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:	St Josephs Nursing Home
Name of provider:	St Josephs Nursing Home
Address of centre:	Lurgan, Glebe, Virginia, Cavan
Type of inspection:	Unannounced
Date of inspection:	09 March 2021
Centre ID:	OSV-0005413
Fieldwork ID:	MON-0030687

About the designated centre

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

The designated centre provides 24- hour nursing care to 52 residents, male and female who require long-term and short-term care (convalescence and respite).

The centre is situated in a rural area but in close proximity to a small town. It is a three storied building with views of Lake Ramon. There are a variety of communal rooms and single and twin bedrooms some of which are ensuites.

The aim of the centre is to provide a homely environment where the residents are cared for, supported and valued in a setting that promotes their health and well-being.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	33

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 9 March 2021	09:30hrs to 15:30hrs	Sheila McKevitt	Lead
Tuesday 9 March 2021	09:30hrs to 15:30hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

Inspectors found that residents did not receive person centred care and support in line with their assessed needs. Some of the care practices observed were institutional and were of a poor standard. This is reflected in the high levels of non compliance found and reported on in this report.

An outbreak of COVID-19 had been reported on the 11 January 2021. A total of 73 confirmed cases had been identified (37 residents and 36 staff members) to date. Sadly 13 residents who contracted COVID-19 had died. Inspectors acknowledged that residents and staff living and working in centre had been through a challenging time. They acknowledged that staff and management had the best interest of residents at the forefront of everything they did at the height of the outbreak and at the present time. However, significant improvement and focus was now required to ensure that the quality and safety of care delivered to residents achieved regulatory compliance.

The nursing home was situated in the heart of the countryside with views of the surrounding fields and wildlife. It overlooked a large green field where two horses could be seen grazing. On the day of inspection residents spend most of their time in the main sitting room which was situated to the rear of the building, overlooking a lake. One resident said although it was a beautiful view you would soon get fed up looking at it everyday.

Inspectors observed residents sitting in chairs positioned around the walls of this sitting room. This seating arrangement did not support residents to easily communicate with each other. It did not make the best use of the available views to stimulate conversation and interest amongst the residents. The two televisions were turned on with morning television programmes being televised on both sets. One television had the volume turned off. The inspectors observed that the residents were not engaged with the programmes.

Inspectors observed that the residents were left unsupervised for long periods of time with no meaningful engagement with members of staff. Inspectors witnessed a number of near misses when residents became uncomfortable or restless and attempted to mobilise on their own. On three separate occasions inspectors had to go and find a staff member to attend to residents requiring assistance. For example, on one occasion a resident with a cognitive impairment was walking directly behind another resident who was walking with her zimmer frame, almost causing the resident in front to fall over.

Staff informed the inspectors that some of the unsupervised residents did display behaviours (How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The inspectors alerted a member of staff who went to assist

the resident. There was no member of staff present to chat with the resident and help him to express his agitation in a more dignified way.

Staff came and went bringing other residents into the sitting room however there was very little meaningful interactions or communication with other residents in the room. On one occasion the inspector observed a member of staff bring a resident into the sitting room, park the chair up by the wall and leave. There was no communication between the staff and the resident or between the staff and the other residents sitting nearby. As a result residents were not introduced to each other or encouraged into a friendly conversation with each other.

Inspectors were informed that there was a vacancy for the post of activities co-ordinator and a Health Care Assistant (HCA) would be providing activities with residents at eleven o' clock. This did not happen and instead at eleven o' clock a HCA entered the sitting room and proceeded to offer residents a choice of hot drinks. The residents remained seated in the same chairs, in the same sitting room for the majority of the day. No activities or entertainments were provided and staff and resident interactions were mostly task orientated and brief.

Inspectors observed call bells ringing for prolonged periods of time. Bells rang for between two to six minutes before they were answered. On one occasion the inspector grew concerned about the prolonged ringing of a bell and asked a staff member to accompany her to that bedroom, there was no one in the room, the bell was than cancelled by the staff member. However if a resident had required assistance in that room no staff member had responded to the call bell.

Despite what inspectors observed residents who spoke with the inspectors provided positive feedback. They said the staff could not do enough for them. One lady who spent the day in her bedroom upstairs said she liked to spend her time in her room.

Residents in the sitting room said there was not much to do and that sometimes they played a game but in general it was a quiet place. They said they looked out for each other and tried to keep themselves busy. One resident explained how he enjoyed reading the daily newspaper that was delivered each day another explained how going outside for a cigarette kept him occupied.

Residents said the food was good, they received a choice and they generally could not fault the food. Inspectors observed the service of morning hot drinks and found that residents were not served their morning drinks in an appropriate manner. For example residents were offered hot drinks in cups with no saucers and biscuits were offered from the packet or from a large plastic container. In addition, the trolley used to serve drinks and snacks was not clean.

Capacity and capability

Inspectors found that there was a defined management structure. However the management team were not clear about their roles and responsibilities and there was no established processes in place to oversee the quality and safety of the service and ensure good levels of regulatory compliance. As a result the inspectors found that two of the four compliance plans from the last inspection had not been appropriately addressed and the provider had failed to bring the centre into compliance with the Health Act 2007.

The centre was not adequately resourced. There was not enough staff with the required skills and knowledge available to meet the needs of the residents. For example housekeeping hours had not been increased even though enhanced cleaning regimes were required as the centre started to recover from the recent outbreak.

Staff were not provided with access to the training they required in a timely manner. This had resulted in some poor practices. For example, the missed opportunities of communication between staff and residents. In addition, staff were not appropriately supervised in their work as a result the inspectors observed several examples where care practices and communications were not person centred and did not uphold the dignity and rights of individual residents in line with the centre's philosophy of care.

Regulation 15: Staffing

There were not enough staff on duty to meet the needs of residents. For example:

Residents requiring supervision were left unsupervised for long periods of time.

Call bells were left ringing for greater than three minutes.

There were no meaningful activities available for the residents as described in the centre's Statement of Purpose.

Residents' assessments and care plans were not completed in line with the centre's policies and procedures.

There were only two house keepers on duty although the centre was still in COVID-19 outbreak and accommodation was spread three floors.

Judgment: Not compliant

Regulation 16: Training and staff development

A training matrix was in place showing the mandatory training and relevant courses completed by staff. However records reviewed found significant gaps in mandatory training including fire, manual handling, safeguarding, CPR and infection prevention and control. Documentation reviewed indicated that the 2020 training schedule had not been completed due to the impact of COVID-19. Inspectors were informed that mandatory training sessions were scheduled for April 2021.

Members of the management team with responsibility for completing audits confirmed that they had not received any training in this area.

There was a lack of oversight and supervision of staff. The lack of training, supervision and oversight had led to poor practices. For example cleaning staff were not clear about what were the required procedures for environmental cleaning and decontamination practices.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and management of this centre did not ensure that the residents received a quality service in line with their assessed needs and preferences for care and support.

The oversight of the service was not robust. Processes were not in place to ensure that care and services were of a good standard. For example:

- The communication between members of the management team was informal and did not ensure that the service was managed and delivered in line with the centre's Statement of Purpose, policies and procedures. For example, minutes of meetings reviewed did not reflect a set agenda and the minutes were vague and did not identify who was responsible for implementing any agreed changes.
- Management issues such as staff vacancies had not been discussed at recent management meetings. As a result there was no clear plan in place to source the staff required to fill the vacancies.
- Audits conducted in 2020 had not been completed in line with a clear quality assurance framework.
- The audit tools used followed a basic format and did not adequately monitor key areas of the service.
- There was no evidence that the audits completed had been analysed, actions plans developed or implemented by whom or within what time frame. For example a falls audit completed had no analysis of the findings and no action plans.
- Audits completed had not been used to improve care practices.
- There was no audit schedule in place for 2021.

- An annual review had been completed however it did not include any residents feedback or a quality improvement plan for 2021.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaint's policy. The complaints on file were reviewed. Inspectors found that not all complaints records included a record of the outcome of the complaint or whether the complainant was satisfied or how the complaint was managed. Although the policy identified a person who was responsible for overseeing complaints there was no evidence that this person had reviewed the complaints on a consistent basis.

Inspectors noted a complaint had been made in 2020 in relation to call bells not being answered in a timely manner. It was not clear what had been done to address this issue. The PIC confirmed that no actions had been taken to audit the call bell answering times following receipt of the complaint.

Judgment: Not compliant

Quality and safety

Overall the quality and safety of care provided to residents was not good and required improvement. As a result the standard of care provided did not take the residents' health, personal and social care needs into account. In addition the premises had not been maintained to an acceptable standard. Inspectors did note that two action plans from the last inspection had been adequately addressed by the provider. These improvements were reflected in the management of residents finances and an improvement in fire evacuation services.

Staff and resident interactions were brief and were largely task orientated. The inspectors noted that staff did not spend time with the residents and there was a lack of meaningful engagement. As a result residents spend long periods with little or nothing to do and with no-one to talk to. In addition the designated centre was not open to visiting which further deprived the residents of opportunity for social interaction and stimulation.

The standard of nursing documentation was poor. This was a non compliance at the last inspection in November 2018, and had further disimproved on this inspection. Inspectors found that care plans did not provide a clear picture of the residents assessed needs or required care. As a result the care plans did not provide up to

date and relevant information about each resident to ensure that staff were able to provide safe and appropriate care.

Inspectors found effective processes were not in place to mitigate the risks associated with the spread of infection and limit the impact of outbreaks on the delivery of care. Inspectors identified some examples of good practice in the management of COVID-19. For example there were sufficient supplies of personal protective equipment (PPE) available and efforts and been made to de-clutter the centre.

Overall the general environment and residents' bedrooms, communal areas, toilets bathrooms, and ancillary facilities inspected appeared clean. However a number of maintenance and infrastructural issues were identified which had the potential to impact negatively on infection prevention and control standards. The provider was working to mitigate these risks through gradual upgrading and ongoing refurbishment of the existing facilities. However inspectors observed the development of two additional single ensuite bedrooms had been prioritised over the ongoing refurbishment work in the centre.

Regulation 12: Personal possessions

The provider was a pension agent for a small number of residents. Inspectors reviewed the process followed and were assured that resident monies were safe guarded by the procedures that were in place.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place which reflected the requirements of the regulations including the management of specified risks. Risk management procedures took into account any HPSC, HSE and Department of Health guidance and were reviewed and updated in a timely manner in line with changing advice.

The provider maintained a register of risks which included a number of hazards and risks in the centre. This had been updated to reflect the COVID-19 pandemic and detailed the measures and actions in place to control any risks identified.

Arrangements were in place for the identification, recording, investigation and learning from serious or adverse events involving residents. However a review of documentation identified that one near miss involving a call bell had not been reviewed in order to prevent a re-occurrence.

Judgment: Substantially compliant

Regulation 27: Infection control

The physical environment in the centre had not been managed and maintained to effectively reduce the risk of infection. For example:

- Surfaces, finishes and flooring throughout the centre were worn and poorly maintained and as such did not facilitate effective cleaning. The relationship between the infrastructure and the cleaning function must be recognised and be a proactive one, and maintenance and other facilities management issues must be prioritised.
- The fabric covers of several mattresses and some resident chairs were worn or torn. These items could not effectively be decontaminated between uses, which presented an infection risk.
- The underside of wall mounted alcohol hand gel dispensers were heavily stained throughout the centre.
- All persons entering the centre were required to dip their footwear into the disinfectant basis on entry to the centre. This appeared visibly unclean. National guidelines do not recommend the use of foot baths to control the spread of COVID-19.
- There were no ancillary facilities including a clean and a dirty utility available on the second floor. The location of the dirty utility rooms should minimise travel distances for staff from resident rooms to reduce the risk of spillages and cross contamination, and to increase working efficiencies. The provider had planned to address this issue.
- One upstairs toilet had a foul smell. The inspector observed a pedal bin overflowing with incontinence wear in the afternoon.

The centre had purchased two fogging-type disinfection machines. Inspectors were informed that these were intended to supplement deep cleaning procedures and did not replace the need for manual cleaning procedures. However inspectors were informed that this machine was used to disinfect rooms prior to cleaning. The use of novel technologies for room disinfection have not been shown to add value beyond standard cleaning and disinfection. If they are used, they should always be used after standard cleaning practices. Inspectors were not assured that staff were effectively trained to use these machines correctly.

Hand hygiene is one of the most important measures to prevent transmission of COVID-19 infection. However facilities for and access to hand hygiene facilities in the centre were less than optimal. For example:

- There was a limited number of hand wash sinks in the centre and many were dual purpose.
- The stainless steel sinks did not comply with current recommended specifications for hand wash sinks.
- Outlets of some sinks appeared unclean.

- Sealant between several of the sinks and walls was not intact which did not facilitate effective cleaning.

Judgment: Not compliant

Regulation 28: Fire precautions

Adequate operational precautions had been taken against the risk of fire.

- Fire-fighting equipment was in place throughout the centre and emergency exits were clearly displayed and free from obstruction.
- Daily checks of fire exits and escape routes to ensure they were unobstructed were being completed and records of these checks were available for review.
- Fire safety records and a directory of visitors are maintained in line with the regulations.
- Personal emergency evacuation plans had been developed for each resident which identified the most appropriate aids suitable to safely evacuate the resident in a timely manner both during the day and at night.
- Staff participated in regular fire evacuation drills, which included simulations.

Issues identified on the last inspection in relation to fire safety had been addressed. An external pathway from the fire door in the sitting room to the external fire assembly point had been constructed for safe evacuation of residents.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Residents assessments and care plans were not completed for each resident on admission. A sample reviewed found the following:

- Comprehensive assessments were not fully completed within 48 hours of the resident being admitted to the centre.
- Comprehensive assessments were not reviewed within a four monthly time period.
- There was inconsistencies in the risk assessment completed for each resident for example, some residents had no skin integrity assessment completed.
- There was no evidence that do not resuscitate orders had been discussed with the resident and or their next of kin.
- Residents did not have care plans in place to reflect their assessed needs. For example one resident who was diabetic did not have a care plan in place for his diabetes.

- Residents care plans were not updated following review by health care professionals. For example one resident had been reviewed by a physiotherapist who made four recommendations regarding changes to the care. This resident had no mobility related care plan in place.
- The daily nurses evaluation was not linked to the residents care plan and some entries had no time of entry.

Judgment: Not compliant

Regulation 6: Health care

The healthcare needs of residents were being met. Inspectors were informed that the General Practitioner (GP) was in the centre reviewing residents and they had access to members of the allied health care team. Inspectors saw that residents were reviewed by a physiotherapist who visited the centre each week. Residents were being reviewed post a fall and those that required specialist seating had a seating assessment completed and they had the appropriate seating in place to meet their assessed needs.

A review of a sample of residents files showed that residents were being reviewed by their GP as required and had a medical review completed every four months.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The assessments and care plans of those residents displaying responsive behaviours did not clearly identify the known behaviours of the residents. A sample of care plans reviewed did not state what interventions may mitigate against these behaviours. The care plans did not reflect the potential triggers and deescalating techniques that the resident response too. They did not provide enough detail to guide staff interventions.

Inspectors noted one incident of responsive behaviour had resulted in a resident pulling a wash hand basin from a wall. Although the resident had been reviewed by their GP post the incident, the resident's care plan had not been updated to reflect the changes made to the resident's plan of care after the GP's review.

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	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant

Compliance Plan for St Josephs Nursing Home OSV-0005413

Inspection ID: MON-0030687

Date of inspection: 09/03/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing levels have been increased to ensure adequate supervision at all times for all residents. We have a designated carer for the sitting room from 8am & activities co-ordinator from 11:00-18:00 7 days a week. We have reviewed our response time to call bells and all staff are aware of the importance of attending promptly. An activity programme has been developed and will be reviewed as appropriate to the residents needs. A new care plan system is in place and All residents assessments and careplans are fully completed in line with our policies and procedures . We have employed a new housekeeper to ensure the cleanliness of the home. We have closed off the top floor of the building to complete maintenance and renovation, to comply with infection prevention and control. This should be complete in 10 weeks.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A new Training matrix is now complete, CPR & fire training for all remaining staff was completed on 13th April. This had initially been booked for January but was cancelled due to outbreak. Manual handling for the remaining few staff has been provisionally booked for June 2021. Safeguarding refresher training completed 19/04/21 for all remaining staff. The PIC has received online training in completing audits. Household staff have now been retrained in environmental cleaning and decontamination practices	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
We have now employed a new PIC to the centre and new practices are in place. Scheduled monthly Governance and Management meetings with an agenda have commenced since the end of March 2021. All responsibilities are discussed at the meetings and are outlined in the minutes so they can be reviewed at the next meeting. We had been actively interviewing for staff & have employed to all vacancies. Staff vacancies are regularly discussed at governance & management meetings & in weekly handovers. A yearly audit plan has been introduced & commenced. Annual review now complete with quality improvement plan updated and residents statements/feedback on the year.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Complaints procedure has been updated. Complaints are reviewed at governance & management meetings monthly. It has also been added to our annual audit plan and will be reviewed monthly. The PIC will ensure that all complainants will be satisfied with the outcome before closing a complaint.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Any incident or near miss will be promptly reviewed by the PIC in order to prevent a reoccurrence of same.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The top floor of the Nursing Home has now been closed off for refurbishment and maintenance throughout the building has now recommenced as we no longer have an outbreak. An audit has now been completed on all soft furnishings and replacements have been ordered. New wall-mounted alcohol hand gel dispensers will be sourced and replaced. The foot disinfectant bath has been removed. All staff compliant with HseLand training & ongoing workshops continue on the floor. The top floor is now closed for refurbishment & general maintenance continues. Household staff retrained in all chemicals & terminal cleaning of rooms. Plan in place to install additional hand washing sinks throughout the building.

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:
A new comprehensive assessment pack has been introduced by the RPR, all staff nurses and PIC have been trained on same. A 4 monthly review of all assessments is now in place and all resident documentation is in one designated care plan file. All staff nurses going forward will continue to update care plans 4 monthly and as and when necessary. This will be overseen by the PIC and discussed at Management meetings.

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:
All care plans have been updated to include responsive behaviour. New behaviour charts have also been introduced to include triggers & de-escalation methods. Daily responsive charts will continue and will be monitored by the PIC.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	19/04/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	12/07/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	29/03/2021
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient	Not Compliant	Orange	09/04/2021

	resources to ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	29/03/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	28/05/2021
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 section 8 of the	Substantially Compliant	Yellow	16/04/2021

	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	16/04/2021
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 adverse events involving residents.	Substantially Compliant	Yellow	14/05/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	12/07/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints	Not Compliant	Orange	15/04/2021

	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.			
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Not Compliant	Orange	15/04/2021
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 response to a complaint.	Not Compliant	Orange	15/04/2021
Regulation 34(2)	The registered provider shall	Not Compliant	Orange	15/04/2021

	ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			
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	30/04/2021
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	30/04/2021
Regulation 5(3)	The person in charge shall prepare a care	Not Compliant	Orange	30/04/2021

	plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
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.	Not Compliant	Orange	30/04/2021
Regulation 5(5)	A care plan, or a revised care plan, prepared under this Regulation shall be available to the resident concerned and may, with the consent of that resident or where the person-in-charge considers it appropriate, be made available to his or her family.	Not Compliant	Orange	30/04/2021
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to	Not Compliant	Orange	03/05/2021

	respond to and manage behaviour that is challenging.			
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	03/05/2021