place to safeguard residents from abuse required review. While records indicated that allegations of abuse were investigated, the inspector was not satisfied that there was full adherence to the policy on safeguarding and investigating allegations of abuse. Records viewed did not demonstrated a full and thorough investigation of all allegations.

From a review of a sample of residents' care plans and discussions with residents and staff, the inspector found that the nursing and medical care needs of residents

were assessed. A number of mobile residents' were seen to freely mobilise around the corridors. Residents had comprehensive access to general practitioner (GP) services, to a range of allied health professionals. Wound care was well managed using scientific and evidenced based practices. Residents expressed satisfaction with the medical care provided and the inspector was satisfied that residents' health care needs were well met. A suite of validated clinical risk assessments was completed for each resident in areas such as falls prevention, pressure and skin integrity, malnutrition risk, oral care and pain management. Some improvements were required in care plan development to ensure that care plans were developed for all issues relevant to each resident and that adequate detail was included in the care plan to guide staff in care delivery. This is particularly important in light of the high turnover of staff.

The inspector followed up on the compliance plan from the last inspection and found that some of the issues identified had been satisfactorily completed by provider, however, some remained outstanding. Improvements noted since the previous inspection with respect to the premises included the redecoration and replacement of floor covering of the entrance lobby and the foyer areas of both floors. There was also an additional shower installed and the bath was relocated to a bathroom on the first floor. Notwithstanding these improvements, the floor covering on a number of corridors was damaged and it would not be possible to clean it effectively. There continued to be a significant lack of storage space resulting in equipment being inappropriately stored in public areas of the centre. In general, the premises lacked a homely feel.

Restrictive practices were robustly assessed, monitored and reviewed on a regular basis. The number of restrictive practices was low, with three residents using bedrails at the time of inspection. All but recently recruited staff had attended training in the care of residents with dementia and in responsive behaviour.

Residents rights were respected and a programme of activity was available to residents. Visiting was facilitated in line with the guidance at the time of the inspection.

Regulation 11: Visits

Visiting was being facilitated in line with the latest guidance on visitation to residential care facilities to reflect the importance of visiting for residents. Visits were facilitated seven days a week. Families had been updated regarding the latest visiting arrangements.

Residents spoken with stated that they were happy with the current arrangements.

Judgment: Compliant

Regulation 13: End of life

From a sample of care plans reviewed there was evidence that the preferences for care at end of life was discussed with residents and their relatives, where appropriate. This was adequately detailed in care plans. There was good access to palliative care services.

Judgment: Compliant

Regulation 17: Premises

Improvements required in relation to the premises includes:

- there is inadequate storage space for equipment such as hoists and wheelchairs and these were seen to be stored on corridors
- a communal room, called The Quiet Room was cluttered and used for storing a desk that was recent removed from a residents bedrooms and also for storing some Christmas related items
- while floor covering had been replaced in some parts of the centre, such as at reception, floor covering in other areas of the premises was worn and damaged

Judgment: Not compliant

Regulation 18: Food and nutrition

This regulation was not assessed in its entirety, however, from discussions with residents some commented that the quality of food could vary throughout the week.

Judgment: Substantially compliant

Regulation 27: Infection control

Required improvements in relation to IPC included:

- linen bags containing recently laundered bed clothes were stored on the floor of the linen room and some blankets were seen to have fallen out onto the floor
- a resident's dentures were stored in an open container on a wash hand basin

in the en suite bathroom of a bedroom shared by two residents
- a basin was observed in the en suite bathroom and it visibly soiled
- bathrooms were not cleaned immediately after use and used cloths were seen on shower hand rails
- sluice rooms were cluttered and used for storing multiple clinical waste bins that were not currently in use
- a bag containing clothes to be laundered was seen in an unused clinical waste bin

Judgment: Substantially compliant

Regulation 28: Fire precautions

Due to the lack of storage in the centre, some equipment was stored on corridors that could obstruct evacuation routes in the event of an emergency, such as fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Improvements required in relation to assessment and care planning included:

- there was inadequate detail in relation to the specific interventions, such as the frequency of blood sugar levels for residents with diabetes or the dietary preferences for a resident identified as requiring encouragement with their fluid intake
- some care plans were generic and did not reflect information given to the inspector about the manner in which a resident may interact with staff
- residents assessments and care planning did not adequately determine all preferences in relation to the provision of personal hygiene

Judgment: Substantially compliant

Regulation 6: Health care

The inspector was satisfied that the health care needs of residents were being met and residents had access to General Practitioners (GPs). During the COVID-19 pandemic, residents continued to have access to a range of allied health professionals through a blend of remote and face to face consultations. There was evidence of referral and access to services such as speech and language therapy

(SALT), psychiatry of later life, dietetics, occupational therapy and physiotherapy. Residents that required assistive devices and equipment to enhance their quality of life were assessed and appropriate equipment provided.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff continued to promote a restraint free environment. There were three residents using bed rails at the time of inspection. The use of the bed rails was risk assessed, a care plan, consent and safety checks in line with national policy were documented. There was evidence of multi-disciplinary input into the decision to use the bed rails.

The inspector reviewed the files of some residents who presented with responsive behaviour. There was evidence of access and referral to psychiatry services. Training records reviewed indicated that staff had attended training dealing with behaviours that challenged and management of restraint.

Judgment: Compliant

Regulation 8: Protection

Significant improvements were required in relation to safeguarding residents. These included:

- allegations of abuse were not always investigated in accordance with the centre's own safeguarding policy
- adequate records were not available to demonstrate that all allegations were fully investigated
- not all authorities required to be notified of allegations of abuse were notified
- Safeguarding care plans were not always put in place in instances where a resident's behaviour may suggest the need for such a care plan.

Judgment: Not compliant

Regulation 9: Residents' rights

There were facilities for occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. The privacy and dignity of residents was respected. The centre had adequate arrangements for residents to

communicate freely and had access to radio, television, newspapers and other media. There was adequate telephone and video call facilities. Residents religious preferences were facilitated insofar as COVID-19 restrictions allowed.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially 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 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Lakes Nursing Home OSV-0000447

Inspection ID: MON-0032839

Date of inspection: 19/05/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Recruitment: Management in the home are supported by the Human Resources team to ensure rigorous application of best practice and highest standards in the recruitment and selection procedures. This includes compliance with Schedule 2 requirements and ensuring that all staff have the required skills, knowledge, attributes and competencies for their roles and responsibilities. Staff Induction: There is a robust induction programme in place for all new staff, suitable for each role. All staff undergo this induction process to ensure that they are clear about the standards of care expected from them and any policies, protocols and guidelines including safeguarding arrangements to be followed when interacting with residents. All staff receive regular performance feedback, supervision and appropriate training to assist them in delivering high quality standards of care. Staff Training: All staff are required to complete mandatory training, including, but not limited to: Fire Safety, Safeguarding and Protection of residents, Manual & People Handling, Care of the Person with Dementia, Management of Behavioural & Psychological Symptoms of Dementia (BPSD)/Responsive Behaviours, Infection Prevention & Control, Medication Competency Assessment, A Human-Rights Based Approach to Care among other training courses. A training schedule is in place to ensure all staff, including any new staff and staff who require updates, are provided with a training schedule during their initial induction phase and where possible within the first 4 weeks after commencement of employment. Staff training needs are discussed during probationary, performance appraisal and clinical supervision meetings, and staff are given the opportunity to identify any areas of training they feel they require. Training is also put in place when there has been observation of staff skills deficits based on individual training needs analysis. Staff Appraisals: Structured staff performance appraisal meetings are completed to ensure that all staff are clear about their roles and responsibilities. These meetings review all aspects of the individual staff member's work performance and to ensure that the staff understand the person-centered philosophy of care and its application in the	

nursing home.
Supervision Oversight: The regional Healthcare Manager will provide further assurance of the supervision process by conducting oversight audits of the records of the supervision meetings, and subsequent feedback on the results will be provided to management in the home and the senior corporate management team at the monthly care and quality management team meetings.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Recruitment: We will ensure that all employees will have the requisite two references on file and that all staff records comply with Schedule 2 of the Health Act.
The induction record, confirming that all the required aspects of induction and orientation have been satisfactorily addressed, will be signed off by the PIC or CNM and employee upon completion.

Medication Management: All nursing staff will adhere to the Safe Administration of Medication Policy and will sign each individual residents' medication immediately after it has been administered as part of the medication administration round.
All Nursing staff will complete refresher Medication Competency Assessments on HSELand by 31/07/2021.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC, supported by the Healthcare Manager will:
• Monitor the turnover of staff. The past year has seen increased staff turnover, partly accounted for by a number of staff who worked on the home on temporary contracts as they had been recruited to supplement the staffing levels during the acute phase of the Covid-19 pandemic.
• Ensure that staff who leave their job in the nursing home will complete an exit interview which may provide better insight into staff turnover.
• Ensure that all complaints and concerns received in the home are recorded, investigated and resolved, and that the complainant receives a response to their concerns.
• Ensure that all allegations of poor performance are taken seriously, investigated fully, recorded comprehensively and that appropriate corrective actions are implemented as

indicated within an appropriate timeframe.
• Complete unannounced random night checks monthly and record findings.
• Schedule additional Safeguarding education and awareness workshops for all staff, including management, including recognition of all suspected types of abuse and the required procedures to follow if there is a suspicion or allegation of abuse, preliminary screening, investigation and notification within required timelines.
• Improve the frequency, screening and follow-up of all recorded adverse incidents and complaints.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC will ensure that there is full compliance with regulation 31 and provide appropriate notification to the Authority of incidents as required.
The PIC will review all complaints and incidents and discuss with the Regional Healthcare Manager as required

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The PIC will foster a culture in the nursing home where all forms of feedback are welcomed and will ensure that all complaints and concerns are taken seriously, reported, recorded, addressed and resolved to the satisfaction of the complainant. Together with the Healthcare Manager, the PIC will review complaints, implement corrective actions, ensuring that lessons are learned and appropriate quality improvements established as indicated.

As part of the Safeguarding workshops scheduled to be carried out in the home in July 2021, we will ensure that all staff are aware that recording all complaints, no matter how seemingly minor, is essential in demonstrating how all issues and concerns are listened to and acted upon appropriately. Staff will be encouraged to record all negative feedback or concerns, even if they have already satisfactorily addressed and resolved them.

We will improve the quality of documentation of complaints, ensuring that there is clear evidence of a thorough investigation and resolution of the issues raised by the complainant.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The storage of necessary medical equipment including wheelchairs and hoists has been reviewed and they are now stored safely and appropriately.

The Quiet Room has been decluttered and all unnecessary furniture has either been disposed of or stored more appropriately elsewhere. Christmas decorations have been stored off site until they are required.

There is a planned schedule of works to improve worn or damaged floor coverings.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The Chefs will meet with residents regularly to ensure that they enjoy the menus, variety, choices and quality of the food in the nursing home. The residents will be consulted regularly about the standard of food on offer and the chefs will respond to popular choices. Chefs will also ensure that if there are residents who have individual tastes that are not on the menu, these will be catered for.

We will review the residents' dining experience to ensure that they all experience an enjoyable, relaxed and unhurried social occasion. We will review the dining facilities and introduce 2 sittings at lunchtime.

A Hospitality audit, which includes an audit of the residents' dining experience will be undertaken by 30/06/2021. The audit outcome and quality improvement plan will be recorded and implemented by 31/07/2021. The PIC will to carry out spot checks on quality of food and feedback from residents.

Regulation 27: Infection control	Substantially Compliant

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

control:
We will ensure that freshly laundered linen is returned to the nursing home and stored on the shelves immediately.
The CNM and nursing staff will carry out daily room checks in place to ensure that residents' bedrooms and bathrooms are left in a clean, presentable and homely condition for the residents each day.
Bathrooms will be cleaned immediately after each use and all equipment used will be maintained in a clean and hygienic condition at all times.
Adherence to the room presentation standard will be discussed at the daily Safety Pause.
Housekeeping records maintained in all rooms.
Sluice rooms have now been decluttered and will be maintained in a clean and hygienic condition at all times. The Housekeeping Supervisor will be responsible for monitoring and maintaining standards of hygiene.
All personal possessions for each resident are stored appropriately within their own room and not left in communal areas.
All excess clinical waste bins have been removed from the nursing home.
All personal laundry will be attended to appropriately and will be stored appropriately in the laundry room while waiting to be laundered.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All unnecessary and unused equipment has been removed from the home and stored off site. Some items of furniture that were beyond use have been disposed of. Sluice rooms and communal spaces that had been cluttered have now been decluttered and are used for their intended purpose.
Equipment such as wheelchairs and hoists are stored appropriately and safely; they do not cause an obstruction and are not stored on corridors when not in use.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Individual Assessment: The PIC and CNM will review the assessments and care plans in conjunction with the named nurses to ensure that assessments inform the plan of care, that the care plan is individualised and person-centred, considering the resident's current medical, health and lifestyle status, and that the care plans are reviewed at intervals not less than 4 monthly or as indicated by the resident's condition or circumstances. These

reviews monitor the effectiveness of the residents' support and treatment provision and promote improved care outcomes.
Wherever possible the care plans are prepared in consultation with the resident or a designated representative.

The PIC, supported by the Healthcare Manager, will ensure that all staff understand what we mean by a Human Rights-Based Approach to Care, with respect to residents' health and social care needs, ensuring that they are always treated with respect and dignity. Staff will be encouraged to communicate with residents in a person-centred way that respects the residents' autonomy. Any decisions about residents will always be made based on the residents' will and preferences.
Staff in the home understand that prior consent is always required and there are established structures including consent records and communication care plans to support consensual decision making. We will ensure that residents are consulted on an individual basis and that they have an opportunity to contribute at Residents' Meetings which are held regularly.

Care Plan Audits: As part of the Mowlam Audit Management system all care plans will be regularly audited and reviewed by the PIC and CNM to ensure suitable nursing care interventions.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All staff within the home will undertake additional Safeguarding training and will participate in the Scheduled Safeguarding workshops in July 2021.
All staff receive regular mandatory safeguarding training, including training in the National Standards for Adult Safeguarding.
The PIC, supported by the Healthcare Manager will be aware of their responsibilities in recognising, reporting and responding to any allegations including escalating any concerns appropriately.
Arrangements are in place to ensure that all staff are aware of the homes safeguarding policies and procedures.
The PIC will ensure that any suspicion, concern or allegation of abuse will be thoroughly investigated in accordance with the comprehensive suite of policies and procedures to safeguard residents including the following:
Policy (PR-001) Safeguarding Vulnerable Persons at Risk of Abuse: Protection of the Resident from Abuse.
Policy (PR-002) Safeguarding Vulnerable Persons at Risk Responding to Allegations of Allegations of Abuse.
Policy (PR-003) the Management of 'Whistleblowing'.

All the nursing home policies are in accordance with the national standards on

Safeguarding Vulnerable Persons at Risk of Abuse and the HIQA National Standards for people living in long term residential care settings.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/2021
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	31/07/2021
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2021
Regulation	The person in	Substantially	Yellow	31/07/2021

18(1)(c)(ii)	charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Compliant		
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.	Substantially Compliant	Yellow	31/07/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/07/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	31/07/2021
Regulation 28(1)(c)(ii)	The registered provider shall	Substantially Compliant	Yellow	31/08/2021

	make adequate arrangements for reviewing fire precautions.			
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	30/06/2021
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	31/07/2021
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 complaint and whether or not the	Not Compliant	Orange	31/07/2021

	resident was satisfied.			
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	31/07/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/08/2021
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/06/2021
Regulation 8(3)	The person in charge shall investigate any incident or allegation of	Not Compliant	Orange	30/06/2021

	abuse.			