Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Maynooth Lodge Nursing Home</th>
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</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>The Brindley Manor Federation of Nursing Homes Limited</td>
</tr>
<tr>
<td>Address of centre:</td>
<td>Rathcoffey Road, Crinstown, Maynooth, Kildare</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>24 September 2019</td>
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<tr>
<td>Centre ID:</td>
<td>OSV-0004593</td>
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<tr>
<td>Fieldwork ID:</td>
<td>MON-0027382</td>
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About the designated centre

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

Maynooth Lodge Nursing Home is single storey purpose built nursing home that is spacious and laid out in two parts one of which is a separate unit referred to as the dementia friendly area. Eleven residents were being accommodated in this secure unit that had a combined area divided by a corridor as the residents' day and dining room. The centre is registered to accommodate 79 residents. All bedrooms (75 single and two twin bedrooms) have full en-suite facilities that are wheelchair accessible with suitable assistive devices, call bells and aids. The main dining room adjoined the kitchen where meals were prepared and cooked. There was ample communal space throughout which included day spaces and sitting rooms, a smoking room, an equipped hair salon, an oratory, laundry, staff and visitor facilities. Residents and visitors had access to a variety of secure well maintained outdoor garden courtyards with raised beds, paved patios and seating areas.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 55 |
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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
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<tbody>
<tr>
<td>24 September 2019</td>
<td>09:50hrs to 17:30hrs</td>
<td>Sonia McCague</td>
<td>Lead</td>
</tr>
<tr>
<td>24 September 2019</td>
<td>09:50hrs to 17:30hrs</td>
<td>Deirdre O'Hara</td>
<td>Support</td>
</tr>
</tbody>
</table>
What residents told us and what inspectors observed

The inspectors spoke with a good number of residents and some families and visitors during the inspection. Some of the residents who chatted with inspectors had lived at the centre for a number of years and others had been admitted more recently. All were generally satisfied with the facility, food and security, but some areas for improvement were highlighted regarding staffing and occupation which inspectors communicated to the provider representative and management team.

Residents and families said they found the centre was very clean and was well laid out and nicely decorated, and that staff were helpful with one family member saying they go above and beyond to help, but many described staff as busy and said that delays in responding or assisting them were sometimes encountered. They also commented on a lack of structured occupation and meaningful activity on a consistent basis which was also attributed to a turnover and shortage of staff.

Deficiencies in staff and responses to residents was observed by inspectors during this inspection. This was a common theme conveyed to inspectors by those spoken with with one saying they do their best.

Residents told the inspectors that staff were kind and caring and they were aware of staff turnover. They also told inspectors of the new staff that had started recently and knew that new staff were due to commence the following week to support activities.

Capacity and capability

Governance and management arrangements were in place and clear lines of accountability evident.

While areas such as recruitment practices, performance reviews, auditing systems, staff training and complaints management were being managed well. The arrangements around the governance and management of staffing resources and policies required improvement to ensure the quality of the service being provided was person centred and as set out in the centre's statement of purpose and suitable to residents needs and numbers.

A review of the availability and allocation of staff resources was required to ensure appropriate staffing was consistently available to meet all residents' needs, preferences and wishes.

The Chief Inspector was contacted with information about the staffing levels in the
centre. Inspectors observed practice in the centre, spoke with residents, as well as their relatives and visitors where possible, spoke with staff, and reviewed records.

Staff spoken with were knowledgeable of residents likes and dislikes, and their interactions with residents were respectful. A programme of staff training was maintained. However, the inspectors observations and general feedback received from residents, visitors and relatives was that there was not enough staff available and that their daily routine was delayed as a result. The interactions observed between residents and staff throughout the inspection were primarily task orientated care.

Staffing rosters confirmed that staffing levels were inconsistent and numbers or shift patterns were not consistently provided as planned. The staffing resources were strained with little scope for covering unplanned absences. A turnover of staff had occurred and while a recruitment drive was on-going, improvement and evaluation of the staffing arrangements was needed in association with resident preferred activities and dependency needs.

Delays in care practices, and in responding to residents and call bells and usual times of snacks, drinks and lunch were provided as some of the findings supporting inadequate staffing arrangements. The rostering, overlap for handover and supervision in both parts of the centre and between shifts, allocation and mix of new and experienced staff throughout the centre also required review and improvement.

While some opportunities for occupation and recreation had been improved since the new provider took over the running of this centre in April 2019, such as the provision of a bus to transport residents on outings, further improvements were required based on the size and layout of the centre, interests and varying dependency levels of residents and number of staff available to support activities. Inspectors observed that while some attempts were made by staff to engage and occupy a small group of residents for a short period, the staffing arrangements found did not facilitate choices or provide opportunities for meaningful activity and recreation for all residents.

There was a policy and procedure in place for the management of complaints and access to an advocacy service was seen advertised. A separate system of managing concerns was also maintained that should be amalgamated with complaints management.

The person or nurse in charge was nominated to deal with complaints, and to ensure that complaints were appropriately recorded and responded to. A person participating in the management of the centre overseen notifications and complaints, and an appeals process was included in addition to access to the ombudsperson or alternative statutory or advocacy agency advertised.

An electronic log of concerns and complaints was maintained in the centre that demonstrated the complaints policy was implemented in practice. Records maintained demonstrated the nature of the complaint, action taken, engagement and level of satisfaction of the complainant.
Management and staff were open to receiving feedback or information in order to improve the service, and residents were consulted with on a regular basis.

A current record of insurance cover was available and the sample of staff files examined included all requirements outlined in Schedule 2.

### Regulation 15: Staffing

Inspectors were not assured there were sufficient staffing levels in the designated centre during the day and rostered at night.

Inspectors observed that the number and experience of staff available was not sufficient to supervise the number of residents, and meet their identified needs in a timely manner. Inspectors spoke with residents, families and staff members during the inspection. They reported that residents were negatively impacted by deficiencies in staffing and levels available at times.

A review and improvement in staffing was required to ensure there are sufficient numbers of staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times and to take into account unplanned absence of staff, turnover and induction of new staff, scheduled training during work shifts and the size and layout of the building set out in two parts.

The planned and actual staff rota required review and consideration to ensure all staff working in the centre were included, ensure there was overlap in shifts for handover and supervision of resident in all areas, and that the preferences and wishes of residents were accounted for.

**Judgment: Not compliant**

### Regulation 16: Training and staff development

Training and development opportunities for staff was supported and provided.

Staff induction, training, performance assessment and development of staff formed part of the recruitment and appraisal systems and arrangements being implemented and in place.

Records seen confirmed that staff had attended a range of mandatory training such as fire safety, safeguarding and moving and handling.

There was a range of supplementary training offered to staff including infection control, responsive behaviour and dementia, falls prevention, and medication.
management. Evidence of this was seen in staff files examined.

Judgment: Compliant

**Regulation 21: Records**

General, staff and resident records were maintained safely in hard and soft copy formats and were accessible.

Schedule 2 records pertaining to staff files were complete with evidence of Garda Vetting obtained prior to staff commencement contract date.

Judgment: Compliant

**Regulation 22: Insurance**

A current certificate of insurance was available for the centre.

Judgment: Compliant

**Regulation 23: Governance and management**

There was a clearly defined governance and management structure that identifies the lines of authority and accountability, specifies roles and responsibilities for all areas and care provision.

Operational and clinical audits formed part of the regular oversight and monitoring process. Management, staff, resident and introductory meetings with relevant parties were held since the registration of the new provider in April 2019.

There were effective procedures in place for the recruitment, selection and vetting of staff. A turnover in some staff disciplines was reported and evident. The recruitment of suitable staff was ongoing to achieve sufficient resources in line with the statement of purpose.

The person in charge works full time and was undertaking a leadership course that is due to be completed October 2019. Arrangements were in place for the absence of the person in charge, as set out within the statement of purpose.

Reporting and management systems were described and in place. The senior management group participated in this inspection and gave assurances that all areas
identified for improvement including those related to staffing, fire safety precautions, meaningful activity and occupation for all residents, and those associated with care plans would be addressed to ensure that the service provided is safe and appropriate. They agreed to review and revise specific policies to ensure practice was consistent and effectively monitored against its guidance.

Audits were being maintained on a monthly and quarterly basis and were to inform the annual review of the quality and safety of the service.

A recent satisfaction survey had been completed with residents in July and some areas identified for improvement such as menu choices had been addressed.

Judgment: Compliant

**Regulation 3: Statement of purpose**

There was a written statement of purpose that described the service and facilities that are provided in the centre, and its aims and objectives.

Judgment: Compliant

**Regulation 34: Complaints procedure**

An effective complaints and concerns process was in place.

The complaints procedure was displayed prominently in the centre. There was a nominated person and management team who dealt with complaints.

The information received and complaints records viewed by inspectors included the nature of the complaint, investigation of the complaint, response and action plans to address the complaint.

The level of satisfaction of the complainant was also documented.

A parallel but separate system of managing concerns was also operating for issues raised that should be amalgamated within the complaints process and reflected in the policy for evaluation and oversight.

Judgment: Compliant

**Regulation 4: Written policies and procedures**
While there were written operational policies to inform practice and a system in place to ensure that policies, procedures and practices are regularly reviewed to ensure the changing needs are met, some policies required further review and development to ensure sufficient guidance and information was included that was specific to this centre.

Policies such as emergency response, fire safety management, and complaints to include concerns required improvement and should be referenced and evaluated during respective training and auditing or drills.

Judgment: Substantially compliant

### Quality and safety

Residents had good access to nursing, medical and allied health care professionals within the group and in the community.

While there were arrangements in place to assess residents' needs, develop care plans, review those care plans and meet their identified needs, improvements were required in relation to developing and updating care plans, prescription and use of PRN (a medicine only taken as the need arises) medicine and the quality of social engagement.

Safety improvements in relation to fire precautions, fire drills and training material was required, with a need to complete a full review of the fire exit signage and the personal emergency evacuation plans for each resident also being identified.

While plans to deliver a meaningful programme of activities formed part of the business objectives, improvements were required to ensure residents were engaged in meaningful occupation and recreational activity. During the inspection there was very little social engagement as the staff present were supporting residents with personal needs. While some residents were seen talking to the staff or watching TV a number of other residents were walking around the units, in the smoke room or seated with little or nothing to do in the environment around them.

A review of care plans found that each resident had a full assessment on admission to the centre, and care plans were in place setting out how their personal and social needs were to be met. In some examples these plans required review to ensure they were updated as changes occurred and sufficiently detailed with agreed interventions to ensure consistent practices were implemented.

There were arrangements for residents to meet in a forum, and residents were supported to vote in recent elections if they chose to do so. Residents had access to television, radio, newspapers and magazines in the centre. Some had personal telephones while others said they could use the centres phone to speak
with their family and friends. Entry to the centre was controlled and reception staff was seen welcoming and facilitating visitors in a friendly manner and assisting them to locate residents within the centre.

**Regulation 28: Fire precautions**

Adequate arrangements had been made for maintaining all fire equipment or building services. For example, the L1 fire alarm system, emergency lighting and fire extinguishers were regularly serviced as required. However, a full review of the fire exit signage to clearly indicate the route to be followed to the nearest final exit or to indicate a final exit door was required as an absence in parts was noted and shown to the management personnel accompanying an inspector through the premises.

Training records were maintained that indicated that all members of staff had recently received fire training. However, the details of centre's fire safety management policy and the content of the training provided required review and improvement.

Inspectors were not assured that all staff working in the centre were adequately prepared for the procedure to be followed in the case of fire and for the safe and timely evacuation of residents as a compartment evacuation procedure had not been practiced during fire drills.

Fire drill records did not include enough information to provide assurance that staff were adequately prepared for the evacuation and safe placement of residents. Fire drills did not include sufficient simulation and testing of evacuation methods available to staff and residents in order to identify the need for additional fire training, equipment or revisions to the fire precautions and personal emergency evacuation plans (PEEPs), the policy or procedures agreed between management, trainer, staff and resident, where appropriate.

**Judgment:** Not compliant

**Regulation 5: Individual assessment and care plan**

While care plans were in place for residents' identified needs, improvements were required to ensure they were updated and provided enough detail to guide staff in how to meet residents' care needs.

There was an assessment carried out prior to residents being admitted to the centre, and then a comprehensive assessment was completed by a nurse when they were admitted to the centre. The assessment included a range of accredited nursing tools to assess resident skills and abilities, and any risks there may be in relation to their care needs. For example, risk of developing pressure wounds or risk of falling.
These were seen to be completed and updated at regular intervals or more frequently if required.

The sample of care plans reviewed set out residents identified need, the goal to care or support, and also the details of how needs were to be met. However improvement was required to ensure they were person-centred and contained sufficient guidance to ensure current interventions were recorded and care or support was provided, as required. For example the monitoring of a residents fluid balance as set out as a requirement in the care plan, another care plan recommended that that the resident wears supportive foot wear, this resident was observed to walk around in socks during the inspection. There were some inconsistencies in behavioural monitoring records and associated care plans and medicine administration records found. For example, gaps were identified in the behavioural monitoring assessment documentation. The antecedents, behaviour and interventions used were not recorded. As a result, insufficient guidance was available to ensure that interventions such as PRN (a medicine only taken as the need arises) was used appropriately and was subject to an evaluation.

Having reviewed a sample of care plans, the inspectors were satisfied that each resident or their relative had been given the opportunity to outline their wishes at the end of life.

Judgment: Substantially compliant

**Regulation 6: Health care**

Residents had access to a medical practitioner provided by the centre. There was access to other specialists available on referral, including physiotherapy, psychiatric services, tissue viability, occupational therapy, speech and language therapy, dietitian, chiropody, dental services and optical services.

There were links with the community palliative care team.

Judgment: Compliant

**Regulation 7: Managing behaviour that is challenging**

Records showed that the centre was working towards a restraint free environment. Inspectors observed that there had been a significant reduction in the use of PRN medicines (a medicine only taken as the need arises) and bed rails since May 2019.

Improvement was required regarding the direction and indication for use of PRN medicines prescribed to support and guide staff when to use this medicine to ensure
it is the least restrictive measure.

The majority of staff had attended training in behaviours that challenge and further training was planned for later this year.

**Judgment:** Substantially compliant

### Regulation 8: Protection

There were systems and procedures in place to ensure residents were safeguarded and protected from abuse. The provider was a pension agent for 12 of the residents, and there were transparent and robust were systems in place to safeguard residents’ money. The staff members responsible for residents’ monies explained the systems regarding documenting transactions, for example, lodgements, withdrawals and balances.

Staff were facilitated to attend training in recognising and responding to a suspicion, incident or disclosure of abuse. A policy was in place to guide practice.

Staff who communicated with the inspectors confirmed that they had received training on safeguarding vulnerable adults and were familiar with the reporting structures in place.

Any allegations of abuse had been investigated in line with the centre's policy and practices.

**Judgment:** Compliant

### Regulation 9: Residents' rights

Residents had access to the television, newspapers and radio to keep them up to date with local and national news and affairs. On the day of inspection there was no dedicated activity staff. It was observed that the main activity provided on the day of inspection was TV, music and radio.

The person in charge and provider assured inspectors that two new members of staff who would be dedicated to activities were due to start working in the centre within the next week. They informed inspectors that once the activity staff were in place there were plans to provide a varied programme of activities and entertainments across seven days of the week.

Residents were also encouraged to go out into the local community and had visited local areas of interest. There was a regional bus available to the centre, which was
shared with another centre.

There was an independent advocacy service available for residents and information about the service was displayed around the centre.

Religious services were provided within the oratory of the centre and some residents attended a local church. Residents could exercise their civil and political rights and there was a polling station in the centre where residents could chose to take part in local elections and the recent referendum.

Staff were observed to address each resident by their preferred name or title and were respectful and kind in their interactions with the residents they cared for. Staff were observed knocking on bedroom doors and waiting for permission to enter.

Residents had opportunities to meet as a group and with management, with minutes of resident meetings maintained.

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:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
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<tr>
<td>Regulation 15: Staffing</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 21: Records</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 22: Insurance</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Compliant</td>
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<tr>
<td>Regulation 4: Written policies and procedures</td>
<td>Substantially compliant</td>
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<tr>
<td><strong>Quality and safety</strong></td>
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<tr>
<td>Regulation 28: Fire precautions</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 5: Individual assessment and care plan</td>
<td>Substantially compliant</td>
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<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 7: Managing behaviour that is challenging</td>
<td>Substantially compliant</td>
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<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
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<tr>
<td>Regulation 9: Residents' rights</td>
<td>Substantially compliant</td>
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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. Specific to that regulation, Measurable so that they can monitor progress, Achievable and Realistic, and Time 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:

<table>
<thead>
<tr>
<th>Regulation Heading</th>
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<tr>
<td>Regulation 15: Staffing</td>
<td>Not Compliant</td>
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Outline how you are going to come into compliance with Regulation 15: Staffing:
Since acquiring the centre, significant challenges from the existing team have required addressing and continue to be addressed on an ongoing basis in line with best practice and deliverance of quality care. Continuing supports and constant reviews are being given to assist the in-house management team with staff improvements to develop their skills and techniques all of which is further intensified with deployment, training and employment of additional critical skills.

S (1) – A weekly review of staffing will be completed by the Regional Compliance and Support Team. This review will include staffing numbers and staff skill mix. In addition, it will include reference to resident numbers and their dependencies.
(2) – A review and amendment of staff allocation has been completed to ensure supervision of residents and to meet resident’s identified needs in a timely manner.
(3) - The Regional Compliance and Support Team are working closely with the HR Department to ensure the recruitment and retention of appropriately skilled staff, to ensure assessed resident needs are met and to take into account unplanned absence of staff, turnover and induction of new staff.
(4) – All training will be planned in conjunction with the Regional Compliance and Support Team to ensure that this does not impact upon rostered staff shifts.
(5) – The Regional Compliance and Support Team have reviewed the planned and actual rotas on a weekly basis to ensure all staff working in the centre are included, appropriate staff handover opportunities and supervision of residents.
M - Ongoing reviews of staffing, rotas and allocations by the Regional Compliance and Support Team. Resident and family meetings will continue to include specific discussion with regard to their wishes and preferences.
A (1-5) Achievable
R (1-5) Realistic
T – 15th October 2019
Regulation 4: Written policies and procedures Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
S – The registered provider has initiated a full review of all policies post inspection all of which will be referenced during respective training, audits and drills.
M – Complete.
A – Achieved.
R – Realistic.
T – 31st October 2019

Regulation 28: Fire precautions Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
S – (1) A full review of fire exit signage to clearly indicate the route to be followed to the nearest final exit or to indicate a final exit door will be completed by the Operations and Compliance Manager.
(2) – The centre’s fire safety management policy will be reviewed and updated.
(3) – The content of fire training provided will be reviewed and updated where necessary.
(4) – Compartment evacuations will be regularly completed to ensure adequate staff preparation.
(5) – Fire drill procedures will be reviewed to ensure sufficient simulation and testing of evacuation methods. These drills assist in identifying additional training needs, equipment or personal emergency evacuation plans of which the Operations and Compliance Manager continues to work with the Training Team.
M – (1) Fire exit signage where necessary will be updated.
(2) – The centre’s fire safety management policy will be reviewed and updated.
(3) The content of the fire training provided will be reviewed and updated where necessary
(4) – Compartment evacuations will be reviewed for their completion
(5) – Fire drill procedures will be reviewed and updated where necessary. The Operations and Compliance Manager will work with the Training Team should any additional training needs be identified.
A – Achievable.
R – Realistic.
T- 1st November 201

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:
S – (1) – The Regional Compliance and Support Team will complete a review of all care plans to ensure that they are updated and scheduled for regular updating.
(2) The care plans will be reviewed to ensure that they provide enough detail to guide staff to meet resident’s assessed needs.
(3) Care plans will be reviewed by residents and their families at regular meetings to ensure that care plans are adapted to be person-centred.
(4) Care plans will be reviewed to ensure that current interventions are recorded and that appropriate care or support was provided.
(5) Behavioural monitoring records, care plans and medicine administration records will be reviewed by the Regional Compliance and Support Team to ensure that they adhere to the Responsive Behaviours Policy. Staff training will be delivered to support staff in this area.

M – (1) The Regional Compliance and Support Team will complete a review of all care plans to ensure that they are updated and scheduled for regular updating.
(2) The care plans will be reviewed to ensure that they provide enough detail to guide staff to meet resident’s assessed needs.
(3) Care plans will be reviewed by residents and their families at regular meetings to ensure that care plans are adapted to be person-centred.
(4) Care plans will be reviewed to ensure that current interventions are recorded and that appropriate care or support was provided.
(5) Behavioural monitoring records, care plans and medicine administration records will be reviewed by the Regional Compliance and Support Team to ensure that they adhere to the Responsive Behaviours Policy. Staff training will be delivered to support staff in this area.

A – Achievable.
R – Realistic.
T – 25th October 2019

<table>
<thead>
<tr>
<th>Regulation 7: Managing behaviour that is challenging</th>
<th>Substantially Compliant</th>
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<tr>
<td>Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:</td>
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<tr>
<td>S – A detailed review has been implemented by the Regional Manager to assist the PIC to improve direction and indication for the use of PRN medication and to subsequently guide the nursing team.</td>
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<td>M – Complete.</td>
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<td>A – Achieved.</td>
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<td>R – Realistic.</td>
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<td>T – 25th October 2019</td>
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<tr>
<th>Regulation 9: Residents' rights</th>
<th>Substantially Compliant</th>
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<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 9: Residents' rights:</td>
<td></td>
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<tr>
<td>S – Dedicated staff have been assigned to the role of activities to conform with the pertinent regulation.</td>
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<td>M – Complete.</td>
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<tr>
<td>A – Achieved.</td>
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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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 15(1)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>15/11/2019</td>
</tr>
<tr>
<td>Regulation 28(1)(c)(ii)</td>
<td>The registered provider shall make adequate arrangements for reviewing fire precautions.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>01/11/2019</td>
</tr>
<tr>
<td>Regulation 28(1)(d)</td>
<td>The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>01/11/2019</td>
</tr>
<tr>
<td>Regulation 28(1)(e)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>01/11/2019</td>
</tr>
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<td>---------------------</td>
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</tr>
<tr>
<td>Regulation 28(2)(iv)</td>
<td>The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>01/11/2019</td>
</tr>
<tr>
<td>Regulation 04(3)</td>
<td>The registered provider shall review the policies and procedures</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/10/2019</td>
</tr>
</tbody>
</table>
referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

| 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). | Substantially Compliant | Yellow | 25/10/2019 |
| Regulation 5(4) | The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family. | Substantially Compliant | Yellow | 25/10/2019 |
| 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 | Substantially Compliant | Yellow | 25/10/2019 |
shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.

<table>
<thead>
<tr>
<th>Regulation 9(2)(a)</th>
<th>The registered provider shall provide for residents facilities for occupation and recreation.</th>
<th>Substantially Compliant</th>
<th>Yellow</th>
<th>01/10/2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 9(2)(b)</td>
<td>The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>01/10/2019</td>
</tr>
</tbody>
</table>