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:	Tymon North Community Unit
Name of provider:	Health Service Executive
Address of centre:	Tymon North Road, Tallaght, Dublin 24
Type of inspection:	Unannounced
Date of inspection:	18 October 2021
Centre ID:	OSV-0007793
Fieldwork ID:	MON-0034545

About the designated centre

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

Tymon North Community Unit opened in March 2020. The centre can accommodate 48 residents, primarily for male and female dependent older persons, over the age of 18 years. The following categories of care are provided: Long-term residential and respite specific care needs catered, general nursing care, active elderly, frail elderly, dementia/Alzheimer's, physical disability, intellectual disability, psychiatry of old age, and general palliative care.
There are three floors in Tymon North Community Unit, the ground floor accommodates the day care and other rooms, 1st Floor has two units namely Clover and Primrose and the second floor has two units named as Cherry blossom and Bluebell. and is located centrally with local services in reach, e.g. frequent bus routes, community centre, Tymon Park, local library shops and a pub is nearby. Tymon North Community Unit provides a residential setting wherein residents are cared for, supported and valued within a care environment that promotes the health and well being of residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	39

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 18 October 2021	08:30hrs to 17:30hrs	Margaret Keaveney	Lead

What residents told us and what inspectors observed

From what residents told the inspector and from what was observed throughout this one day inspection, it was evident that residents were content living in Tymon North Community Unit. The inspector observed that there was a calm and tranquil atmosphere within the centre and residents spoken with expressed great satisfaction with the staff and the service provided to them. Those residents who could not articulate for themselves appeared relaxed, and it was evident that staff took care in dressing and attending to the personal care of residents who could not perform such activities unassisted.

On arrival to the centre the inspector was met by a receptionist who guided them through an infection prevention and control procedure which included the wearing of a mask, temperature monitoring and the completion of a COVID-19 health questionnaire. Throughout the inspection, the inspector observed that staff were compliant with COVID-19 standard precautions, with face masks worn correctly and good hand hygiene practices observed.

Following a short opening meeting, the inspector was accompanied on a tour of the premises by the director of nursing (DON) who had recently started in their role in the centre. During this walk-around, the inspector observed that a number of residents were up, dressed and ready for their day. Many were seated in the dining rooms enjoying their breakfast, while others chose to be served breakfast in their bedrooms.

The centre is laid out over two floors, with administration offices and a day care centre on the ground floor and residents' bedrooms and communal areas on the first floor. The entrance foyer of the centre was decorated with bright photographic murals of famous Dublin landscapes for residents' enjoyment.

The design and layout of the centre supported the free movement of residents throughout, with wide corridors, armchair seating at corridor ends and clear signage to communal areas. The centre was warm, bright, well-maintained and appeared clean. Residents' day rooms were comfortable, bright spaces and were seen to be well equipped with activity items, such as books, board games and arts and crafts equipment, for use during group activities or as and when residents chose. The inspector observed that staff had gone to great efforts to attractively decorate these rooms for the upcoming Halloween festivities. The inspector was informed that the director of nursing was proposing to add additional indoor plants to communal areas in order to assist with air purification and add a sense of homeliness within the centre. Residents had access to a spacious balcony garden and to an enclosed courtyard garden. Both were set out with seating and planted raised beds for residents to enjoy. The inspector was informed that it was planned that next spring each resident, and their family, would be invited to plant a section of the raised beds, in an effort to enhance their sense of being at home in the centre.

Residents' bedroom accommodation comprised of 40 single and 4 twin, ensuite bedrooms. One resident spoken with expressed great delight with their walk-in shower facilities, and said that cleaning staff were 'very hardworking' and that their bedroom was cleaned daily. The use of decorated, privacy screens in twin bedrooms added to the sense of comfort and homeliness in these bedrooms and also ensured that the privacy and dignity of residents was protected. The inspector saw that there was sufficient wardrobe and locker space in residents' bedrooms and that each had a television for entertainment. However, the inspector observed that residents were not provided with a unit that could be locked, in which to store their valued possessions. The inspector saw that residents were supported to personalise their bedrooms, with family photographs, bed throws and indoor plants, to help them feel at ease in the home.

During the inspection, the inspector spoke directly with four individual residents. Overall feedback from those residents was that they felt safe living in the centre and that the staff who delivered their care were kind and considerate. They said that staff were approachable and would address any concerns brought to their attention. One resident described the staff as 'very helpful but not intrusive'. Staff were observed to speak with residents in a friendly and unhurried manner. The inspector also observed staff assisting residents gently and respectfully. For example staff were seen knocking on resident's bedroom doors prior to entering.

Mealtimes were seen to be a relaxed occasion. Staff assisted residents, in need of support during mealtimes, in a kind and patient manner. Residents spoken with voiced great satisfaction with the food provided to them, with one resident commenting that 'the food is very tasty' and that staff were familiar with their likes and dislikes. A choice of menu was offered to residents daily, with staff discussing the menu with residents the day before the choice was available. Residents could choose to dine in any of the communal areas or in their bedrooms. The inspector observed that residents were offered snacks and drinks throughout the day, and fresh water was available in jugs throughout the centre for resident's enjoyment.

Throughout the day, residents were observed to participate in a range of one to one and small group activities which included music, games and bingo. Staff were seen spending time with residents on a one to one basis, accompanying them on walks and assisting them to complete a drawing and chatting and reminiscing.

The inspector observed that visitors arriving to the home adhered to appropriate infection prevention and control measures. They were received by residents in a number of comfortable and private designated visitors' areas. The inspector spoke with three visitors who were very complimentary of staff in the centre, with one visitor stating that staff were 'highly caring' and that communication from staff to families throughout the COVID-19 pandemic had been frequent and clear and that they were very grateful for this. Another visitor informed the inspector that they visited their family member daily and were always made to feel welcome by staff.

Staff spoken with were knowledgeable of their role and reported that they were well supervised and supported. Although the Director of Nursing had recently only assumed their role in the centre, the inspector observed that they were familiar with

many of the residents and their interests, and that many residents were familiar with them by name.

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 on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection to monitor compliance with regulations and to follow up on solicited and unsolicited information submitted to the Chief Inspector of Social Services. Overall, the inspector found that residents received a good standard of care that met their assessed needs. There were systems in place to ensure that residents had access to healthcare and that residents lived as independently as possible. However, improvements were required to ensure that robust management systems were in place to monitor and review the quality and safety of care delivered to residents, that staff were well supervised and that guidance was in place to respond to unexpected emergencies.

Tymon North Community Unit is operated by the Health Service Executive. There is a clear organisational structure within the centre. The provider had assigned the general manager for Community Healthcare Organisation 7 (CHO7) as the person with responsibility for senior management oversight of the service. On the day of the inspection, the director of nursing was acting as the full-time person in charge, as their application for this role was under review by the Health, Information and Quality Authority. Normally the person in charge reports directly to the general manager and is supported in their role by two assistant directors of nursing, two clinical nurse managers (CNMs), staff nurses and care staff.

While the provider had adequately resourced the centre, they did not have sufficient governance and management arrangements in place to consistently monitor and review residents' care and the service provided to them. The inspector was provided with evidence that the general manager had identified this significant gap in the oversight of the service, and that a new management meeting format and schedule had commenced in the month prior to the inspection which, when fully established, would systematically inform the provider of the care being provided to residents and any opportunities for quality improvement within the centre. The provider had not completed a review of the service for 2020.

The inspector was not assured that the provider had adequate arrangements in place to appropriately manage and respond to a further outbreak on the centre. Discussions with the general manager indicated that this had been identified in a recent review of the infection prevention and control documents and plans were in place to update the contingency plan to reflect the most recent advice from the

Health Protection and Surveillance Centre (HPSC).

The statement of purpose described the centres' objectives and services provided. However, it required updating to ensure that it accurately reflected the registration conditions under which the designated centre was currently operating.

There were adequate staffing resources available to ensure that care was provided in accordance with the centre's statement of purpose and to meet the assessed needs of the 39 residents living in the centre. During the inspection, staff were observed to know the residents well and to provide dignified and person centred care to them. The inspector was informed that a recruitment campaign was planned to address gaps in planned, permanent staffing levels, which were currently being filled by agency staff.

Staff had access to mandatory and supplementary training, which included infection control, safeguarding, manual handling, fire training and wound healing. The inspector saw from training records reviewed that refresher training in safeguarding had been completed by all staff following the recent reporting of an alleged safeguarding incident to the Chief Inspector of Social Services. Staff spoken with demonstrated a good knowledge of the complaints and safeguarding procedures. Records evidenced that there was a robust induction programme in place for all new staff. However, there was no appraisals systems in place for staff, to determine if they required additional training and professional development to improve the outcomes for residents living in the centre.

The inspector reviewed the complaints log which evidenced that complaints received in 2020 and 2021 were well managed and responded to. Two complaints remained open on the day of the inspection and the inspector observed that the management team continued to engage with the complainant and update them on the complaint investigation. Inspector observed that some complaints had to lead to improvement in the service provided, such as the introduction of colour coded dirty laundry bags in the centre. Residents and family members spoken with told the inspector that they knew how to make a complaint if needed and felt comfortable and supported by all staff to do so.

Regulation 15: Staffing

On the day of the inspection there was a sufficient number of staff available, with the appropriate skills, to meet the assessed individual needs of the 39 residents living in the centre, and the size and layout of the centre.

The rosters reviewed showed that there was a nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

While staff were appropriately supervised when completing their day to day duties, there were no arrangements in place to ensure that staff were provided with adequate supervision and appraisal to improve care provision for the residents living in the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improvements to the overall governance and management systems in the centre were required, in order to ensure that the provider had clear oversight that safe, appropriate and consistent care was being delivered to residents in the centre. For example:

- The inspector was not assured that the provider had appropriate oversight that the care being delivered to residents and the resources in the centre were sufficient to meet the needs of the residents. For example, there was no evidence that the provider regularly met with the centre's management team to discuss the care and needs of the residents.
- The inspector was not assured that adequate monitoring systems were in place to ensure that a safe and quality service was being consistently delivered to residents. For example, there was no evidence that audits on key areas of the service had been completed, such as those on nutrition and falls.
- The centres' COVID-19 contingency plan did not reflect the most recent guidance from the Health Protection and Surveillance Centre (HPSC).
- Although the provider had completed a comprehensive COVID-19 review report following a significant outbreak in the centre that began in April 2020, learning from risks identified during this review had not been included in the centres' current COVID-19 contingency plan.
- The provider had not completed an annual review report of the service in 2020, and residents and their families' views on the service had not been sought. Therefore, potential improvements to the service had not been identified by the provider.

Judgment: Not compliant

Regulation 3: Statement of purpose

The current version of the centre's statement of purpose did not contain the correct

information set out in the Certificate of Registration.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure in the centre. This was displayed in the entrance to the centre. There was a nominated person who dealt with and oversaw the management of complaints received. There was evidence of effective management of the complaints with the satisfaction level of the complainant recorded.

Judgment: Compliant

Quality and safety

Overall, residents in the centre were supported and encouraged to have a good quality of life. Residents were facilitated to access health services, and to make choices about their daily routines and activities. However some improvements were required in care planning, in providing opportunities for residents to participate in the organisation of the service and in risk management within the centre.

The inspector reviewed documentation related to the care of seven residents. Pre-admission assessments were completed to gather information about residents' needs prior to their move to the centre. Following their admission, care plans for residents were developed and informed by a number of clinical assessments, including those on mobility, nutrition, cognition and skin care. Although many of the care plans reviewed were person centred with evidence that they had been developed with the resident, or where appropriate their family, the inspector observed that as residents' care requirements changed, not all care plans had been updated accordingly. Such gaps in care planning meant that staff were not sufficiently guided on how to safely care for these residents, and that residents' care needs could not be appropriately evaluated and reviewed to inform continuity of care.

A general practitioner (GP) visited the designated centre daily and a physiotherapist was available to attend to resident's needs five days per week. Residents had access to a number of community based allied health professionals through a referral system, including dietetics, occupational therapy and speech and language therapy. GP and allied health interventions were documented in resident records. The director of nursing promoted residents' education on their health matters, with large posters displayed throughout the centre on the importance of regularly drinking

water and hydration.

The provider had in place adequate facilities and resources to support recreational activities for residents. The activities programme was scheduled over seven days and included ball games, arts and crafts, music and poetry and newspaper reading. Many residents were observed to partake in group and one-to-one activities during the inspection and a number of residents spoken with said that they particularly enjoyed the daily bingo sessions at which small prizes were awarded. The inspector observed that staff engaged with residents in a positive and supportive manner and were seen to knock and announce their presence before entering resident's bedrooms. Residents had access to telephones, newspapers and televisions, and the provider facilitated their right to vote at national and local elections. There were arrangements in place for residents to access an advocacy service.

However, the inspector was not assured that residents' rights to be consulted about and participate in the organisation of the designate centre were being sufficiently met by the provider. The centre's Statement of Purpose stated that a residents' meeting was to be held every 12 weeks, however, the inspector observed that only one residents' meeting, per unit, had been held in the 12 months prior to the inspection. There was also a lack of documentary evidence that residents' opinions on the quality of the service provided had been sought and acted upon since the last inspection, for example by means of satisfaction surveys. However, the inspector was told that a survey on the service had been issued to residents in early October 2021 and that the results would be included in the annual review report for 2021.

The registered provider ensured that visits by residents' family and friends were facilitated seven days per week. There was no requirement to book visits in advance. Reception staff ensured that a record of all visits was maintained and that visitors completed appropriate infection prevention and control measures on arrival to the centre. Residents received visitors in a number of dedicated rooms within the centre, including the balcony and enclosed garden when the weather permitted. Visitors spoken with expressed great satisfaction with the visiting arrangements in place.

The centre had a risk management policy in place, which included the risks specified under regulation 26. However, the inspector saw that the policy addressing the risk of accidental injury to residents, visitors and staff, still referred to the old centre at St Brigids Crooksling. This was also a finding during the last inspection. The provider had identified and developed appropriate risk assessments on clinical, service and environmental risks pertinent to the centre and there was a Safety Statement in place that had been recently updated. Nonetheless, the inspector found significant gaps in the providers' risk management measures for the centre, and was not assured that there were adequate arrangements in place to sufficiently protect residents from the risk of harm. This will be further discussed under regulation 26 below.

The person in charge worked closely with the cleaning supervisor to ensure that there was effective oversight of infection prevention and control procedures within the centre. The centre appeared to be clean, and completed cleaning schedule

records were viewed by the inspector. There were sufficient hand hygiene stations and sinks throughout the designated centre. Cleaning trolleys were well organised and housekeeping staff who spoke to the inspector were knowledgeable about good infection prevention and control procedures. Inspectors saw evidence that bedpan washers were serviced regularly. There were processes in place to ensure that all staff adhered to infection prevention and control procedures on entering the building.

Regulation 11: Visits

The inspector found that the person in charge ensured that the latest guidance from the Health Protection Surveillance Centre on visiting to residential services was being followed, with infection prevention and control measures in place to ensure that residents safely received their visitors.

There was sufficient space for residents to meet visitors in private within the designated centre.

Judgment: Compliant

Regulation 26: Risk management

The inspector was not assured that the provider had effective arrangements in place to protect residents from the risk of harm. For example, the following was noted during the inspection:

- The provider did not have an emergency plan in place to respond to major incidents such as power outages, flooding and gas leaks.
- There were no formal arrangements in place for the investigation and learning from serious accidents and incidents involving residents in the centre. For example, the Health and Safety Committee, who were tasked with incident and accident oversight, had not met within the last 12 months. Also there was no evidence that investigations were completed following an incident to ensure that any risks were identified and managed.

Judgment: Not compliant

Regulation 27: Infection control

There was effective management and monitoring of infection prevention and control practices within the centre, with regular auditing of practices. Staff were observed to

adhere to good hand hygiene practices and to appropriately wear personal protective equipment to minimise the spread of infection in the service.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The inspector observed that for a number of residents, care plans had not been developed or updated as the resident's care needs changed. For example, one residents' nutrition care plan had not been updated to include nutritional care advice issued by a dietitian following a recent review. The inspector also observed that although a risk assessment on smoking had been completed for one resident, a smoking care plan had not subsequently been developed.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provided ensured that residents had appropriate access to medical and healthcare services through regular visits from the GP and reviews and referrals to allied health professionals as required.

Judgment: Compliant

Regulation 9: Residents' rights

Residents did not have sufficient opportunities to be consulted about and participate in the organisation of the centre. For example, the provider did not facilitate regular resident meetings or surveys, to allow residents to express their wishes and preferences on the quality of the service provided.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Tymon North Community Unit OSV-0007793

Inspection ID: MON-0034545

Date of inspection: 18/10/2021

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: The following arrangements have been applied to ensure that staff were provided with adequate supervision and appraisal to improve care provisions for residents 1) A Personal Development Plan and Performance Appraisal for staff initiated with management that will be progressed to all other staff, targeted for completion by the end of February 2022. A key focus of the training needs analysis during appraisals process is to take into account the needs of the residents 2) Engagement with external agencies e.g. NMPDU, INMO to provide training on Care Plan –targeted for Feb 2022 with ongoing reviews 3) Ensuring adequate skill mix through staff delegation and staff off duties. 4) Ongoing application of an induction programme of new staff and agency staff. 5) Nursing handovers with periodical supervision from nursing administration and weekly case discussion.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1) Monthly face to face meeting with DON and represented registered provider to discuss care needs of residents. This is supported by weekly reports from the DON to representative provider to discuss the care needs of the residents. MDT meeting every Thursday with a member of nursing administration to attend. 2) Copy of MDT meetings and outcomes given to the Director of Nursing. A new MDT	

form developed.
3) Nutrition audit completed on the 18/11/21.
4) Falls audit completed on the 18/11/21.
5) Night CNMs are tasked with documentation audits. Auditing schedule in place and will be monitored by nursing admin.
6) COVID 19 contingency plan updated to reflecting the most recent HSPC guidance and learnings on risks identified during the COVID-19 review report linked to the previous outbreak within the centre in April 2020
7) Resident surveys completed with the analysis to be included in the 2021 annual review report. 8) Advocacy services/Your service Your say Posters with contact details displayed throughout the unit.
9) Suggestion boxes are provided throughout the services which are checked weekly to capture complaints and compliments beginning 28/11/21
10) Engagement with Patient Advocacy Services to ensure information on service provision are made available to resident and families initiated on the 18/11/21.
11) Annual Review Report 2021 of the service will to capture residents and families views on service improvements for the units targeted for completion January 2022.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Statement for purpose updated to ensure that it reflects the registration conditions under which the designated centre is currently operating.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
1) Emergency plan has been updated to reflect major incidents, which captures arrangements with local suppliers to assist in emergency to provide food and shelter.
2) An update on formal arrangements for investigations and learnings from serious incidents/accidents to protect residents from harm
a. Critical incident reviews completed on the 24/8/21 on two serious incidents. Corrective measures implemented post review. ISBAR communication implemented. Safety pause is used during handover.
b. Health and safety committee reconvened to meet monthly to discuss issues to resolve issues to support the CHO7 Health and Safety Officer. The Health & Safety Committee

will meet with the Quality Patient Safety (QPS) Committee on a quarterly basis.
c. New health and safety representatives to complete a refresher course in Feb 2022.
d. CHO 7 health and Safety officer completed a walk around on the unit on 29/11/21. This resulted in the completion of a local health and safety checklist for staff.
e. Investigations are completed following incidents to ensure that any risks are adequately identified and managed.

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:
1) Documentation checklist developed and implemented to ensure care plans are updated based on changing resident's care needs.
2) Nursing metrics audit implementation plan with NMPDU in progress.
3) Care plan training for nurses planned for Feb 2022.
4) Care plan audits and a review audit in 2 weeks post initial audit to see the level of recommendation compliance introduced in Nov 2021, A key focus is to ensure care plan reflect residents up dated care needs.
5) A smoking care plan developed in line with existing risk assessment on smoking
6) All nurses to read and sign recordings on clinical practice guidance from NMBI.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Initiatives introduced to improve opportunities for residents to be consulted on the service
1) Client satisfaction surveys carried out in October 2021 with a commitment to complete on annual basis.
2) Residents and family forum established to meet on a quarterly basis.
3) Residents and family facilitated to meet with Patient Advocacy Service representative independently on the 18/11/21.

Initiative to enable residents' to express their wishes and preferences on the quality of the services
1) The catering manager has developed and implemented a menu satisfaction questionnaire for residents. A key focus is to capture resident's feedback on newly introduced menus. Residents' survey generated a 85% satisfaction rate with the 15% dissatisfaction rate reflected more variety on menu.

2) New menu with more options and varieties to be introduced 6/12/21.
3) A catering circle meeting will be introduced with catering manager, ward CNM, household assistant and residents once every two months commencing from 15/12/21.

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	28/02/2022
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	18/11/2021
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under	Not Compliant	Orange	31/01/2022

	section 8 of the Act and approved by the Minister under section 10 of the Act.			
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Orange	30/11/2021
Regulation 23(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the Chief Inspector.	Not Compliant	Orange	31/01/2022
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 centre.	Substantially Compliant	Yellow	30/11/2021
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or	Not Compliant	Orange	30/11/2021

	adverse events involving residents.			
Regulation 26(2)	The registered provider shall ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.	Not Compliant	Orange	22/11/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	15/11/2021
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	01/12/2021
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and	Substantially Compliant	Yellow	01/12/2021

	participate in the organisation of the designated centre concerned.			