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:	Sonas Nursing Home Riverview
Name of provider:	Storey Broe Nursing Service Limited
Address of centre:	Morrison Terrace, Mullauns, Ballina, Mayo
Type of inspection:	Unannounced
Date of inspection:	07 April 2021
Centre ID:	OSV-0005504
Fieldwork ID:	MON-0032441

About the designated centre

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

Sonas Nursing Home, Riverview is a modern building that opened in 2017. It is registered to provide care for 53 male and female residents who require long-term, continuing, convalescent or respite care. Care is primarily provided to people over 65 years with low to maximum dependency care needs. The centre is located near the river Moy in Ballina and is a short drive from the train station, shops and business premises in the town. Residents' accommodation is provided in five double and 43 single rooms. Residents have access to appropriately spacious communal sitting and dining areas, a visitors' room and an enclosed courtyard garden that can be accessed from several points around the building. The centre has good levels of natural light and windows throughout enable residents to see the outdoors when seated in armchairs. Catering, laundry and staff areas are also located within the building. The aim of the centre as described in the statement of purpose is to provide a residential setting where residents are cared for, supported and valued within the 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:	50

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 7 April 2021	11:00hrs to 17:30hrs	Catherine Sweeney	Lead
Thursday 8 April 2021	11:00hrs to 16:00hrs	Catherine Sweeney	Lead
Wednesday 7 April 2021	11:00hrs to 17:30hrs	Gordon Ellis	Support
Thursday 8 April 2021	11:00hrs to 16:00hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

Inspectors spoke with nine residents over the two days of the inspection. Some of the residents told the inspectors that it was 'easy to live in the centre' and that staff were kind and respectful to them. Inspectors observed staff talking with residents in a kind and person-centred manner. Residents appeared relaxed and comfortable in the company of staff.

Some of the residents explained how they felt safe in the centre and that they knew who to speak to if they had any issues or concerns. Other residents stated that they did not feel that they had an opportunity to express their concerns or issues with staff. Three residents told the inspectors that it had been some time since they attended a residents meeting and they did not know when the next meeting would be scheduled.

A number of residents complained that there was not much to do during the day. They stated that they did not know if there was a schedule in place. They explained how they loved to play bingo and skittles, and while they were sometimes facilitated to do so, they said that they would like to know when the activities were going to happen. Residents described how they felt that activities only took place if there was time for them. Residents told the inspectors that the staff were very busy. Inspectors found that there was no activities schedule in place on day one of the inspection nor did they observe any scheduled activities taking place. An activities schedule was in place on day two of the inspection

Some residents said that food was served to a high standard and was presented in an appetising way. Residents were observed to be facilitated with their meals in a dignified and respectful manner. Residents said that meal time was an important part of their day.

During the inspection a resident disclosed a complaint to the inspectors. The complaint was communicated to the person in charge. The management teams response to the complaint was not in line with regulatory requirements or with the centre's own policy.

Capacity and capability

This was an unannounced inspection by Inspectors of social services to review an application made by the provider to vary the registration of the centre, with changes to the layout of the centre and to increase the registered beds from 53 to 60.

The centre was last inspected in January 2021 and found to have a satisfactory level

of compliance. However, since that inspection, a review of the rosters found that staffing levels were not in line with the levels set out in the centre's statement of purpose. Although the provider was in the process of recruiting nursing staff, the level of nursing staff available to cover all shifts was compromised. A decision had been made to reduce the night time level of nursing staff from two to one. This decision had not been risk assessed and no action had been taken to reduce any risk associated with this decision. An immediate action plan was issued to the provider in relation to staffing and residents rights.

There was a clear organisational structure in the centre that was in line with the centre's statement of purpose. The person in change was supported by an assistant director of nursing. The person in charge was also supported by a management team comprising of a regional quality manager and a quality and governance coordinator.

Information requested on this inspection was not produced in a timely and efficient manner. Information such as the residents dependency levels, staff training records, risk management, and residents files were updated on the day of inspection. Staff files did not contain the information required under Regulation 21. Information required to be held in the centre was not available on the day of inspection including a Garda (Police) vetting certificate for a member of staff who had commenced employment in the centre.

The provider had systems in place to monitor the service. A review of a sample of the clinical and environmental audits completed found that the recommendations and actions were poorly documented and did not identify a quality improvement action plan. The quality and effectiveness of some of the governance systems in place required review. For example, while there was a system for documenting risk management, risks such as the reduction of night time nursing levels had not been identified.

Inspectors spoke with a number of residents who expressed clear dissatisfaction with the level of communication and opportunities for social engagement in the centre. Residents identified that the quality of social care in the centre had deteriorated over the past two months.

A review of the training records for the staff in the centre found that records of training was recorded on a matrix that did not identify the job description of the staff member. It was difficult to review if staff had received appropriate training commensurate to their role. The inspector cross-referenced the staff names from the daily roster to establish what training had been completed.

The person in charge confirmed to the inspectors that there were residents accommodated in the centre whose care plan included full life support intervention in the event of a sudden deterioration in health. A review of the training records found that only two out of ten nurses and three care assistants in the centre had up-to-date training in basic life support.

Some gaps were identified in elder abuse training, responsive behaviour training and, fire safety training. On-site training in fire safety and manual handling was

scheduled for the week following the inspection. All other training was delivered through an on-line training portal. Online training included safeguarding of vulnerable adults, infection control, and an introduction to the fundamentals of care.

The person in charge had not completed the on-line training modules and did not have access to the training content. This meant that the person in charge did not know what information was being presented to the staff members, or if the training was at an appropriate standard to meet the requirements of regulation. Inspectors requested a copy of course content from the fire safety and the safeguarding modules of the training. The person in charges sourced these from the external training company on the day of the inspection. The online fire training module did not contain all the requirements of training as identified under regulation 28.

A review of the system of records management was required to ensure that information recorded was accurate and accessible and in line with regulatory requirements.

The provider had a system in place to record complaints. Some complaints from residents and visitors had been recorded however, the documentation and management of complaints was inconsistent and therefore could not be used to improve the quality of the service provided.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

A review of the detail of the application to vary the condition of registration found that action was required to ensure that the new areas of the centre complied with regulations and standards. The provider had proposed to add a day room, a store room, a twin bedroom and five single rooms to the designated centre.

One of the single bedrooms was occupied by a staff member on day one of the inspection and could not be assessed. This room was vacated and assessed on day two of the inspection.

A review of the staffing levels in the centre found that there was an inadequate level of nursing staff available to meet the needs of the residents in the centre and for the size and layout of the centre. The staffing levels, proposed for 60 residents in the centre's statement of purpose, were not available.

The proposed day room was reviewed and found to have no call bell facility. This meant that residents using this room would not be able to call for assistants if needed.

The twin bedroom was divided into two bed spaces. Only one bed space had access to a window, providing natural light and ventilation. The other bed space did not have ceiling light over the bed space, making the area dark, even in daylight. The only light accessible to the resident would be a strip light above the bed. A table lamp was also available. The room was fitted with privacy screens, however, when

these screens were in position, the access to light in this bed space was further reduced. Furthermore, the screens compromised the access to the light switch for the en-suite toilet.

A number of fire safety precaution assurances were required. These are identified under regulation 28, fire precautions.

Judgment: Not compliant

Regulation 15: Staffing

The centre did not have adequate staffing to meet the needs of the residents or for the size and layout of the centre.

There were 50 residents accommodated in the centre on the day of inspection. Of these, 26 were assessed as having high to maximum care needs, with 24 residents assessed as having low to medium care needs. However, the assessment of resident's care needs were found to be out of date. This meant that staffing was not calculated based on the accurately assessed needs of the residents.

In addition, staffing in the centre was not in line with the centre's statement of purpose. The provider had an on-going recruitment process in place and two staff nurses had recently been recruited. However, due to a shortage of nursing staff, a decision had been made to reduce the night time level of nurses from two nurses to one without a documented risk assessment.

The staffing in the centre on the day of inspection was not adequate to support the admission of seven further residents as proposed in the application to vary the registration of the centre.

An urgent compliance plan was issued to the provider in relation to staffing following this inspection. The provider gave assurance that staffing would be reviewed and appropriately risk assessed, with levels meeting the needs of the residents. Revised rosters were submitted providing assurance that the centre had resources to provide two nurses to cover night duty.

Judgment: Not compliant

Regulation 16: Training and staff development

Significant gaps were found in the training records of staff in the centre. These included

- basic life support for nurses and carers

- management of responsive behaviours (challenging behaviours)
- safeguarding and prevention of older person abuse training.

Judgment: Not compliant

Regulation 21: Records

Staff files did not contain the information as set out in Schedule 2 of the regulations. A review of staff files found that one member of staff, rostered for duty, did not have a Garda (police) vetting certificate or employment references on file on day one of the inspection. Both documents were made available to the inspectors on day two of the inspection. Another file reviewed found that a Garda vetting certificate was obtained on a date after a staff member had commenced duty in the centre.

Staff rosters did not identify the role of the staff member. This included staff who told the inspectors that they were multi-task attendants(MTA). MTA's were not identified on the roster. The person in charge told the inspectors that there were two staff members allocated to the provision of activities on the day of inspection. A roster reviewed found that only one staff member was allocated to activities. The second was roster as a health care assistant. The system of rostering did not reflect the staffing in the centre on the day of inspection.

The training record of staff did not identify the role of the staff member, and therefore did not identify the appropriate training required for that role.

By the second day of inspection, the person in charge had reviewed and updated the roster layout, identifying the role of each staff member.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors identified the following areas of non-compliance during the two days of inspection;

- poor staffing management
- Inadequate identification and management of risk
- inadequate record keeping
- poor awareness of safeguarding issues and residents' rights
- inadequate complaints management
- poor oversight of nursing documentation
- poor oversight of staff training

Judgment: Not compliant

Regulation 34: Complaints procedure

An ongoing complaint made by a resident in relation to an issue that was causing distress and affecting the quality of life of the resident was not documented and addressed as a complaint, in line with the centres complaint's policy. This resulted in the complaint not having been addressed to the satisfaction of the resident.

A review of the complaints log found that documentation of complaints was inconsistent and did not always record the investigation outcome, the learning identified or the satisfaction of the complainant.

Judgment: Not compliant

Quality and safety

This inspection took place during the COVID-19 pandemic when national Level 5 restrictions were in place. The centre had recovered from a small, controlled outbreak of COVID-19 in January 2021. The provider had a centre-specific COVID-19 contingency plan in place. Visiting was facilitated in line with the Health Protection Surveillance Centre visiting guidelines.

Improvements were required in relation to the management of resident protection and residents rights. Inspectors found that the systems in place to safeguard residents and to ensure their rights were upheld, required immediate review.

A review of a sample of residents files found that while each resident had an assessment and care plan in place, not all assessments had been updated in line with residents needs and regulatory requirements. This posed a risk to the accuracy and effectiveness of the residents care plan. Assessments, used to inform the development of care plans, were incomplete and out of date. On the evening of day one of the inspection clinical and nursing assessments were reviewed and updated off-site, by a member of the management team who was not involved in the direct care of the resident.

Some care plans reviewed were found to be detailed and person-centred. Improvements had been made to some of the residents social care plans since the last inspection. However, a review of a care plan relating to a resident with complex psycho-social needs found that the residents care plan had not been informed by appropriate assessment, had used language that was discriminatory and did not uphold the residents' right to independent advocacy.

Residents were supported in the centre by a doctor of their choice and a team of allied health care professionals. A physiotherapist was on duty five days per week. A review of the referral process to allied health care professionals was required to ensure that residents had timely access to this support.

Inspectors found evidence that a resident's right to autonomy, respect, dignity, and non-discrimination was not respected in the centre. It was not clear that staff understood the rights of the residents and their role in protecting and promoting these rights. A resident with specific concerns and who would have benefited from having an advocate was not facilitated to access advocacy services..

The person in charge confirmed that two staff members were allocated to support activities on the day of the inspection. A review of the roster found that only one activity coordinator had been rostered. The person in charge confirmed that a health care assistant had been reallocated to activities recently. Residents told the inspectors that the opportunity for activities and social engagement has reduced considerably over the past few months. Residents described feeling 'a bit fed up' and 'finding the day very long'. Three residents separately described how they used to enjoy bingo and a bowling game in the afternoon. They explained that while these activities still happen occasionally, they did not know when they would be scheduled. They said that 'activities are fitted in, if the staff have time'. One resident explained that there had been no recent residents meetings to discuss this issue. A review of the meeting notes found that the last resident meeting had been held in January 2021.

Inspectors did not observe activities taking place on day one of the inspection. There was no activity schedule displayed on the activities board. A more structured approach to activities and social engagement was noted on day two of the inspection.

An urgent compliance plan was issued to the provider in relation to residents' rights following this inspection. In their response, the provider gave assurance that systems were in place to facilitate residents to communicate their issues and concerns to staff. Referral to advocacy services would be facilitated for residents in accordance with their assessed needs and, an activity programme, developed in consultation with the residents was put in place following the inspection.

Regulation 27: Infection control

A review of the infection control policy and practice in the centre found that the centre was in compliance with regulation 27.

The centre was visibly clean on the days of the inspection. Cleaning staff demonstrated a good awareness of the cleaning systems and products in use.

Judgment: Compliant

Regulation 28: Fire precautions

A number of assurances were required in relation to fire safety precautions. These included

- a full fire risk assessment of the centre completed by a suitably qualified professional
- emergency lighting and signage required in internal courtyard
- confirmation of fire compartment boundaries was required
- fireproof certification of the window in the day room
- fireproof certification of ceiling hatches
- assessment for the requirement for a repeater panel

In addition, inspectors found that

- fire drill reports did not include enough comprehensive information and detail to provide assurance that staff were adequately prepared for the evacuation of the premises or to identify the need for additional fire training or revisions to the fire precautions or procedures.
- a smoking shed located in the internal courtyard has an electrical supply, is connected to the call bell system and is a fixed structure, is not included on the floor plan of the centre.
- Personal Emergency Evacuation Plan (PEEP) for each resident was not dated on file or when it was last reviewed for each resident.
- fire safety training content was not in line with requirements of Regulation 28, fire precautions

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of a sample of residents files found that assessments were inaccurate and out of date. This was evidence by

- a resident who had been assessed as being at high risk of malnutrition had not been appropriately reviewed and referred to the dietitian. The resident continued to lose weight.
- poor assessment and care planning for a resident with complex psychosocial needs.

Judgment: Not compliant

Regulation 6: Health care

Residents had good access to a doctor of their choice. Residents were also supported by allied health care professionals such as physiotherapist, occupational therapist, speech and language and psychiatry of later life. However, a review of the residents care plans found that some referrals to allied health care professionals were not made in a timely manner. This delay posed a risk to residents at risk of malnutrition who required adjustments to their care plan.

In addition, a review of a care plan for a resident with complex psychosocial needs, and the care described by the nurse management team was not in line with evidence-based nursing practice.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Non-compliance to residents rights was evidenced by a failure:

- to risk assess a resident's psychosocial well-being and to develop a professional, appropriate and person-centred care plan.
- to communicate effectively with residents in relation to opportunities for activity and social engagement.
- to identify and facilitate access to advocacy services.

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	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Sonas Nursing Home Riverview OSV-0005504

Inspection ID: MON-0032441

Date of inspection: 07/04/2021

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**
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration: Staffing levels as per Statement of Purpose are now in place. The nursing compliment had been appointed but not commenced. Full nursing compliment is now rostered. Four additional HCAs have been appointed. Call bell is now installed in the new day room. The new twin bedroom has had a ceiling light installed over the second bed. A sun tunnel has been installed allowing natural light into second bed space The light switch to the ensuite has been made more accessible.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • All residents Barthel index assessments are now up to date. • Staffing is risk assessed by the PIC with the Quality Manager and HR team, is documented and is adequate to meet the changing needs of residents and additional 7 residents. • Staffing is in line with SOP • A comprehensive risk assessment and risk management plan has been developed relating to staff absence/changes. This is reviewed by PIC and activated accordingly.	

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• We are currently liaising with Basic Life Support education providers and hope with the easing of current restrictions in-house training will be provided to all nursing staff. A risk assessment is in place. 30/08/2021.

• Staff are now completing refresher responsive behavior and safeguarding and prevention of older person abuse training. 31/05/2021

• PIC has assessed the online training and is assured that it is appropriate to meet staff needs and regulatory requirements.

• Staff rosters identify the role of staff member and staffing in the centre.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

• All staff files have been re-audited and are now compliant with the Schedule 2 regulations.

• Staffing rosters now clearly identify the role of each staff member.

• We recently introduced a new online training platform (01/03/2021). We are now able to print a training matrix which identifies each staff members role.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

1. Issues identified with the staff files are now compliant as per Schedule 2
2. Spot checks on same are been conducted by the Quality Manager.

Risk assessment is a live process in Sonas Riverview. There is an extensive database of identifed live risks with various levels of risk ratings. The risk expressed by the inspector in relation to the staffing has now been documented. The home management team (which consists of the PIC and the APIC) had rostered according to the needs of the residents at that time but had not documented their decisions. All future roster changes will be documented. In this case the risk was assesed as low risk.

The staff files and training matrix are now up-to-date. Systems to assure the processes for maintaining same are now in place. For example spot checks and weekly reviews on Mondays. .

A full and comprehensive review of residents assessments and careplans has been completed by the management (PIC & APIC) and the nursing team and are informed by appropriate assessment and uphold the residents' right to independent advocacy.
This has been audited by the Quality Manager.

All staff have undertakien refresher courses in safeguarding. 31/05/2021.
The home management team (PIC & APIC) have registered to complete "Promoting a HRBA in health and social care services" programme.

All residents have been reminded of the Sage advocacy services available to them. This will be kept as an agenda item on the residents meetings. Referrals will be made accordingly.

The process of how we log, investigate and respond to concerns/complaints is now under review. All staff have been reminded that resident feedback is encouraged and all concerns should be reported to the nurse in charge. To ensure consistency, all concerns/complaints will be logged and reviewed on a weekly basis with the Quality Manager. Learning from complaints has always been disseminated to the team at the Quality & Safety meetings and this will continue. The outcome from all complaints will be documented consistently and as per company policy. The quarterly complaints/concerns/compliments audit will be completed comprehensively and audited by the Quality & Governance Coordinator.

A full review of nursing documentation is underway. A system has been implemented which ensures that records are kept up-to date in a timely manner. The Quality Manager is supporting the nursing team with person centred care planning. Further training was also provided on the 19/05/2021.

A new online training platform was launched on 01/03/2021. The home management team (PIC & APIC), administrator and HR team are working hard to train all staff on the full capabilities of this system and on the production of relevant reports from same. The Quality Manager will review the training matrix on all site visits. The adminsitrator will publish a report every Monday for the PIC.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
This complaint has now been resolved to the satisfaction of the resident in line with the centers complaints policies.

The process of how we log, investigate and respond to concerns/complaints is now under review. All staff have been reminded that resident feedback is encouraged and all concerns should be reported to the nurse in charge. To ensure consistency, all concerns/complaints will be logged and reviewed on a weekly basis with the Quality Manager. Learning from complaints has always been disseminated to the team at the Quality & Safety meetings and this will continue. The outcome from all complaints will be documented consistently and as per company policy. The quarterly complaints/concerns/compliments audit will be completed comprehensively and audited by the Quality & Governance Coordinator.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Additional documentation and assurances to support this compliance plan were submitted to the chief Inspector. This included: a full fire risk assessment of the centre is to be completed by a suitably qualified professional, report issued by 25/06/21, addition of emergency lighting and signage in the internal courtyard, confirmation of fire compartment boundaries, fireproof certification of the window in the day room, fireproof certification of ceiling hatches and installation of repeater panel and linking of smoking shelter to fire detection centre will be included in Fire Risk Assessment Report 25/06/21.

• Residents PEEPS have been updated. These will be updated as part of the quarterly care plan reviews of if resident's abilities or room number changes.
• Fire training was provided for all staff by a suitably qualified fire training instructor. 25/05/2021.
• An updated fire drill record template was introduced subsequent to the updated fire guidelines issued by HIQA in January 2021. This template requires detailed information about different fire scenarios, staff response and actions and lessons learned. It is signed by the provider and/or the PPIM. The Quality Manager will review this on all site visits to ensure that all drills are comprehensively recorded.

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 full and comprehensive review of resident's assessment and careplanning is underway by the management and nursing team. This will be audited by the Quality Manager. 31/05/2021.

The home has good relationships with psychiatry of later life and has support from a dietician and SALT. More comprehansive records will be maintained which detail the rationale for weight loss and/or care decisions. SAGE advocacy have been contacted and supported the home and will continue to support the residents. All weights and MUST scores will be reviewed weekly and will continue to be reported to the Quality Manager as part of the weekly report. The Quality Manager will also review all residents records routinely to ensure that all Clinical KPIs are identified and addressed.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The home has good relationships with psychiatry of later life and has support from a dietician and SALT. More comprehansive records will be maintained which detail the rationale for weight loss and/or care decisions. SAGE advocacy have been contacted and supported the home and will continue to support the residents for complex issues. All weights and MUST scores will be reviewed weekly and reported to the Quality Manager as part of the weekly report. The Quality Manager will also review all residents records routinely to ensure that all Clinical KPIs are identified and addressed. Compliance plan discussed at all handovers and in recent staff meetings.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A further resident survey has been undertaken 15/04/2021 and all feedback has been used to inform the services. Regular feedback will be sought through residents meetings, resident/representatives surveys, a resident/representative meeting 01/07/2021, comments cards and care plan review meetings.
• Residents have been reminded that SAGE advocacy services are available to them. Staff have also been reminded.
• The home management team and the Quality Manager will guide and mentor the team

with person centred care planning.
• Residents feedback has been sought re. the social and recreational programme available. This feedback has informed the weekly schedule. On the day of inspection the weekly schedule was not displayed on the residents noticeboards. The PIC/APIC now ensures that this is displayed every day. A copy of the schedule is also provided to the residents.

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
Registration Regulation 7 (3)	A registered provider must provide the chief inspector with any additional information the chief inspector reasonably requires in considering the application.	Not Compliant	Orange	21/05/2021
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	Red	20/05/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/08/2021
Regulation 21(1)	The registered	Not Compliant	Orange	31/05/2021

	provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Yellow	31/05/2021
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	Yellow	31/05/2021
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	19/05/2021
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire	Substantially Compliant	Yellow	25/05/2021

	prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	25/05/2021
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	25/05/2021
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective	Not Compliant	Yellow	19/05/2021

	complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.			
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	Yellow	19/05/2021
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	19/05/2021
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a	Not Compliant	Orange	19/05/2021

	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	31/05/2021
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	31/05/2021
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of	Substantially Compliant	Yellow	30/06/2021

	evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Red	16/04/2021
Regulation 9(3)(f)	A registered provider shall, in so far as is reasonably practical, ensure that a resident has access to independent advocacy services.	Not Compliant	Red	16/04/2021