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:	Rockshire Care Centre
Name of provider:	RCC Care Limited
Address of centre:	Rockshire Road, Ferrybank, Waterford
Type of inspection:	Unannounced
Date of inspection:	23 February 2022
Centre ID:	OSV-0000688
Fieldwork ID:	MON-0035903

About the designated centre

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

Rockshire Care Centre is a two-storey, purpose-built nursing home that was constructed in 2007. The centre is registered to provide care to 38 residents and resident accommodation is provided in 32 single en-suite bedrooms and three twin en-suite bedrooms. There are a number of additional bathrooms and toilets suitably located and accessible. Communal accommodation is provided in a number of lounge areas on both floors which were well furnished and comfortable. The sitting room on the first floor is called the Parlour and is available for family events, birthday celebrations or private meetings. There is a large sitting room on the ground floor which leads to a well maintained, secure and sheltered garden. There is a separate large dining room, quiet room, hairdressing room, activities room and physiotherapy treatment room.
The centre provides residential care predominately to people over the age of 65 but also caters for younger people over the age of 18. It is a mixed gender facility and offers care to residents with varying dependency levels ranging from low dependency to maximum dependency needs. It offers care to long-term residents and to short-term residents requiring rehabilitation, post-operative, convalescent and respite care. It has one specific respite bed for residents with dementia. The centre provides 24-hour nursing care and nurses are supported by care, catering, household and activity staff. Staff are supported by the person in charge and the management team. Medical and allied healthcare professionals provide ongoing healthcare for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	29

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 23 February 2022	07:30hrs to 19:15hrs	Catherine Furey	Lead
Wednesday 23 February 2022	07:30hrs to 19:15hrs	Susan Cliffe	Support

What residents told us and what inspectors observed

Inspectors arrived to the centre unannounced in the morning. At the time of the inspection, the department of Public Health had declared the recent COVID-19 outbreak over. Residents were no longer confined to their rooms and inspectors observed that the resident's daily lives were returning to normal following a long period of restrictions due to the outbreak. From the observations of inspectors, and from speaking to residents, it was clear that residents were generally happy living in the centre. Overall, inspectors found that more could be done to ensure a person-centred ethos of care was consistently delivered.

On arrival, inspectors were met by the nurse on night duty who ensured a necessary symptom screening for COVID-19 prior to accessing the centre. The changeover of staff was beginning and inspectors began a walk around of the centre, speaking with staff on both day and night duty. The senior nurse manager arrived to the centre and met with inspectors. The person in charge and registered provider arrived later in the morning and remained for the duration of the inspection. The centre is registered to accommodate 38 residents and there were 29 residents living in the centre on the day of inspection. The person in charge outlined that a number of the residents were living with a confirmed diagnosis of dementia while a number of others had suspected cognitive impairments. Many residents who the inspectors met were unable to fully verbalise their needs and wishes. Inspectors observed that these residents appeared well-dressed and groomed and were seated comfortably. Inspectors spoke with residents who gave their views on what life was like in Rockshire Care Centre. Residents described the recent prolonged restrictions as very tough, but they were understanding of the reasons for them and were grateful that it was now over. Residents described the staff as hard-working and at times "rushed off their feet". One resident who had previously voiced their concerns regarding the centre's call bell system stated that the new system was a huge improvement and waiting times for assistance had reduced.

Breakfast was predominantly served in residents' rooms and lunch and tea time meals in the dining room. Lunch was served in two different sittings; at 12 midday for residents who required assistance and 12:30 for other residents who were more independent. Inspectors observed that residents who required assistance were tended to discreetly and their independence gently encouraged with regard to feeding themselves where possible. Residents told the inspector that the food was delicious and plentiful, and residents were seen to enjoy the offerings for main course and dessert menus. A choice of hot and cold drinks was provided with meals and throughout the day. Staff had access to a kitchenette to make snacks for residents if requested during the night. The inspectors identified that improvements were required to the overall dining experience in the centre. Residents continued to be socially distanced at dining tables, despite sitting next to each other in the sitting rooms before and after their meals. As a result, residents were unable to chat and the dining experience was antisocial. The dining room itself was sparsely decorated and the walls were heavily stained in some areas. The overall decor could be

improved to make it a more enjoyable and homely area, and more conducive to the dementia-specific requirements of the residents living in the centre. Inspectors saw that all residents had returned to the adjacent sitting room before 13:15. Staff told inspectors they had to "clear the dining room" before they took their own breaks.

The centre is laid out over two floors. There is sufficient communal space on both floors, however the upstairs parlour was not currently used by the residents, who preferred to go downstairs to the main sitting room which had sufficient space to accommodate a large number of residents. Residents were seen independently using the lift to access the communal areas. As the centre was not at full occupancy, all residents currently resided in single ensuite bedrooms and the centre's three double occupancy rooms were vacant. As seen on previous inspections, the personalisation of residents rooms varied, with some rooms devoid of color, pictures and personal objects and others containing individual items, family photographs and residents' own soft furnishings. The large sitting room leads out to an enclosed garden area. Previously these doors were unlocked and residents had unrestricted access to the outdoors. Staff told inspectors that the doors were currently locked due to the cold and wet weather and that the area was not used in winter time.

Inspectors observed that given the size and layout of the building, one member of cleaning staff was not sufficient and as a result, the centre was not cleaned to a high standard. Inspectors found many instances of dried grime and dirt build up on equipment, furniture and doors. Some vacant bedrooms in the centre were not appropriately cleaned and still contained items and notices relating to the previous occupant.

The activities programme had been reinstated following the COVID-19 outbreak. Residents were facilitated with a range of scheduled activities. On the morning of the inspection, residents gathered for a general knowledge quiz and were seen to engage well and enjoy this activity. Inspectors observed that there were long periods of time when some residents did not appear to be sufficiently engaged, particularly residents with dementia. The television was on for most of the day, mainly providing a background noise. Inspectors found that at busy periods of the day, when staff were assisting residents into the dining room for example, the volume of the television and of the staff chatter, combined with some residents calling out proved to be very distracting and not in keeping with a homely ambiance.

Overall, inspectors found that while the residents had a good quality of life in this centre, this could be further enhanced by ensuring that care was delivered in a person-centred manner. 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

Overall, the findings of this unannounced inspection were that the centre did not have the capacity or capability to deliver a person-centred and high quality service to the residents. The governance and management systems in place were not effective in ensuring a safe and consistent service to the residents. Inspectors found evidence of repeat non-compliance in relation to care planning, healthcare, staffing, infection control and overall governance and management. Following the inspection, an urgent compliance plan was issued to provide further assurances in relation to;

- Regulation 27: Infection control. The registered provider was requested to undertake a full deep clean of the centre and to arrange for large quantities of personal protective equipment (PPE) to be removed from an open external storage shed where it was being inappropriately stored.
- Regulation 29: Medicines and pharmaceutical services. A full review of all medication management systems was requested.

The registered provider of the centre is Rockshire Care Centre Limited. There are two company directors, both of whom are involved in the operational management of the centre, in the roles of general manager and human relations manager. The company directors are also registered provider to another nearby designated centre. The person in charge of the centre has been in the role since February 2021, having previously worked as a staff nurse and senior nurse manager in the centre. The person in charge was responsible for the overall delivery of care, supported by a senior nurse manager with responsibility for overseeing clinical care. There is a dedicated physiotherapist who spends two to three days in the centre. A team of nurses and healthcare assistants provide direct care to residents and are supported by an activities coordinator, catering team and domestic team. The registered provider outlined that a small number of staff worked across both of their designated centres and were not contractually obligated to either one.

The centre had a recent history of poor compliance with the regulations identified over the course of a three-day inspection of the centre on 26 November, 6 December and 13 December 2021. The cumulative negative findings over the three days of inspection had a direct impact on the quality of care delivered to residents. The registered provider had multiple engagements with the office of the Chief Inspector, culminating in the issuing of a notice of proposed decision to cancel the registration of the centre on 28 January 2022. In response to this notice the provider had submitted written representation describing the changes that had been undertaken to improve the levels of compliance within the centre. This inspection was conducted to assess the changes outlined in the representation, and whether these changes had been effective in improving regulatory compliance and ensuring the safety and welfare of residents in the centre.

The management team met with the inspectors during the inspection and outlined the improvements that were being implemented. For example;

- A new, improved call bell system was in place, with multiple screens throughout the centre to easily identify who was calling.
- The introduction of new domestic equipment, products and methods in line with best practice guidance.

- Online training had been provided to the domestic staff
- The management team, comprising of the person in charge and senior nurse manager were rostered in a completely supernumerary capacity to ensure clinical oversight was maintained
- There was enhanced supervision of healthcare and nursing staff documentation of residents' basic care needs including daily intake and output charts and repositioning charts.
- An improved system of weekly and monthly audits to ensure wounds are assessed regularly and to ensure recommendations of wound care specialists are followed.
- The storage of oxygen had improved and all cylinders were suitably stored outside in a locked facility with appropriate cautionary signage.
- A full review of all food and drinks served to residents had taken place, training had been provided to catering staff and a new menu was in place which ensured that residents had sufficient choice at all mealtimes, and were sufficiently hydrated throughout the day, particularly those on a modified diets and those requiring assistance with their oral intake.

However, inspectors found that while some of these previous non-compliance's had been addressed, not all of the changes outlined in the representation had been implemented, particularly with regard to staffing levels within the centre. Furthermore, new non-compliance's were identified on this inspection which did not assure inspectors that the registered provider had taken all necessary actions to ensure the safety and welfare of the residents.

Repeat non-compliance was found with regard to;

- Regulation 15: Staffing
- Regulation 23: Governance and management
- Regulation 27: Infection control
- Regulation 5: Individual assessment and care plan
- Regulation 6: Healthcare

Additionally, new non-compliance was found with regard to;

- Regulation 11: Visits
- Regulation 21: Records
- Regulation 29: Medicines and pharmaceutical services

On the day of inspection, there were appropriate staffing levels and the skill-mix of staff was sufficient to meet the individual and collective needs of residents. However, a review of the rosters showed that staffing levels and the skill-mix at night time were not sufficient to meet the needs of residents and supervision of staff. This is discussed further under Regulation 15: Staffing. Inspectors found that the daily deployment of nursing and healthcare assistant duties was task-based in nature and did not support the best possible personalised individual care and attention that is outlined as the aim of Rockshire Care Centre in its statement of purpose.

The person in charge was collecting weekly key performance indicators on aspects of care such as falls, wound care and restraint. Inspectors found that the systems in place to monitor, evaluate and improve the quality of the service were not implemented by the management team. Audits were carried out to analyse key areas such as medication management, clinical documentation and infection prevention and control, however the audit tools in use were not comprehensive enough to identify poor practices and action plans following audits did not demonstrate what improvements had been made or how the audit was promoting and supporting good clinical governance. For example, high levels of compliance were found in a recent medication management audit, in contrast to the inspector's findings during the inspection. The system of risk identification in the centre required further oversight to ensure that the management team were risk-aware and identified any potential and actual risks, both clinical and environmental.

A number of additional training sessions had taken place including training in care planning, wound care and modified diets. A review of the training matrix identified that staff had attended mandatory training sessions, however the majority of training was delivered via an online platform or through the centre's own staff. Inspectors found that there was no mechanism to ensure that the learning from online training modules was reflected in practice. For example; a number of staff nurses had recently completed an online medication management module, however best-practice medication management practices were not being implemented.

All accidents and incidents such as falls and injuries that occurred in the centre were comprehensively recorded. Incidents of responsive behaviour were not always followed up appropriately, and the management of these incidents was not always person-centred in nature. This is discussed further in the Quality and Safety section of the report.

Complaints were generally well-managed in the centre in line with the centre's own complaints procedure. Some improvement in the documentation and follow up of minor complaints and concerns was required, to ensure all residents' concerns were addressed promptly and to their satisfaction.

Regulation 15: Staffing

The centre did not have enough staff to provide a contingency in the event of planned or unforseen absences, or in the event that seperate staffing teams were required for cohorted resident care. Inspectors reviewed worked and planned rosters and identified that there was a reliance on staff to work additional hours and also a reliance on staff who were based in the provider's other designated centre to cover absences. For example;

- Over a two-week period, three nurses had worked a total of 96 hours, 24 hours more than their contracted hours.
- Staff worked between two centres to ensure all nursing shifts were filled.

There was an insufficient number of cleaning hours allocated to ensure that the centre was appropriately cleaned. This was a repeat finding from the previous inspection. While additional housekeeping staff had been employed, no additional cleaning hours had been put in place. The impact of this is discussed under Regulation 27: Infection control.

Following the findings of the last inspection, the centre had committed to rostering two staff nurses at night. This arrangement was yet to commence. The provider outlined that recruitment was ongoing and a number of new staff were due to commence employment in the coming months. An additional healthcare assistant had been rostered on duty at night in the interim. From 6pm there was one nurse on duty until 7.45am.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors examined the training records held in the centre. There was a range of training completed including safeguarding vulnerable persons at risk of abuse and fire safety training. Inspectors found that there was an over-reliance on online training. For example, all staff nurses completed online medication management training, however findings on the day as outlined under Regulation 29: Medicines and pharmaceutical services found that there were a number of medication practices that were not in line with current recommended guidelines. Face-to-face training was required for all nurses to ensure adherence to best-practice guidance in respect of medication management.

Judgment: Substantially compliant

Regulation 21: Records

Inspectors reviewed a sample of staff and residents records during the inspection and found that records were not maintained in line with Schedules 2, 3 and 4 of the regulations as follows:

- Two current members of staff had no staff file, including Garda (police) vetting disclosures and written references, held on the premises
- Two staff members did not have appropriate written references from the most up-to-date employers in place
- The worked roster contained several staff members who worked in a different designated centre

- Records of medication, nursing care and specialist health care instructions were not consistently maintained in respect of each resident as detailed under Regulation 5: Individual assessment and care plan and Regulation 6: Healthcare

Judgment: Not compliant

Regulation 23: Governance and management

The actions taken by the provider to achieve compliance following the notice of proposed decision to cancel the registration of the centre were not sufficient to ensure the safety, care and welfare of the residents. Inspectors found that many of the issues found on the last inspection in November 2021 had been addressed, however the overall levels of compliance with the regulations remained very poor, and new non-compliance's were identified on this inspection.

Inspectors were not assured that the governance and management systems in place were sufficient to ensure that the service provided to residents was safe, effective and consistently monitored. For example, audits of clinical practice and environmental audits of the premises showed high levels of compliance and did not identify the issues found by inspectors during the inspection.

The cleaning systems in place were inadequate to ensure the centre was cleaned to a high standard. Environmental and infection control audits did not identify that some equipment, furniture and areas of the centre required further cleaning. Cleaning staff had completed online cleaning training courses since the previous inspection, however further supervision and oversight of cleaning staff was required to ensure that new members of staff were adhering to best practice guidance. For example, new staff were not aware of the guidelines regarding topping up of alcohol hand gel dispensers and were seen to decant from a large bottle into multiple dispensers, which is not recommended.

There continued to be inadequate resourcing of staff to provide a contingency in the event of staff absences and planned leave. The registered provider's two designated centres were interdependent, and as a result Rockshire Care Centre did not have an independent staffing resource. Additionally, the systems in place were not conducive to providing a person-centred model of care and the overall approach to care delivery was task-based in nature. For example, there were two staff nurses on day duty; one was assigned to care for residents and administer medications, and one assigned to clinical administrative duties, wound care and observations. This arrangement did not promote a holistic model of care.

Overall, the governance and management in the centre was not strong enough to maintain sufficient clinical oversight of residents' nursing and medical needs, as seen from the continued non-compliance's found in relation to residents care planning and healthcare delivery, and the additional non-compliance in relation to medication

management on this inspection. Due to these deficits in nursing knowledge and skills, inspectors were not assured that residents were consistently provided with high-quality and safe clinical care.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centre had a detailed complaints procedure, which was prominently displayed in a number of communal areas. A review of the centre's complaints log identified a low level of documented complaints. All documented complaints were seen to have been investigated and well managed. Residents confirmed that they were aware of how to make a complaint.

The person in charge outlined that some minor complaints and concerns from residents were not documented and were dealt with on an individual basis and followed up accordingly. However, in the absence of a record of these complaints, inspectors could not be assured that the complainant was satisfied with the outcome. Additionally, these undocumented complaints and concerns were not captured in the complaints audit, and there was no documented evidence of measures required for improvement in response to these issues.

Judgment: Substantially compliant

Quality and safety

The quality of life for residents in Rockshire Care Centre had improved greatly since the outbreak of COVID-19 had been declared over. Residents' were no longer isolating in their bedrooms and were encouraged to participate in social engagements and activities in the centre. Staff were observed to be kind and compassionate in their interactions with residents. Despite the good nature and respectful approach of staff, inspectors were not assured that the centre was operating with a person-centred approach to care. Inspectors observed task-orientated practices and the delivery of daily routines which did not protect each resident's human rights. Clinical oversight of the medical and nursing care of the residents continued to be insufficient to ensure the safety and well-being of residents was maintained to a high standard.

The centre had made some improvements in relation to overall infection prevention and control practices;

- The laundry was in the process of being refurbished to ensure the surfaces and floors could be adequately cleaned and to support the unidirectional flow

of laundry and to ensure surface and floor cleanable and support dirty to clean flow.
- New domestic equipment and products including a flat-mopping system supported best-practice cleaning and decontamination procedures.

Notwithstanding these improvements, inspectors found that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by HIQA in 2018 were not fully implemented by staff. Findings in this regard are detailed under Regulation: 27

Inspectors reviewed a number of residents' medical and nursing records. Following the last inspection, all residents who had contracted COVID-19 had been reviewed by their GP and had a supportive plan in place including regular medical and physiotherapy reviews to support a full return to their baseline condition. A number of residents had been reviewed by the dietitian due to significant weight loss associated with COVID-19 infection, however there continued to be gaps in the weight records of these residents. Documentation around resident's wound care had significantly improved and there was a new system in place to ensure that wounds were regularly assessed, appropriate referrals to wound care specialists made, and the recommendations followed. The system of daily wound dressings did not support holistic care. For example, one nurse was assigned to wound dressings but not involved in any other aspects of the resident's daily care. This system could be improved if both staff nurses were responsible for delivering total care to an assigned group of residents each day. Inspectors found that while the findings from the previous inspection had been addressed for the most part, further issues as detailed under Regulation 6: Healthcare were identified which required significant improvement to ensure a consistent high level of medical and nursing care provided to the residents.

The clinical oversight of medication management in the centre was very poor. The systems in place such as transcribing of medications and inappropriate storage of medications did not promote safe practices and placed residents at risk of poor outcomes. Inspectors uncovered a series of medication errors and omissions that the centre had not identified. Urgent action was required to ensure the safety and well-being of residents with respect to medications. Findings are detailed under Regulation 29: Medicines and pharmaceutical services.

Resident's care plans were reviewed and overall, the system in place had been improved and streamlined to ensure that unnecessary and irrelevant information was no longer documented. While improvements to the system were acknowledged, inspectors found that this was a work in progress as residents' changing individual needs were not always reflected in their care plan. Daily nursing documentation did not always detail relevant changes, for example on return from hospital the required changes to the residents care plan were not documented. Care plans were not always appropriately revised when changes to a resident's condition occurred. Findings of poor practice in relation to residents' care plans are detailed under Regulation 5: Individual assessment and care plan.

The use of restraints such as bedrails in the centre continued to be high, as

identified on a number of previous inspections. Records reviewed by the inspectors showed that bedrails were individually risk assessed prior to use and included a multi-disciplinary approach. Restraints were regularly checked when in use. There was evidence of discussion with residents and their representative, and consent was obtained for the use of all restrictive equipment. However, the use of alternatives to restraints were minimal. Inspectors were not assured that the centre was committed to promoting a restraint-free environment.

Records of daily care including intake and output, repositioning and personal care interventions were recorded on the electronic system by healthcare assistants and overseen by the staff nurse. The level of documentation had improved since the last inspection and provided assurances that residents basic needs in relation to hydration, nutrition and pressure area care were being met.

Inspectors observed the delivery of meals to residents. There had been significant improvements in the quality of food served to residents. Generally, residents attended the dining room for meals and some chose to remain in their rooms. Inspectors observed food delivered to rooms was warm and appetising. All residents were provided with nutritious meals of the appropriate consistency to ensure that residents received a diet that was in line with their individual modification and dietary requirements.

Group activities had resumed following a period of restriction due to the COVID-19 outbreak. A schedule of activities was in place from Monday to Friday however this did not extend to weekends. The person in charge outlined that a visiting musician attended one day of the weekend and the activities coordinator would leave details of any television programmes or sports that were suitable for residents to watch over the weekend. No additional staff were rostered to ensure activities were conducted over the weekend. This was important as the centre had a number of residents with a diagnosis of dementia who required specific dementia-friendly therapies and activation. The centre also had a small number of younger residents who required enhanced engagement to ensure their social needs were met in the nursing home environment.

Regulation 11: Visits

Residents were facilitated to receive visitors in the centre, however inspectors found evidence that the current visiting arrangements placed unnecessary restrictions on residents' rights to have visitors;

- While indoor visits to the centre were allowed, visitors were required to book in advance.
- Visitors were required to provide proof of vaccination certification

There was no risk assessment in place to support current level of visiting restriction.

Judgment: Not compliant

Regulation 18: Food and nutrition

Significant improvements were noted with regard to the quality and presentation of food served to residents. Residents requiring modified diets were offered choice at each mealtime and modified diets were attractively presented. There were suitable arrangements in place to ensure that residents who required assistance were served a hot meal and provided with timely assistance. The chef was knowledgeable about residents individual needs and met with the management team regularly to ensure any changes in a resident's requirements were communicated.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place which included the measures and actions in place to control the five specific risks outlined in the regulation. The centre maintained a register of clinical and environmental risks however, inspectors found that this did not include a number of risks identified during the course of the inspection which could impact on the safety and well-being of the residents. For example;

- The risks associated with transcribing of medications
- The risks associated with restricted visiting to the centre
- The risks associated with staff working across two separate designated centres

Judgment: Substantially compliant

Regulation 27: Infection control

The inspector found that the registered provider had not ensured that some procedures were consistent with the standards for the prevention and control of health care associated infections. This presented a risk of cross infection in the centre. For example:

- Since the previous inspection, there had been no additional cleaning hours put in place. This is discussed under Regulation 15: Staffing
- The centre was not cleaned to a high standard. Inspectors observed areas of dust and grime build-up, windows and glass panels which were dirty and

smudged, multiple staining on walls, doors, radiators and furniture, and stained fabric armchairs.

- Procedures for terminal cleaning of rooms were ineffective: a vacant room which had been signed off as terminally cleaned one week previously was found to have stained pillows and a duvet in the wardrobe, a bed table with rusty legs that was not fit for purpose, a vase of dried flowers on the windowsill and an old jug of water and glass on the bedside table.
- Inspectors observed that alcohol hand gel was routinely decanted into wall-mounted dispensers throughout the centre. This is not in line with best practice guidance.
- Access to staff hand wash sinks were less than optimal throughout the centre. There was a limited number of dedicated clinical hand wash sinks in the centre; those that were in place were not in line with the current recommended best-practice guidelines.
- Linen trolleys were not always used to segregate laundry at the point of care. A store room was found with multiple alginate bags containing soiled clothing and linen stored on the floor. Staff identified that the system in place was that these were stored on the floor from morning until later in the day when they were brought to the outside storage facility for collection by the linen company.
- Storage areas in the centre did not promote good infection control practices. As identified on previous inspections the upstairs store room was being used to house the cleaning trolley, alongside boxes of PPE and resident personal hygiene products.
- Boxes of PPE were inappropriately stored in a maintenance shed alongside garden equipment and bags of compost.
- The centre's sluice room was poorly ventilated and did not facilitate effective infection prevention and control measures. For example, clean items for use throughout the centre such as waste paper bins and cushions were stored adjacent to and on top of the bedpan washer; the floor was visibly dirty and the handwashing sink did not comply with current recommended guidelines.
- In the absence of sluicing facilities on the first floor staff confirmed that they rinsed sanitary equipment in the resident's en-suite sink after use and did not routinely bring them to the sluice room for appropriate cleaning and disinfection.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors were not assured that the medication management systems in place were safe and effectively monitored.

- The system of monitoring and reviewing medication management was ineffective. The centre had completed a recent medication audit which identified high levels of compliance with medication management, in direct

contrast to what inspectors observed on the day.

- The centre has a policy on transcribing and routinely transcribe medications from residents' prescriptions onto a Kardex which is then used as the record of what medication to administer to residents. Medication had been transcribed by two nurses to a Kardex on 29th December 2021. There was no GP signature for any of these medications, which is not in line with best practice guidance and with the centre's own policy on transcribing. Transcribing medications is a high-risk practice and can contribute to errors.
- There was no system in place for the safe disposal or return of medications to the pharmacy. Medications which were no longer required by a resident were not segregated from other medications and were kept on the medication trolley, potentially leading to errors.
- Medications were stored on the trolley with no identified expiry dates, some having been dispensed three years ago
- The controlled drugs cupboard contained a large overstock of controlled medications which were no longer prescribed for resident use.

Inspectors found that the medication management systems in place directly contributed to medication-related errors. These errors had not been identified by management or staff.

- The available quantity of an important medication indicated that a number of doses of the medication had not been administered since the medication was dispensed from a pharmacy. This medication had been signed as administered every day.
- A pain-relieving medication was being administered without a prescription. This medication was a lower dosage to the medication prescribed to treat the resident's pain. Staff were unsure as to why the resident was receiving this medication and there were no associated records founds in the residents daily, nursing or medical notes.
- Insulin pens were found to be stored in the fridge, despite the manufacturer's instructions clearly stating that it was not to be refrigerated. A number of insulin pens in current use were not labelled with a date of opening. This is important as the medication was required to be disposed of after a certain length of time. The dosage labelled on the insulin pens was different to the current dosage prescribed by the GP. Insulin is a high-risk medication and incorrect storage can lead to potential ineffectiveness of the medication.
- A topical patch was in use, which had specific instructions regarding its application. These instructions were not being followed, which could contribute to potential side-effects.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors examined a sample of residents' individual assessments and care plans.

Nothwithstanding the general improvements seen in the overall care planning systems in place, a number of care plans required improvement to ensure that appropriate and detailed information was obtained to guide the health, personal and social care needs of the resident.

- There was no medication management care plan in place for a resident on a long-term pain-relieving medication. As discussed under Regulation 29: Medicines and pharmaceutical services, there was confusion amongst staff regarding the specific dose of this medication. The lack of a documented individual plan of care meant that staff could not say with certainty why the resident was receiving the medication or why the medication dose had changed. There was no evidence-based pain assessments conducted for this resident.
- There continued to be a lack of clear direction around end of life care preferences. These were not consistently recorded in the resident's individual care plan, resulting in a lack of clarity with regard to each resident's wishes and preferences at end of life.
- There was no established system to record personal and relevant information on matters which were important to each individual, such as life story information, likes and dislikes, past occupation, hobbies and interests. Inspectors found some examples of this type of information being gathered in a document entitled "A Key to Me", but it was not always used to inform person-centred care planning.

Judgment: Not compliant

Regulation 6: Health care

Inspectors found that recommended medical treatment and professional expertise from allied health professionals were not consistently followed. This could potentially lead to poor outcomes for residents. For example:

- A direction from an acute hospital discharge summary stated that the dose of an important medication was to be changed, and follow up blood tests to be taken six weeks later. There was evidence that staff had contacted the residents GP following the residents return from hospital, however the information was not followed up again and the recommended treatment was not given.
- Following the last inspection, a full review of resident's weight loss had been completed with input form the GP and dietitian. This identified nine residents who required weekly weights. A review of records found that only four of these had been completed for the present week and five were overdue. This is important as some of these residents had lost up to 15% of their body weight and a weekly review was required to determine if the recommended advice from the dietitan was benefiting the resident.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Residents records showed that consistent efforts were not always made to determine and to alleviate the underlying causes of the resident's behaviours that challenge. Alternative techniques and therapies were not always trialled prior to administering sedative or psychotropic medications as a means of managing the behaviour.

Inspectors examined a sample of care plans and behaviour charts for residents identified as displaying behaviours that challenge. Some care plans did not identify potential behaviour triggers or detail techniques to de-escalate the behaviour to ensure that these behaviours were managed and responded to efficiently.

The use of restrictive equipment such as bedrails throughout the centre was very high. 35% of the residents had one or more bedrails in place on the day of inspection. Records showed that alternatives to bedrails were not always trialled. For example; for one resident the only alternative trialled prior to applying a bedrail was a call bell. There was no alternatives such as sensor mats and alarms in use.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors found that residents were not always facilitated to exercise choice, and the service was not always person-centred in nature.

- A small number of residents with cognitive impairment were routinely woken by night staff to be given their breakfast. Inspectors found no documented evidence that the residents, or their representatives had requested this practice. Staff informed inspectors that the practice was to ease the workload of the day staff.
- A resident told inspectors that despite repeated requests they were not provided with a GP of their choosing on admission to the centre.

Inspectors found that residents did not have appropriate opportunities to participate in activities in accordance with their interests and capabilities as follows:

- Not all residents had detailed social care plans and assessments in place to guide staff to carry out appropriate activities and engagement, as detailed under Regulation 5: Individual assessment and care plan.
- The full schedule of activities was only in place on weekdays. There was no

additional staff assigned to provide activities on the weekend. Inspectors found that two of the communal toilets were designed and laid out in a way that did not fully promote the privacy and dignity of the residents and was not conducive to a homely environment. There was an open space above the cubicle doors. In addition there were no locks on any of these toilet doors.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Rockshire Care Centre OSV-0000688

Inspection ID: MON-0035903

Date of inspection: 23/02/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure that there is a staffing contingency in the event of planned or unforeseen absences and to allow for separate nurse led teams should it be required the following is now in place: · Two staff nurses are rostered until 8pm on day duty · Additional housekeepers have been recruited to facilitate a second housekeeping shift seven days per week · Activities staff are now rostered seven days per week · Staff Nurses are no longer rostered across two designated centres. Ongoing measures: · Staff nurse recruitment has now been completed which will allow for a second staff nurse on night duty, to date 4 nurses have been recruited. Two nurses commenced week commencing 18th April and the remaining two will commence week commencing 16th May.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Due to the pandemic the majority of training was facilitated online. Face to face training has recommenced in the home where possible to allow for more interactive training where it is required. Review of all training and facilitators will be conducted by the HR manager and the quality manager by May 31st 2022	

A continuous improvement and quality manager will commence 2nd May 2022, this role will allow for the assistance of staff development, identify and escalate training gaps and oversee quality improvement. Progress in this area will be fed back to PIC and the provider at fortnightly governance meetings.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
All staff files are stored and maintained in Rockshire Care Centre and include Garda vetting disclosures and appropriate written references on completion of induction period.

One to one guidance is currently being provided to all nursing staff inclusive of but not limited to the maintaining of records of medication and nursing care and the procedures for documenting, actioning, and communicating specialist health care instructions.

Where non conformances are identified going forward, the quality manager and or PIC will determine if further training is required, a personal improvement plan specific to the staff member will be commenced. Failure to meet targets set out in the personal improvement plan will be escalated in accordance with internal disciplinary procedures.

The provider is actively recruiting for additional experienced clinical management staff who will direct and oversee the quality of records and ensure that they are actioned and communicated to the required departments.

The provider has recruited a quality manager who will monitor all operations such as records and where required assist the PIC to audit such records.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider is currently recruiting experienced clinical managers that will lead, advise and manage the development and implementation of a safe quality service.

The provider has engaged the services of an experienced clinical manager on a contract basis to assist the current management team in the implementation of change and bolstering governance and management of the Centre.

New additional audit tools are now in use for the areas of medication management, care planning and environmental hygiene. These are to be utilised by the staff nurses and senior nurse manager who have received training in the rationale and importance of such audits. These audits will be reviewed by the PIC at the end of each month and feedback provided to staff nurses and the provider on a monthly basis. Where staff nurses are not meeting the standards required following training and mentorship by the experienced clinical manager and the quality manager, internal disciplinary procedures will be followed.

Quarterly home audits are to recommence with the pharmacist to audit stock levels and rotation in the home. Weekly medication audits to commence with a new medication audit tool, this will be undertaken by the staff nurses and overseen by the PIC. The use of this audit tool, rationale and accountability have been outlined to staff nurses on a one to one basis. Monthly auditing by the PIC will continue and quarterly audits by the quality manager to support the PIC in a provision of a tiered approach to quality assurance in this area.

Weekly mini audit of weights by SNM/PIC to ensure that correct procedures are in place, MDT input has been received where indicated and that the plan of care has been communicated to all relevant departments. These audits will be reviewed by PIC and end of month and feedback disseminated to the necessary departments at monthly meeting.

Additional housekeeping shifts are in place, one to one guidance has been provided to these staff with regard to the home's procedures and best practice. Housekeeping checklists and the procedures for cleaning of the home have all been reviewed and updated. The aim of the new cleaning procedures is to allow for more targeted and thorough cleaning throughout the home. The updated checklists are more user friendly for the staff and will allow for the senior clinical staff to oversee the cleaning of the home in a more efficient manner ensuring it is meeting the required standard. A meeting has been held with housekeeping staff to ensure they are confident with these changes and to encourage their feedback and collaboration going forward. Where continuous improvement is not evident or deviation from procedures is found on audit internal disciplinary procedures will be followed. This will be communicated to the provider in governance meetings.

The resourcing of staff has been reviewed. Additional staff nurses, health care assistants, housekeeping staff and kitchen assistants have been recruited and will provide contingency staffing in the event of staff absences and unplanned leave.

Seven-day activities schedule is now in place to ensure that a range of meaningful activities are provided, suitable for the resident profile. Younger residents' activities care plans have been reviewed by the PIC and the activities coordinator to provide activities that are more suited to their needs and preferences. Local day centers have been contacted for these residents.

All restrictive practices used in the centre have been reviewed by the PIC which resulted in a reduction in the use of bed rails by 25% One to one guidance will be provided to staff nurses on a person centred approach to the use of restrictive practices and on associated documentation highlighting responsibility and accountability.

To ensure that the home maintains a high standard of holistic person centred care the following measures have been taken:

· Person centred care training is scheduled onsite on the 27-04-2022 and 05-05-2022
· One to one guidance has been provided to the nurses and senior nurse manager regarding the required review of procedures in the home which will ensure a holistic model of care. The staff nurses will now work in separate teams with their own group of residents, they will be responsible for all aspects of care for these residents which will include but is not limited to medication administration, clinical administrative duties, wound care, observations, and specialist health care follow up and communication.
· This revised model of care will be overseen by the senior nursing team and the quality manager support will support the team to provide a high standard of evidence-based care.
· More frequent meetings with all departments to outline audit findings and required actions, encourage discussions and a collaborative approach to quality improvement. Feedback given to provider in governance meetings and any required escalators measures outlined.
· Personal improvement plans to be utilised in all departments to drive forward a culture of continuous improvement.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All complaints regardless of severity will be recorded as per procedure on EpicCare to allow for appropriate actioning, measuring of complainant satisfaction and auditing of complaints for quality improvement purposes.

Regulation 11: Visits	Not Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
All visits to the home are to be facilitated as per the most up to date HPSC guidance. All next of kins/resident representatives and where appropriate residents have been updated regarding visiting guidelines at present. This has been recorded via EpicCare.

Risk assessment has been updated to reflect current guidance.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
A risk assessment for the transcribing of medications is now in place and has been communicated to all relevant staff.

Visiting risk assessment has been updated in line with current guidelines.

Staff Nurses no longer work across the two nursing homes.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Extensive deep cleaning of the home has been completed, fabric armchairs are being recovered in a wipe clean material on a rotational basis, a painting contractor have been engaged to address identified areas of concern.

Additional housekeeping staff have been recruited to facilitate two housekeeping staff each day.

All cleaning procedures reviewed, and one on one guidance provided to housekeeping staff. Cleaning checklists reviewed and updated, new terminal cleaning checklist in place. Housekeeping staff have received guidance on these and monthly staff meetings to be facilitated to allow for feedback, inform of audit findings and quality improvement strategies. All terminally cleaned rooms are to be checked by senior nursing staff and signed off that they have met the required standard. Personal improvement plans and disciplinary procedures will be commenced where required.

Procedure for the correct cleaning and refilling of hand sanitisers updated and communicated, schedule of cleaning updated and put into use. Efficacy of this will be assessed in environmental audit by the contracted clinical manager.

The registered provider has commenced a review of optimal number and location of handwashing sinks in line with current HPSC and WHO guidance.

Procedure for linen has been reviewed and communicated to staff. Experienced clinical manager will conduct environmental audits which will identify any issues with procedures. Any non-compliances will be actioned immediately with findings

communicated in monthly staff meetings. Recurrent non-compliances will be escalated accordingly.

Appropriate storage areas are now in place that are conducive to good infection control practices. PPE is now stored in a designated area.

Appropriate area on the first floor has been identified for installation of new sluice room and associated remedial works. Initial site visit for installation took place 20/04/22.

The cleaning of sluice rooms and use of storerooms have been outlined with housekeeping staff in a meeting held on 14-04-2022.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The provider has commenced recruitment of additional experienced clinical staff who will implement and oversee safe and effective medication management systems and provide quality assurance.

A quality manager who will commence in May 2022 will assist the PIC to monitor systems, conduct audits and drive accountability and action.

A weekly medication management audit tool has been developed and implemented which will be conducted by the named nurses and monitored by the management team. One to one training in the use of this audit has been provided to the nurses and positive feedback obtained. A monthly audit to continue by the PIC until the required standard has been achieved. Pharmacy home audits to recommence on a scheduled basis as was procedure prior to the pandemic. Quarterly audit by the quality manager to support service improvements. An annual audit by the PIC has been developed and implemented also to encompass procedures and ensure they are in line with current best practice. Findings and required actions will be feedback to staff in monthly meetings.

One on one guidance provided to all nurses regarding medication management procedures, medication error procedure and accountability. Non conformance will be escalated by PIC through personal improvement plans and disciplinary procedures where indicated.

Medication error and near miss procedure updated to include reflective practice and retraining when required.

Medication procedures reviewed by PIC and pharmacist, procedure for ordering and returning of medications that had changed during the pandemic has now recommenced

preventing a build-up of excess stock and a timely return of medications that are no longer required. All excess stock and unrequired controlled drugs have been returned to the pharmacy.

Pain assessment and care planning procedures outlined with staff nurses on a one-to-one basis to ensure confidence and clarity.

Insulin administration and storage SOP in place and has been communicated to staff nurses.

Transdermal patch SOP updated and communicated to staff nurses.

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 registered provider identifies the need for additional experienced clinical management staff who can provide guidance, knowledge and promote evidence-based practice. The provider is actively recruiting for additional management staff an experienced clinical manager has been recruited to oversee current actions.

One to one guidance is being provided to nursing staff in the area of care planning, going forward the quality manager will identify and escalate training gaps in this area and support the PIC where required.

The "Getting to Know You" document is currently under review and following completion care planning procedures will include the incorporation of this information. This will be introduced to staff nurses in a meeting on 3rd of May 2022

Named nurses are being trained to audit their own care plans on a weekly basis, a care plan audit tool is being developed to facilitate this to ensure it can identify gaps but be completed efficiently. Monthly auditing by the PIC to ensure a holistic model of care. Quarterly auditing by the Quality manager for quality to identify further training needs or non-conformances by the named nurses.

Regulation 6: Health care	Not Compliant

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

Procedures following a residents return from hospital reviewed to ensure that medical notes and information received is reviewed by SNM/PIC within 48 hours post return to ensure correct follow up and communication of care. Weekly SNM meeting with PIC on resident clinical care and actions.

Weekly mini audit of weights by SNM/PIC to ensure that correct procedures are in place, MDT input has been received where indicated and that the plan of care has been communicated to all relevant departments. Quarterly audit by quality manager to ensure evidence-based practice.

Weekly care plan audit by the named nurses, monthly audit by the PIC. Quarterly care plan audit by the quality manager. Feedback provided in monthly staff meetings and plan for following month provided.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Training in managing behaviours that are challenging has been provided to staff by an external provider in house. Further training in this area will be provided to staff on the 27-04-2022 and 05-05-2022 in the Person Centred Care Training sessions.

One to one guidance in this area to be provided to all staff nurses so that they can provide assurances that they are confident in the home's procedures, alternative techniques used prior to the administration of psychotropic medications. This will also cover effective and holistic care planning in this area.

All restrictive practices have been reviewed and the use of bed rails have been reduced by 25% since inspection.

Staff nurses will be provided with on to one guidance by an experienced clinical manager on the use of restrictive practices the homes procedures ensuring that they are used as a last resort and holistic care planning in this area encompassing best practice. Monthly meetings with PIC and staff nurses will present potential targets for working towards a restraint free environment.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: All residents are offered a choice of GP on admission and staff endeavor to facilitate this choice however there are limitations with local to GPs to the number of new patients that they can accept. Going forward GP choice will be addressed during the preadmission assessment.

Breakfasts are served to residents as per their request or the request of their nominated representative or due to the need of the resident.

Activities schedule is now in place seven days per week.

The "Getting to know you" document is currently under review in collaboration with the Activities Coordinator. Following completion of this, the document will be utilised during care planning procedures to guide staff on how to provide appropriate activities and meaningful engagement.

All local day centres have been contacted for residents who wish to avail of them, as they are currently full, referrals will be sent to place residents who are interested on their waiting lists. This option will also be incorporated into the updated "Getting to Know You" document that is completed on admission.

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 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Not Compliant	Orange	09/04/2022
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	02/05/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	31/05/2022

	have access to appropriate training.			
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	31/05/2022
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	31/07/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	02/05/2022
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated	Substantially Compliant	Yellow	22/04/2022

	centre.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Red	28/02/2022
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Red	28/02/2022
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and	Not Compliant	Red	28/02/2022

	disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	28/02/2022
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in	Substantially Compliant	Yellow	28/02/2022

	response to a complaint.			
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	31/05/2022
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Not Compliant	Orange	01/05/2022
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	05/05/2022
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance	Not Compliant	Orange	05/05/2022

	with national policy as published on the website of the Department of Health from time to time.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	02/05/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	02/05/2022
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	22/04/2022