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:	Firstcare Beneavin Manor
Name of provider:	Firstcare Beneavin Manor Limited
Address of centre:	Beneavin Road, Glasnevin, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	23 June 2021
Centre ID:	OSV-0005756
Fieldwork ID:	MON-0033409

About the designated centre

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

Beneavin Manor is a purpose-built centre in a suburban area of north Dublin providing full-time care for up to 115 adults of all levels of dependency, including people with a diagnosis of dementia. The centre is divided into three units, Ferndale, Elms and Tolka, across three storeys. Each unit consists of single bedrooms with accessible en-suite facilities, with communal living and dining areas. There is an enclosed outdoor courtyard accessible from the ground floor. The centre is in close proximity to local amenities and public transport routes.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	81

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 23 June 2021	13:00hrs to 20:25hrs	Niamh Moore	Lead
Thursday 24 June 2021	10:00hrs to 15:35hrs	Niamh Moore	Lead
Wednesday 23 June 2021	13:00hrs to 20:25hrs	Michael Dunne	Support
Thursday 24 June 2021	10:00hrs to 15:35hrs	Michael Dunne	Support

What residents told us and what inspectors observed

From what residents told us and what the inspectors observed, the general feedback from residents was one of satisfaction with the care provided in the centre. Many residents commented on the staff team and expressed that they were kind to them. Although residents were content with the service they received, inspectors found that there were gaps in oversight arrangements in a number of areas in the centre. These findings, and other areas identified as requiring improvement, are discussed under the relevant regulations in this report.

On arrival at the centre, inspectors were guided by a staff nurse through the infection prevention and control measures necessary on entering the designated centre. This included a temperature check, a questionnaire, hand hygiene and the wearing of a face mask. For visitors and service providers, this measure also included a lateral flow (antigen) test to check COVID-19 status.

On the first day of the two day inspection, inspectors held a short opening meeting with the person in charge of the centre. The centre was based across three floors, the ground floor (referred to as the Tolka unit), first floor (referred to as the Elms unit) and the second floor (referred to as the Ferndale unit). Each floor was then separated into two further units, the park and green units. Inspectors were told the Elms park unit was closed and residents were accommodated in the other five units on the day of inspection.

Inspectors found that the premises and environment was warm and comfortable. The centre was clean, well laid out and overall was well maintained. Seating areas within dining and communal areas had been set up to facilitate social distancing.

Inspectors greeted the majority of the residents within the centre and spoke to seven residents in more detail. Inspectors also spent time in communal areas observing how residents spent their day, how they interacted with staff, each other and participated in meaningful activities.

Activities were provided on each floor by an allocated staff member. Residents were observed to be engaging in activities such as art and watching movies. There was an activity schedule for each floor which recorded activities seven days a week. However inspectors were aware that two planned activities did not occur on floor two during the inspection. Inspectors were told this was due to the activity staff member assisting with the provision of care to residents.

Residents' bedrooms were personalised with residents' belongings and personal possessions and were observed to be clean and comfortable spaces. Residents confirmed with inspectors that they were happy with their bedrooms.

Allocated staffing levels in one of the units did not ensure sufficient supervision of residents. Inspectors observed that a number of residents with complex needs were

left unattended in their bedrooms. A resident was walking throughout the corridors unsupervised and on one occasion, carried a "wet floor" sign used by domestic staff. A resident who was displaying responsive behaviours was trying to call for staff attention for some time while the area was unsupervised.

Inspectors observed a meal-time and found it to be a pleasant and enjoyable experience. Residents were assisted in a respectful and dignified manner with good engagement by staff. Residents were complimentary of the food choices provided to them by the catering staff in the designated centre.

Inspectors observed good hand hygiene practices by staff and compliance with personal protective equipment (PPE) on the day of inspection.

Staff who spoke with inspectors during the inspection were knowledgeable about the residents and were aware of their needs and preferences for daily care routines. Overall, inspectors observed that staff were attentive to residents' needs in a kind and caring manner. However, inspectors found that there was inconsistencies with staffing, as second floor staff were under pressure and as a result were unable to attend to residents' needs at all times. During the two inspection days, five staff members told inspectors that there were times when they found it difficult to complete all of their tasks and duties.

In summary, residents gave positive feedback on their experience of living within the centre. However, a number of areas required improvement to ensure that all residents were offered a safe, comfortable and meaningful quality of life. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Information was not readily available to inspectors during the inspection. Inspectors found that governance and management systems required strengthening and general oversight required review. There were insufficient management systems to ensure the safe delivery of care, particularly in the areas of safeguarding, staff resources and complaints management.

Firstcare Beneavin Manor Limited is the registered provider for Firstcare Beneavin Manor. There was a defined management structure within the designated centre. The provider employed a person in charge, who was supported within their role by an operations manager, an assistant director of nursing and three clinical nurse managers (CNM).

This unannounced inspection was prompted by unsolicited information and notifications received by the Chief Inspector. This raised concerns about supervision of residents, staffing levels, care of residents and poor communication with families.

Inspectors found evidence to support some of the concerns raised which is discussed in the report. The inspectors also followed up on actions required from the previous inspection which took place in December 2020.

Improvements were required in how the centre used the information they collected to drive quality improvements. Gaps were found in risk assessments and safeguarding which will be further discussed within this report. Furthermore, while management meetings were held between the PIC and member of the Firstcare management team, there were gaps seen in oversight arrangements. The recording of management meetings needed to improve. The provider informed inspectors of improvement plans they have developed but this had not been recorded in minutes. Management meetings did not identify action plans to ensure areas for improvement had been addressed.

Inspectors were told that staff members were allocated per floor and then per unit on the floor during the day. There was a CNM assigned to each floor. There was one nurse on duty during the day for each of the five units. Nurses were supported by a team of care assistants and social activity workers during the day.

Inspectors found that there was insufficient staffing levels on floor two of the centre and that residents with high support needs were being supported to retire to bed at 6.15pm. The staffing levels on this floor required review due to the complexity of residents needs and their level of dependency.This will be discussed further under regulation 15 and 23.

There were arrangements in place for staff to access mandatory training which included Fire safety, moving and handling and safeguarding training. The staff training matrix indicated that all staff were up to date with their mandatory training. Staff had access to supplementary training, which included Infection prevention and control training, cardio pulmonary resuscitation (CPR), medication management, dementia, care planning and complaints management training.

There was an induction programme available for new staff. This involved new staff members shadowing experienced staff for seven shifts. Inspectors found evidence that a recently recruited health care assistant was working on their second shift. This staff member was not recorded on the original roster provided to inspectors.

Improvement was required in the management of information. This inspection took place over two days and the systems in place made it difficult for inspectors to retrieve the information requested. Inspectors were not given access to all the documentation that they requested, for example inspectors were not given access to contracts of care and information relating to audits was slow to be received. Inspectors had access to a roster that they were told was incorrect one hour before the close of the second day of inspection.

There was no schedule of audits within the centre. Following a review of audits, inspectors found that while information was collected, it was not sufficiently analysed to develop clear quality improvement plans with appropriate timelines and allocated to appropriate personnel. This is further discussed under Regulation 23:

Governance and Management.

The centre had a complaints procedure and register in place. The PIC was identified as the centres complaints officer and complaints were overseen by a member of the Firstcare management team. Inspectors reviewed a sample of complaints within the register. The centre had open complaints that were still under review. While there was thorough investigation and responses seen in some complaints, inspectors observed that not all complaints were sufficiently investigated. Inspectors found that improvement was required in the management and oversight of complaints received. This is discussed under Regulation 34: Complaints Procedures.

Regulation 15: Staffing

Inspectors found that the staffing was insufficient to meet the needs of the residents on the Ferndale unit. The outcome for the residents on this unit was:

- Lack of activity provision due to the activity coordinator being assigned to the provision of care.
- On occasions, residents were unsupervised in communal areas.
- Inspectors observed and were informed that residents on this unit who were not mobile were in bed at 18:15pm.
- Staff informed inspectors that there was not enough time to complete their duties and tasks due to the complex needs of the residents on this floor and inadequate staffing levels. This resulted in residents having to wait for staff input but also resulted in residents not receiving the required levels of supervision they needed.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors found evidence where the centre had not followed their own induction process. For example, a new staff member who was due to be shadowing permanent staff and supplementary to the rota was rostered on the rota for their second shift. This meant that this new staff member was not appropriately supervised by more senior staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that a review of the management systems within the centre was required. For example:

- Inspectors were informed that the provider was in the process of carrying out a review of staffing levels. This review would take into account the needs of residents based on dependency levels and the layout of the building with a view to establishing appropriate staffing levels. As this process was not complete, on the day of inspection staffing levels were not sufficient on the second floor.
- The provider failed to have sufficient oversight with regard to safeguarding, complaints management and audits. Inspectors were not assured that the information documented from audits, risk assessments and complaints were analysed sufficiently and required improvements implemented.
- Information was not forthcoming during the inspection. Documents were requested on a number of occasions and some documentation was not provided to inspectors.
- Inspectors did not see evidence that the analysis of information was leading to quality improvement plans being developed and put into action. For example, provider assurance reports issued to the provider were not discussed within management meetings to drive learning for the centre.
- There was a lack of evidence that audits were used to inform service improvements. Care plan audit information provided to inspectors was for one unit only and inspectors were not assured that the results of these audits would improve the quality of care plans going forward. Audits contained analysis and action plans but were found not to be signed off by the management team. An audit of a care plan indicated a score of 57.6% regarding its compliance however actions to address this low compliance level was not available for inspectors to review.

An annual review of the quality and safety of care delivered to residents was completed for 2020. However this review did not incorporate feedback or consultation with residents families.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors followed up on the compliance plan from the previous inspection and requested access to a sample of contracts of care. Inspectors were not given access to any of the resident contracts during the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors found evidence where the centre had not followed their own complaints policy relating to the recording and investigation of verbal complaints.

Inspectors were not assured that the centre had sufficiently investigated, analysed or put in place measures required for improvement in response to all complaints. For example, inspectors reviewed the complaints audit completed in May 2021. While there was some evidence of learning and an action plan being developed, inspectors found that a key trend had not been identified. This related to 20% of complaints received throughout 2021 relating to one individual. As a result this was not addressed in the action plan.

Judgment: Substantially compliant

Quality and safety

While there were examples of good quality care interventions which enhanced the lived experience for residents in some parts of the designated centre, inspectors found that this was not consistent across the service. There were a number of improvements required to ensure that residents' health and social care needs were prioritised in all units of the designated centre. These improvements are highlighted under the regulations relating to care planning, health care, managing behaviour that is challenging, restrictive practice and protection.

All care records seen indicated that residents were assessed prior to being offered a place in the nursing home. Upon admission, a comprehensive assessment of residents needs was conducted and resulted in the formulation of care plans to meet their defined needs. Where residents were unable to contribute to these care plans the views of family members were accessed and incorporated into the plans. A variety of accredited assessment tools were used by staff to assess residents needs and were incorporated into individual care plans. Inspectors also found that care interventions were not sufficiently specific to the need identified in the care plan and therefore presented difficulties in ensuring that care inputs were appropriate.

Residents had access to a GP service who visited the centre on at least two occasions per week but visited more often if required. There was access to dietetic support, speech and language therapy and tissue viability nursing by referral to community based services. Input from occupational therapy and physiotherapy was provided in house as they formed part of the designated centres staff team. There were also arrangements in place for residents to receive specialist input from psychiatry of later life and the palliative care team as and when required. Referrals for other health services such as dental, aural and opticians were made by referring to the GP service or arranged on a private basis. A review of clinical information collated in audits and systems to ensure the timely delivery of aids required

improvement to ensure residents health care needs were met on a consistent basis.

Residents were happy with the quality and quantity of food available to them throughout the day. There was good oversight of the meal service with residents views on food provision sought at regular intervals. A lunchtime meal service was observed to be well managed by the staff team with residents in receipt of appropriate levels of support to be able to enjoy their meal. There was sufficient space available in the dining room with suitable seating available for all residents present. The inspector observed soft music being played in the background which promoted a calm dining experience. A number of residents who chose to remain in their rooms had their meals brought to them by staff who provided additional assistance where needed.

There was a policy and procedure was in place to inform the care and management of residents who experienced responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). Observations carried out in a unit for residents with responsive behaviours found that they were supported in a manner that preserved their dignity and autonomy. There was a one to three staff to resident ratio with one staff nurse and four to five care staff available for 21 residents on the unit. This level of support promoted the supervision and care for residents. In instances where residents were displaying responsive behaviours staff responded quickly and intervened in a person centred manner and were able to diffuse conflict situations as they arose.

There were a number of restrictive practices observed and reviewed on the day of the inspection. Care records reviewed indicated that where residents had a restrictive practice in place such as bed rails or sensor mats there was a risk assessment in place for its use. Residents' consent was obtained or if they were unable to provide consent due to impairment discussions were held with family members. There was clear rationale in place for the introduction of restrictive practices which were subject to regular review. Inspectors noted that the least restrictive option was always trialled first. The restrictive practice register presented to inspectors however did not indicate that practices which prevented residents from moving without hindrance in and out of their respective units as an environmental restraint.

All staff were facilitated to attend training in recognising and responding to a suspicion, incident or disclosure of abuse. Staff training records made available to inspectors confirmed that all staff had attended this mandatory training. There was a policy and procedure in place to support staff in this area which they found useful. Inspectors observed staff and resident interactions over the course of the inspection and found that staff demonstrated empathy and respect for the residents.

While there were policies and procedures in place to protect residents from abuse bolstered by staff safeguarding training, inspectors found a concern of abuse which was not effectively managed. Documentation relating to two incidents were reviewed with clinical staff and indicated that the potential harm posed by a residents behaviour was not captured, recorded or communicated in a manner that

safeguarded other vulnerable residents living in that unit.The risk assessment associated with a resident's behaviour was not appropriate to protect the residents.

Inspectors reviewed residents' questionnaires that the centre were completing with residents. There was evidence of resident consultation in the centres quality improvement plans and projects. Inspectors found however that activity provision was not consistent throughout the centre. The lack of activity provision was evident on the second floor with residents in the upstairs communal room sitting without having meaningful activities available to occupy them. The activity worker assigned to this area was found to be spending potions of their time engaged in caring duties.

The centre was completing lateral flow testing for all visitors and service providers. A staff nurse was assigned to complete the test and then visitors would wait outside the designated centre for 15 minutes while the results were received. Window visits were available for visitors who declined the lateral flow test. The use of this testing was being reviewed to clarify the requirement of the test going forward for visitors who were vaccinated. The centre had allocated visiting rooms on each floor. Inspectors were told that compassionate visits took place in residents' bedrooms. Two residents told inspectors that they would like to have their regular visits from their family members in their bedrooms. The person in charge told inspectors that this was under consideration.

Regulation 11: Visits

The centre had a COVID -19 Visitor Policy which was updated on 23/04/2021. Each floor has its own private visitors meeting room. Inspectors were told visits occurred from 11am to 7:15pm seven days a week.

Inspectors saw that visits with family members external to the designated centre were risk assessed.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Inspectors found that while care plans identified resident's needs, interventions to meet those needs were difficult to evaluate. Interventions required a more clear structure which the provider acknowledged during the inspection. It was also found that some care plans did not reflect the changing needs of residents and meant that current interventions were not suitable.

Judgment: Substantially compliant

Regulation 6: Health care

A review of a medication audit provided for one unit over a series of months found that there was a recurrent issue that had not been dealt with or signed off as completed by appropriate personnel.

A recommendation made by a medical professional regarding the provision of equipment in March 2021 and in May 2021 to enhance two resident's safety was not dealt with by the provider. The provision of this equipment was not actioned by the person assigned to do this despite this omission being highlighted in the residents care notes. This delay put the resident at potential risk of injury and harm.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

One restraint register for one of the units was provided for inspectors to review. This register indicated the type of restrictive practices currently in operation in that unit. However not all environmental restraints were documented in this register. For example, the register did not include where residents were unable to exit their unit without the assistance of staff, due to doors being locked. In addition, due to a lack of resources on one of the units, residents were encouraged to retire early to bed.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found a recent concern where improvements were required to ensure residents were safeguarded from abuse. Documentation relating to robust risk assessments and the updating of care plans, detailing the nature of the risk and the specific interventions to manage this risk were not in place and resulted in residents being put at risk. Information regarding a resident's behaviour on a specific date was not entered into the risk assessment which meant this risk was not properly managed and as a result potentially put other residents at risk of abuse.

Judgment: Not compliant

Regulation 9: Residents' rights

The activity schedule on one of the units was not adhered to on both days of the inspection. During observations throughout the inspection, inspectors were not assured that all residents had sufficient access to meaningful activity.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The majority of residents spoken with were happy with the quantity and quality of food provided. There was a varied menu on display which informed residents of the three menu options available to choose from. There was also a vegetarian option available for residents. The food for the designated centre was prepared on the campus and transported to each of the individual units within the designated centre prior to being served to the residents.

Residents had their nutritional status regularly assessed with referrals made to the dietitian and speech and language therapist when a concern arose. Resident preferences regarding their diet options were recorded in their care plans. Inspectors were shown documentation by a member of the clinical team which confirmed that residents with specific dietary requirements were provided with appropriate textured diets.

Judgment: 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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 18: Food and nutrition	Compliant

Compliance Plan for Firstcare Beneavin Manor OSV-0005756

Inspection ID: MON-0033409

Date of inspection: 24/06/2021

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:
1. There is a preplanned/ approved activity programme for each unit and there is a full time Social Care Lead allocated to each unit. The PIC / ADON/ CNM will visit each unit daily at various times to ensure that the activities as planned on the programme are happening and will monitor workloads to ensure that activities are not negatively impacted on 28.06. 2021.
2. There is a staffing review underway, which commenced in May 2021, in line with the expert panel recommendation. This will be complete 28.09.2021.
3. There is an approved staffing grid in use, which outlines staffing levels. This grid is kept under review and has been reviewed 1.07.2021. The staffing levels for the unit indicated that an additional staff member may be warranted where dependency levels are higher, however the current occupancy for the unit is 14 (58%), staffing levels are 1 x staff nurse; 3 HCAs which equates to a 1:3.5 ratio, which is sufficient to meet the current needs of residents.
4. The CNM / Nurse will report to the PIC/ADON immediately if any staff member has not reported for work, the PIC/ ADON will arrange for additional cover, review workloads of other areas to ensure that care, supervision & activity needs can be met as required. Where a staff member does not present for work and does not contact the nursing home to provide an explanation, the CNM will notify the PIC/ ADON and the PIC/ ADON will cover their planned next shift(s) 28.06.2021.
5. There will be a daily check of each unit between 6pm & 7pm, to monitor the numbers of & reasons why residents may be in bed early. Where the reason for this is because of fatigue, pressure area care management, residents' choice etc. this will be recorded in the residents' care plan. The PIC will monitor for trends/ patterns to ensure that those residents rights are respected. 28.06.2021

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Provider had put in place a very robust and thorough induction programme for new staff, which includes training prior to work placed induction and a 7-day supernumerary program to support their inclusion and to ensure that they have opportunity to become familiar with the residents, staff, systems, and the building. The PIC will ensure that all staff on induction will not be included in roster staff numbers and will ensure that staff on induction will have adequate support 28.06.2021.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The PIC will ensure that all information regarding safeguarding issues, changes to previously agreed action plans are discussed with senior staff prior to making any decisions / changes, risk assessments will be reviewed with senior team prior to making any changes. Risk assessment which are specific to individual residents will be filed on EPIC to ensure ease of access 28.06.2021.
2. The audit program has been documented and will be available for future inspections. The PIC/ ADON & CNMS will attend audit analysis training to ensure that they can fully understand data collected, analyse this, create action plans, and show evidence of learning from audits 31.08.2021.
3. There is a FirstCare system in place whereby all documentation that is to be maintained should be stored in the PICs office in 12 Evidence Folders. These will be updated to ensure that all necessary documents are stored only in the PIC Office, are readily available & easily accessible. Those staff collecting data will be advised of the time periods & dates in which they must present their completed audit tools to the PIC for analysis. The evidence folders review will continue to be part of governance reviews 31.08.2021.
4. There are formal monthly governance meetings – there are references to complaints, PARs etc being discussed , moving forward the minutes will be recorded with more detail as to the exact discussions, agreed actions plans etc. 31.08.2021.
5. Currently there are both computerised and 'hard copy/ records of individual resident files, all of these hard copy documents will be scanned to EPIC and in future only EPIC records will be maintained (apart from visiting plans, GP records) 31.12.2021
6. The Contracts of Care are now stored in the PIC's office and will be provided immediately on request from inspectors during inspection 28.06.2021.
7. A recent Family survey was completed, and data is to be analyzed and collated, a further survey will be completed by 10th December and the findings from both of these surveys will be included in the Annual Review for 2021. 31.01.2022

8. The provider has provided onsite support, a very experienced clinical facilitator will work directly with the PIC/ ADON/ CNMs & Nursing Staff focusing on resident risk and risk management, care planning and ensuring that risk is understood by all teams. 28.06.2021

Regulation 24: Contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
The Contracts of Care are maintained, and they will be stored in the PIC office to ensure that for future inspections they are readily available. 28.06.2021

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. All senior nursing staff in the nursing home will attend formal & informal complaints training. 30.09.2021
2. Complaints received May -July will be analyzed as per Audit program in August, and this will be supported by a member of the senior management team to ensure that learning is evident from the analysis. In addition, the previous audit analysis will be reviewed and updated to ensure that learning is reflected in the audit & the action plan addresses any identified patterns/ trends 31.08.201.
3.The PIC/ ADON will review priority entries in the EPIC CRM system and will monitor for entries regarding engagements with others, which may be considered as complaints when reviewed in more detail 26.07.2021.

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:
Care plan review in progress, with a plan to restructure how care plans are recorded to

ensure that they are updated and amended to reflect changes in residents care & care needs. The Roper Logan & Tierney Nursing Model will be used to guide the care plans, making them more 'user friendly' . A pilot study will be completed by 31.08.2021 which will then be reviewed to determine if this system will be more effective. This project will be supported on site by an experienced Clinical Facilitator.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The recommendations that the physiotherapist and occupational therapist make regarding equipment and falls preventative measures are now recorded in a specific Falls Clinic Diary, the Diary is maintained by the PIC who monitors that the recommendations have been actioned and ensures that equipment is ordered and in place 28.06.2021.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
There is only one restraint register in place, which details all of the restrictive practices (including bedrails, posey alarms, bed against walls, specialist chairs). This has been reviewed and the environmental restraint risk assessment, which was on the risk register will now also be included in the restraint register. 28.06.2021

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The PIC will ensure that all information regarding safeguarding issues, changes to previously agreed action plans are discussed with senior staff prior to making any decisions / changes, risk assessments will be reviewed with senior team prior to making any changes, and care plans updated. Risk assessment which are specific to individual residents will be filed on EPIC to ensure ease of access. 28.06.2021

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. The PIC / ADON/ CNM are visiting each unit daily at various times to ensure that the activities as planned on the program are happening and will monitor workloads to ensure that activities are not negatively impacted on 28.06.2021.
2. The PIC is meeting with Social Care Team staff fortnightly to monitor and review the activity program, and to be assured that the programs include activities that meet the needs of all residents 2.07.2021.
3. In supporting this a new multisensory program which is interactive and can support meaningful interaction and care outcomes is now in place (records are being maintained to monitor effectiveness/ impact) Social Care Staff have been advised that they must ensure that planned activities go ahead, and if this is not the case, they must inform the CNM/ADON/ PIC immediately so that staffing can be reviewed 28.06.2021.

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	28/09/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	28/06/2021
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	31/12/2021
Regulation 23(e)	The registered	Substantially	Yellow	31/01/2022

	provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Compliant		
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Not Compliant	Orange	28/06/2021
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Substantially Compliant	Yellow	30/09/2021
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which	Substantially Compliant	Yellow	30/09/2021

	includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.			
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	31/08/2021
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Not Compliant	Orange	28/06/2021
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	Substantially Compliant	Yellow	28/06/2021

	respond to that behaviour, in so far as possible, in a manner that is not restrictive.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	28/06/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	02/07/2021