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:	Mooncoin Residential Care Centre
Name of provider:	Mooncoin Residential Care Centre
Address of centre:	Polerone Road, Mooncoin, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	13 July 2023
Centre ID:	OSV-0000254
Fieldwork ID:	MON-0040650

About the designated centre

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

Mooncoin Residential Care Centre is a purpose-built two-storey premises, which provides residential care for 78 people on the ground floor. The centre can accommodate both male and female residents, for long-term and short-term stays. The centre caters for residents of all dependencies, low, medium, high and maximum, and 24 hour nursing care is provided.
In total there are 74 single and two twin bedrooms. All bedrooms have full en-suite facilities. Various communal areas are located around the centre which is surrounded by well maintained grounds including a secure garden area and courtyard.

According to their statement of purpose, Mooncoin Residential Care Centre aims to provide the highest quality of residential care in a happy and homely atmosphere in which each resident feels cared for, comfortable and content. They aim to provide a home away from home, with a highly professional care service, where staff promote individuality and encourage residents to enjoy the company of friends and companions.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	65

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
Thursday 13 July 2023	09:45hrs to 17:20hrs	Bairbre Moynihan	Lead
Thursday 13 July 2023	09:45hrs to 17:20hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

Inspectors greeted and chatted to a number of residents in the centre to gain an insight into their experiences of living in Mooncoin Residential Care Centre and in more detail to five. Overall, residents were very positive about how they spent their days in the centre. Residents spoke very positively about staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. Residents informed inspectors that there was enough staff available to meet their needs and always came to them when they called. From what inspectors observed, there was evidence that the residents had a good quality of life in which their independence was promoted.

Inspectors arrived in the morning for an unannounced inspection following an application by the registered provider to renew the registration of the centre. Inspectors were greeted at the entrance by a staff member. Following an introductory meeting with the person in charge inspectors were guided on a tour of the premises.

On the morning of inspection, residents were up and about, some were reading the daily newspapers, some were relaxing in their bedrooms. A small number of residents who spoke to an inspector stated that they preferred to remain in their bedrooms.

Mooncoin Residential Care Centre is registered to accommodate 78 residents with 65 residents on the day of inspection. The centre operated as three units - Elm and Hawthorn, Ash and Oak and Beech and Sycamore. The centre had 74 single en-suite rooms and two twin en-suite rooms. In addition, residents had access to two assisted bathrooms which had decreased by one since the last inspection. Communal space was available for each of the three units however the majority of residents were congregating in the main sitting room and Sycamore sitting room. The environment was well maintained and exceptionally clean. The corridors were sufficiently wide to accommodate walking aids and handrails were installed in all circulating areas. The layout and the signage in the centre helped to orientate residents and facilitate them to move around the building independently. The inspector observed that the corridors were decorated with pictures. The bedrooms were homely and very personalised. Some residents had brought in their personal furniture and memorabilia. Many residents had pictures of their families framed in their rooms.

The registered provider had employed 1.5 WTE (wholetime equivalent) of activities co-ordinators. Activities were available for residents six days a week. Activities observed on the day of inspection included a sensory class in the morning, exercises with the physiotherapist and choir practice in the afternoon. Inspectors also observed one to one activities taking place. A "glam day and spa day" was planned for the day after inspection and residents spoke about the summer party that was planned. Residents had recently taken part in a documentary called the "Hands

project" which is online for public viewing. An activities timetable was on display in the centre and up to date and activities were displayed on a white board at the entrance to the centre. Residents had access to an enclosed garden and courtyard. Raised flower beds were in place in the enclosed garden. Gardening had commenced at the request of the residents at a residents' meeting. The hairdresser attended the centre on a Thursday. WiFi was available for residents and six newspapers were provided daily.

The dining experience was observed. Residents attended the dining room or the Elm sitting room for lunch. The dining room was busy. Residents reported that the food was very good and that they were happy with the choice and variety of food offered. Some residents commented that they got something different every day. Residents requiring a modified diet were provided with the same choice. Staff were available to assist residents who required assistance and this was provided in a relaxed, discreet and unhurried manner. Outside of mealtimes residents were provided with drinks and snacks. The chef had good system in place for the oversight of residents' dietary needs. In addition, management updated the catering staff on resident's who were losing weight.

The next two sections of the report present the findings of this inspection in relation to governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection carried out to further inform the application received to renew registration of the centre. Inspectors found that the registered provider was operating the designated centre in breach of the centre's conditions of registration. Inspectors identified that the registered provider had made changes to the configuration of the designated centre as set out specifically in Statement of Purpose within the footprint of the designated centre on the floor plan declaration. The registered provider is required to only provide services, within the facilities as set out the Statement of Purpose, as agreed with the Chief Inspector at the time of registration. Any changes to services provided must be agreed in advance with the Chief Inspector. The inspectors reviewed the areas that had changed use and also the impact on residents with regard to space following the above modifications.

The previous monitoring inspection on 30 November 2022 indicated that storage was an issue for the designated centre with multiple findings of inappropriate storage observed during inspection. The inspectors found that these issues had not been addressed and were further exacerbated by the changes to the centre that had been made by the registered provider.

Mooncoin RCC Limited was the registered provider for Mooncoin Residential Care Centre. There was a clearly defined, overarching management structure in place and staff were aware of their individual roles and responsibilities. The management team

and staff demonstrated a commitment to continuous quality improvement through a system of ongoing monitoring of the services provided to residents. The centre was well-resourced, ensuring the effective delivery of care to residents.The Person in Charge worked full time in the centre and was supported by an assistant person in charge who was supernumery, one clinical nurse manager and team of nursing, caring, activities, housekeeping, catering, administration, accounts and maintenance staff.

The registered provider had a training matrix in place. Staff had access to mandatory training and management had good oversight this. A week of training was scheduled four times a year with the next date planned for 4 September 2023. During this time the number of staff on annual leave was reduced to facilitate staff training. The majority of staff had completed safeguarding training and infection prevention and control training. The person in charge and the assistant director of nursing had recently completed designated officer training with the HSE for safeguarding. In addition, the centre had a train the trainer in manual handling and a small number of staff had undertaken training in palliative care. The clinical nurse manager oversaw the induction of new staff. Gaps were identified in restrictive practice training, however, this was only recently identified as being mandatory for staff and the gaps were being addressed at the next training week in September.

The annual review of the quality and safety of care was completed for 2022. The review outlined aims for 2023 which were aligned to the themes of the National Standards for Care Settings in Older People in Ireland. There were good management systems in place to monitor the quality and safety of the service. A schedule of clinical and environmental audits evaluated key areas such as infection control procedures, residents' documentation and medication management. The quality of care was monitored through the collection of weekly data, such as monitoring the use of antibiotics and psychotropic medications and the incidence of wounds and falls. Analysis of the information gathered through these systems was used to inform the development of quality improvement plans. Audits and improvement plans were discussed at the quality and safety committee meetings and at wider staff meetings across all departments, which were held regularly. Systems of communication were strong with minutes of these meetings evidenced a sharing of information with all staff. Incidents were reviewed and all requiring reporting to the office of the chief inspector were notified as required. The majority of incidents were falls related. Trending of these was completed through a falls audit.

The complaints procedure was updated to include the changes required under S.I. 628 of 2022 and this was displayed prominently in the centre. The record of complaints was reviewed by the inspector. These records identified that complaints were recorded and investigated in a timely way and that complainants were advised of the outcome of their complaint. A record of the complainant's satisfaction with how the complaint had been managed was also documented.

Regulation 14: Persons in charge

The person in charge worked full-time in the centre. She had the necessary experience and qualifications to fulfill the regulatory requirements of the role.

Judgment: Compliant

Regulation 15: Staffing

Following a review of staffing rosters and the staff on duty during the inspection, inspectors found that staffing levels and the current skill-mix were sufficient to meet the assessed needs of the residents.

The provider was informed on the inspection that the current arrangement whereby not all bedroom door had automatic closers in the event of a fire alarm sounding would need to be kept under review to ensure the timely evacuation to a place of safety in a fire emergency.

Judgment: Compliant

Regulation 16: Training and staff development

While the registered provider and management had good oversight of staff training. A small number of gaps were identified. For example;

- 13 staff fire training was out of date.
- 12 staff had not completed training in managing behaviours that challenge within the previous two years.
- The centre had commenced training in restrictive practices which was mandatory for staff. Training was ongoing to ensure all staff were training. 42 staff training was outstanding at the time of inspection.
- Six staff training in safeguarding was out of date.

Judgment: Substantially compliant

Regulation 19: Directory of residents

An updated directory of residents was maintained in the centre. This included all of

the information as set out in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that the registered provider was operating the designated centre in breach of the centre's conditions of registration.

Areas requiring action were identified to ensure the service provided is safe, appropriate and effectively monitored:

- The registered provider had made changes to the configuration of the designated centre as set out specifically in the Statement of Purpose within the footprint of the designated centre on the floor plan declaration. The registered provider is required to only provide services, within the facilities as set out the Statement of Purpose, as agreed with the Chief Inspector at the time of registration. Any changes to services provided must be agreed in advance with the Chief Inspector. The inspectors reviewed the areas that had changed use and also the impact on residents with regard to space following the above modifications. Inspectors identified that:
    - A clinical store room was now in place of a day room
    - A sluice room was now in place of an assisted bathroom (in the Oak Unit);
    - An office was now in place of a hoist & wheelchair storage area (opposite the Sycamore Sitting room);
    - Store room 12 was now in place of a sluice room.
- In the absence of a decision of the chief inspector such action was not appropriate and should not have taken place. The chief inspector was looking for assurance that all due care and consultation was given to residents regarding decisions made about their home and the processes underpinning the application to renew the registration of the designated centre, however, this was not available.

The registered provider and person in charge failed to assess the impact on space for residents from the reconfiguration.

- While management systems were in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored, the registered provider and person in charge had shown a lack of understanding of their statutory responsibilities regarding residents' rights and consultation as referenced in other areas of this report.
- The provider had failed to address findings of the previous monitoring inspection on 30 November 2022 that indicated storage was an issue for the designated centre with multiple incidences of inappropriate storage found

again during this inspection.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspector reviewed a sample of residents' contracts of care. These were agreed on admission to the centre and they detailed the services provided to each resident whether under the Nursing Home Support Scheme or privately. The type of accommodation was stated along with fees, including for services which the resident was not entitled to under any other health entitlement.

Judgment: Compliant

Regulation 31: Notification of incidents

All incidents were notified to the Office of the Chief Inspector within the required timeframes.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints officer and appeal's officer for complaints had not completed suitable training at the time of inspection to deal with complaints in accordance with the designated centre's complaints procedures.

Judgment: Substantially compliant

Quality and safety

Overall, residents were supported and encouraged to have a good quality of life. Residents' needs were being met through very good access to healthcare services, opportunities for social engagement and, overall, a premises that met their needs. The quality of residents' lives were enhanced by the provision of a choice of interesting things for them to do during the day. The inspector found that a ethos of respect for residents was evident. The inspector saw that residents appeared to be

very well cared and residents and relatives gave very positive feedback regarding all aspects of life and care in the centre.

Staff supported residents to maintain their independence where possible and residents' healthcare needs were well met. Residents had comprehensive access to general practitioner (GP) services, to a range of allied health professionals and out-patient services. There was evidence that residents had access to other allied healthcare professionals including, speech and language therapy, physiotherapy and occupational therapy. Overall, residents expressed satisfaction with the healthcare service provided. Staff consulted with residents and their next-of-kin regarding all aspects of care.

Overall, the inspectors found that the premises was very bright, clean with an ongoing painting programme in place. Since the last inspection corridors were painted and the registered provider was in the process of painting the compartment doors a different colour. New flooring was installed in the dining room and the registered provider replaced the dining room table cloths. The centre met the required 4 m2 of communal space for residents. However, as discussed earlier in the report communal space for residents was replaced with a clinical store room.

The centre had an up-to-date infection control policy in place. The assistant director of nursing was the dedicated infection prevention and control link nurse and had undertaken an infection prevention and control post graduate qualification. The role of the link nurse included for example; environmental audits. Housekeeping staff had received cleaning training since the last inspection and a member of the housekeeping team described to an inspector the learning from the training. The infrastructure of the onsite laundry supported the functional separation of the clean and dirty phases of the laundering process. This area was well-ventilated, clean and tidy. Notwithstanding the good practices, improvements were required in regulations 17 and 27.

An issue identified on previous inspections was the absence of automatic fire door closers to bedroom doors. The provider had given assurances to the Office of the Chief Inspector with regard to managing the risk in their compliance plan response to the most recent inspection carried out on 30 November 2022. Previous to this inspection, the issue of absent door closers had been accepted on the basis of procedures in place to close doors during evacuation and the granted fire safety certificate reports. The provider had submitted a fire safety audit and action plan to the Office of the Chief Inspector, including ongoing actions in Personal Emergency Evacuation Plans (PEEPs), staff training, drills and ongoing review of fire doors. On this inspection, inspectors found that closing bedroom doors on evacuation was clearly noted on all PEEPs. Inspectors found that staff were knowledgeable to ensure that bedroom doors were closed as part of all fire drills. Fire drill records clearly reflected that bedroom doors were closed as part of the drill. Fire drills were carried out on a monthly basis, and satisfactory evacuation times were recorded. A risk assessment and action plan of fire doors was carried out by the provider in January 2023 which identified specific controls. These controls included daily checks of escape routes, weekly checks of door sets, special attention to closing bedroom doors in staff training and fire drills. A daily fire door maintenance and check log

was kept at each of the three nurses stations in the centre. The provider was informed on the inspection that the current arrangement is acceptable only on the continued monitoring of fire safety management of the absence of bedroom door closers by the registered provider and provision of adequate staffing levels to support any evacuation.

An inspector observed a sample of care plans. These were generally person centred and updated at least at four monthly intervals in line with regulations. However, while care plans were dated as being updated the information in some of the care plans reviewed was not up-to-date. This will be further discussed under Regulation 5: Individual assessment and care planning. Validated risk assessments were regularly and routinely completed to assess various clinical risks including risks of malnutrition, pressure ulcers and falls.

The registered provider had an up-to-date policy on behaviours that challenge in place. An inspector was informed that no residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The registered provider completed a quarterly restrictive practice audit. The most recent audit identified that 10 residents had bedrails in place which was an increase from five in the last quarter. Bedrail assessments were in place and up-to-date. Not all resident files reviewed indicated if less restrictive options were trialled in line with the national policy on restraint.

Residents gave positive feedback regarding life and care in the centre. Inspectors identified that staff were knowledgeable about resident's likes and interests. Feedback was sought through resident meetings and a satisfaction survey. Two resident meetings had taken place in 2023 in January and May. It is unclear from meeting minutes reviewed the number of residents that attended the meetings. Items discussed included resident's wishes to have a garden party. This was planned for 16 July 2023. There was no evidence from meeting minutes provided to inspectors that consultation had taken place between the registered provider and residents about the loss of communal space. This is discussed under regulation 9.

Regulation 17: Premises

Ongoing actions were required to ensure the premises conformed to the matters set out in Schedule 6 of the regulations:

- Storage in the centre had not been addressed since the last inspection. For example;
    - Hoists were stored in a clinical room at the main entrance and a treatment room in Beech and Sycamore.
    - 12 Wheelchairs and four walking frames were stored behind a partition in the sitting room in Sycamore unit. Inspectors were informed that they were only stored there during the day while residents were sitting in chairs in the sitting room. However, a number of wheelchairs

remained at lunchtime when they should have been in use.
    - A number of wheelchairs were stored in Elms sitting room. Staff confirmed that these wheelchairs were always stored there.
- Tiling in two of the assisted bathrooms were broken and chipped. This was identified in meeting minutes reviewed with an action to replace them.
- There was a break in the integrity of the flooring outside room 53.
- Changes to the footprint of the centre was discussed under Regulation 23: Governance and management.

Judgment: Not compliant

Regulation 27: Infection control

While inspectors observed that the centre was generally clean on the day of inspection, improvements were required in order to ensure procedures are consistent with the national standards for infection prevention control in community services. For example:

- Signage indicated and staff confirmed at the feedback meeting that the contents of urinals and bedpans were manually decanted into the sluice prior to inserting them into the bedpan washer. This practice increased the risk of environmental contamination and multi-drug resistant organism (MDRO) cross infection.
- The majority of hand hygiene sinks in the centre were not compliant with the required specifications with the exception of one which was recently replaced but not completed at the time of inspection.
- The sink and water dispenser in the clinical room were stained and required review.
- The temporary closure on two sharps boxes were not engaged.
- A comfort chair on Hawthorn unit was observed to be worn and torn.

Judgment: Substantially compliant

Regulation 28: Fire precautions

An action was required in fire precautions so that the registered provider is assured that residents could be safely evacuated in a timely manner. For example;

- Hoists containing a battery were observed beside oxygen cylinders in clinical rooms. Inspectors were informed that hoists were charged in the clinical rooms.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of care plans. While the care plans were dated as being up-to-date the information in the COVID-19 and visiting care plans was not in line with the guidance in place at the time of inspection.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider had access to a general practitioner who attended onsite every second Thursday. Outside of working hours an out of hours service was used. Inspectors were informed that there was timely access to health and social care providers. There was evidence from the review of resident files that residents were referred and reviewed by health and social care providers as required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

An inspector reviewed a sample of resident files who had bedrails in place. The following is not in line with national policy and did not provide assurance that restraints were used in the least restricitive manner for the least amount of time:

- Not all records reviewed indicated if less restrictive options were trialled.
- The inspector was informed that safety checks were completed in line with what was indicated in the care plan, however, the documentation to support this was not up-to-date.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Actions were required to ensure compliance with regulation 9: Resident's Rights.

Residents were not adequately consulted about the changes that had been made to

the layout of the designated centre and as such their feedback was not taken into consideration when the changes were planned for their home. This was evidenced by:

- Lack of information provided for residents and /or their representatives about the planned changes
- Lack of evidence that changes were discussed in resident meetings.

The registered provider and person in charge did not ensure that residents are enabled to exercise choice and control over all aspects of their lives. Actions taken by the registered provider and the person in charge to engage with and consult with residents regarding changes to the layout of the building did not support person centred care.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Mooncoin Residential Care Centre OSV-0000254

Inspection ID: MON-0040650

Date of inspection: 13/07/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training from the 4th to the 8th of September has all of those due various training listed for training this block.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A meeting was held with almost all residents in the Centre on July 24th, and for those who choose not to attend a 1:1 consultation was held, to discuss the changes to the Centre layout. The DON attended explaining the changes, and offered to show anyone who would like to see them and sought feedback. Residents acknowledged their thanks for the information but didn't verbalize that it had any impact as they had not noticed the changes included as per page 9. It is our view that the changes undertaken have had no negative impact on residents' enjoyment or access to communal spaces. This is now evidenced by the meeting held with residents on July 24th. It is also worth noting that there remains ample communal space throughout the centre, far in excess in fact of what is required by regulation. Inappropriate storage has been reviewed and reassigned. There is no unnecessary equipment stored in the Resident's dedicated day areas, and the hoists are not being stored in clinical rooms.	

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Complaints officer and Appeals officer have completed training on complaints and all staff nurses are currently undertaking the training.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Hoist storage has been changes to store rooms 12 and 6.

Wheelchairs and walking frames when not in use during the day are stored in Store rooms 12 and 6.

Changes to the footprint of the center are explained in Regulation 23.

Tiles to be replaced are scheduled for maintenance to replace.

The flooring outside room 53 has been made safe.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Staff have been informed the full contents of a bedpan or urinal should be carefully disposed of into the bedpan washer as per best practice.

Handwash sinks remain on the risk register for ongoing review.

The clinical store was cleaned on the day of inspection and is now on a regular cleaning schedule.

Nursing staff have been reminded about sharps safety and procedures and this will be subject to audit on the environmental audits in the center.

The comfort chair has been removed for repair.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
When pointed out on the day of inspection, the charging unit was moved to a different location and that will remain the new charging location for Maxi hoist batteries.

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:
The DON has audited 100% of all the residents care plans and has an action plan that is person and time specific to feed back to the individual named nurses responsible for care planning.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Restrictive practice continues to have a high priority in respect of residents' quality of life, and unless refused by residents who request the use of bedrails, it is and will remain center policy to try alternatives to restrictive practices whenever possible and to reduce restrictive practices where possible through continuous review and resident consultation.

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: We have met with the residents about the change to the rooms listed as part of their last residents meeting. Residents will continue to have input to all aspects of life within the center.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	08/09/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/09/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/10/2023
Regulation 27	The registered provider shall ensure that	Substantially Compliant	Yellow	31/08/2023

	procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	13/07/2023
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Substantially Compliant	Yellow	31/08/2023
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	Substantially Compliant	Yellow	22/09/2023

	consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	08/09/2023
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.	Substantially Compliant	Yellow	31/08/2023