Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	TLC Centre Maynooth
Name of provider:	TLC Nursing Home Limited
Address of centre:	Straffan Road, Maynooth, Kildare
Type of inspection:	Unannounced
Date of inspection:	06 February 2019
Centre ID:	OSV-0000684
Fieldwork ID:	MON-0023503

About the designated centre

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

TLC Centre Maynooth is a ground floor nursing home located on the outskirts of Maynooth, Co. Kildare. The centre is registered to accommodate up to 141 residents within two buildings that are divided into five areas- Kinvara House, The Courtyard, Oak House, Arkle House and Champ House (Corridor 4). Kinvara House is in a separate building that accommodates 57 residents. Bedroom accommodation consists of 41 single bedrooms and eight double/twin bedrooms with full en-suite facilities. A variety of open plan and communal spaces were available. Meals were transported to Kinvara House kitchenette/dining room from the kitchen located in the other/main building. Oak House located in the main building accommodates 12 residents living with dementia or Alzheimer's disease, bedrooms comprise eight single and two twin/double. The Courtyard accommodates 32 residents in single en-suite bedrooms. Arkle House and Champ House (Corridor 4) consist of 20 twin/double en-suite bedrooms. These areas share the facilities and communal areas within the main building. The ethos of the centre is to promote residents independence and value individuality. The aims of the centre are to meet the individualised needs of residents by encouraging them to continue to lead as active and fulfilling a life as is within their desires and capacities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	141

How we inspect

To prepare for this inspection the inspector or 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
06 February 2019	15:00hrs to 21:45hrs	Sonia McCague	Lead
06 February 2019	15:00hrs to 21:45hrs	Leanne Crowe	Support

Views of people who use the service

Residents spoke positively about the staff and management. While residents spoken with felt cared for and safe in the centre, some identified areas for improvement as did some relatives.

Some of the residents spoken with thought that the programme of activities in the centre did not always meet the residents' different needs and preferences. A number of residents were dissatisfied with the quality and temperature of the food, stating that it was sometimes cold and didn't always take residents' personal preferences into account.

Capacity and capability

This centre is operated by a well established governance and management group who strive to provide a service that fulfils its statement of purpose and achieve its objectives. In recent months, changes in staff, additional activity and demands had impacted on the overall service. As a result, some improvements were necessary to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Improvements in relation to the deployment of resources and effectiveness of the oversight arrangements and management systems including staff training, supervision, skill-mix and support available to ensure a safe and consistent care service were required. Improvement in relation to staff access to and completion of resident records and aspects of the premises that may adversely impact on the care and welfare of residents was required.

During the inspection feedback held with the management group, it was evident that some areas identified as in need of improvement had already been identified by management and measures were being taken or were planned to address them. The management team had learned lessons from incidents and events that had occurred and demonstrated a commitment to review and improve the overall management systems in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

The improvements required from the previous inspection were partially addressed as further improvement in relation to food, end of life planning and maintaining behavioural records was required. Assurances were given that improvements would be brought about as a result of the learning, and from the findings of the inspection and monitoring reviews on-going.

Inspectors were informed of the baseline staffing levels and skill-mix required for the designated centre, with 141 residents accommodated in two buildings. A copy of the planned and actual rosters were made available. These were reviewed with management and discussed with staff on duty. A turnover of staff had occurred in recent months and the recruitment and replacement of staff was on-going. For example, five nurses engaged within the recruitment process were named and listed on the day duty roster for this month. Of the five, one had a commencement/training date of 16 February 2019. A relief panel of nine nursing staff were also listed. However; the availability from this panel was limited as a requirement to redeploy senior nursing managers to replace nurse shifts and vacancies was evident.

Arrangements were described for staff to be supported and supervised to carry out their duties; however, the need to redeploy nurse managers/supervisors to deliver direct care due to the absence of nurses detracts from their intended role and function of ensuring staff are appropriately supervised.

A review of staffing numbers, supervision and allocation of skill-mix was required as some practices observed reflected task orientated delivery of care as opposed to person centred care by staff familiar with each resident and their needs and preferences.

Based on the inspection findings, training and educating staff in relation to the management and delivery of person-centred services that are informed by up-to-date personalised care plans which are subject to review was also required.

A comprehensive staff training programme was described by management. Staff training was initiated following the recruitment and selection of new staff and refresher training was to be provided thereafter. But gaps in mandatory and relevant staff training and refresher were noted and further training and staff development was required for staff to improve and ensure positive outcomes for all residents.

There was a policy and procedure for the management of complaints. A complaints log was in place which recorded all complaints and the outcome of the complaint. However, the satisfaction level of the complainant was not consistently recorded when concluded as resolved. Additionally, the majority of issues raised were documented as concerns, but the complaint's policy did not have a formal process for managing issues in this manner.

Regulation 15: Staffing

The numbers and skill-mix of staff at the time of inspection were insufficient to meet the needs of residents in a person centred manner.

While a planned staffing roster was available that outlined the numbers and skill - mix of staff required to meet the needs of the residents, and the size and layout of

the designated centre, the actual numbers and skill-mix required was not available consistently or available on the day of this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Mandatory and relevant training formed part of the training programme outlined with specific topics to be completed by staff dependent on their role and responsibilities. The audit record of staff training was available and was inspected with the person in charge. A number of gaps in mandatory and relevant staff training were identified and highlighted for follow up.

Staff were not appropriately supported or supervised on a consistent basis at all times.

Judgment: Not compliant

Regulation 23: Governance and management

Leadership, governance and management arrangements were in place, but some areas of oversight and monitoring required improvement to ensure residents experienced a personalised and appropriate service by trained staff within a suitable environment.

An established governance structure was in place with clear lines of accountability at individual, team and service levels so that all staff working in the service were aware of their responsibilities and to whom they reported to.

Management arrangements and systems were in place to monitor and oversee the service through on-going audit and monitoring of key performance indicators and outcomes. Areas for improvement within these systems were identified and are outlined in the dimension summaries within Regulations that were non-compliant.

Inspectors were informed that the annual review of the quality and safety of care delivered to residents in 2018 was near completion and a review of the statement of purpose and function document was also underway.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifications of incidents and events were submitted to the Office of the Chief Inspector as required.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a policy and procedure in place for the management of complaints. The policy was under review at the time of the inspection. A 'complaints, concerns and compliments' log was maintained in the centre, with the majority of issues raised with staff being recorded as concerns. However, inspectors found that the complaints policy did not refer to concerns, and therefore a formal process had not been set out for managing such items. Inspectors noted that details of concerns were recorded, as well as any action taken, but records did not consistently include the date of resolution or the satisfaction or dissatisfaction of the complainant with the outcome of the complaint. Complaints were documented in line with the centre's policy.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Schedule 5 policies and procedures were available in the centre.

Judgment: Compliant

Quality and safety

The centre was homely and welcoming to all. While management and staff aimed to promote safety and quality in the provision of health and social care services, improvements were required.

The matters arising from the previous inspection in relation to the premises and use of office facilities in communal space and air/room temperature were being managed satisfactorily. But other necessary improvements in the premises were

identified.

Measures had been taken to monitor the temperature of the environment and manage office space within communal areas, but factors such as the noise levels within open plan communal areas required review to ensure the impact of noise from activities did not affect those relaxing or meeting with visitors and sitting on the periphery of these areas. A separate area or a room for quiet reflection or meeting family in private in each House or building was required as 62 residents were sharing twin bedrooms (31 bedrooms) in the centre. A review of the storage arrangements and facilities for waste management in some areas was also needed.

Residents had a range of assessments completed on admission. The assessment process involved the use of validated tools to assess areas such as a resident's dependency level, risk of malnutrition, falls and mobility, skin integrity and pain level. Observation and safety checks were also recorded as part of the care practice. However, improvement in the overall assessment, recording and care planning process was required to ensure all identified needs were supported with a personalised care plan detailing specific interventions agreed that were updated as changes occurred. A review of or a revised care plan was not implemented and recorded sufficiently to guide staff delivering care and some responsible staff were unable to access the assessment and care plan records.

Some care plans available were generic in nature and would not aid evaluation of interventions and treatments prescribed or given. Of the care plans reviewed by inspectors, gaps in care plan recording and in the review process were evident. Additionally, assessments carried out by other health care professionals had not been referenced, updated or reflected within the care plans seen to ensure an agreed or consistent practice was delivered. A lack of recorded evidence was found in relation to some aspects of care being planned in consultation with residents.

Management and staff spoken with were aware of the needs of residents' with responsive behaviours but treatment plans were insufficiently documented or detailed to describe the behaviour or to guide staff to make considered evaluations regarding progress or deterioration of the behaviour support treatment and care delivery.

A restraint-free environment was promoted within the centre, with management and staff endeavouring to trial alternatives before implementing any restraint as a last resort. Policies and procedures for fire safety management, risk management and responding to emergencies was also in place.

Unsolicited information received by the Office of the Chief Inspector included concerns regarding food temperature at mealtimes. Management and staff told inspectors they had also been made aware of this concern and were in the process of reviewing the serving arrangements in place during mealtimes.

Inspectors observed the preparation and serving of an evening meal in Kinvara House. They concluded that the dining experience for all residents required improvement as a social occasion that offered all residents opportunities to interact, socialise and engage. Many residents dined in their bedrooms and inspectors were

not assured that this arrangement was person-centred or appropriate.

There was a programme of activities in place throughout the centre. During the inspection, inspectors observed groups of up to 11 residents singing in communal areas in each building. Inspectors noted that while this was a very positive experience for those taking part, many of the other residents accommodated in these units were in their bedrooms during this time. Additionally, inspectors were informed that many of the activities took place in communal areas rather than dedicated activity rooms. The management team were asked to review the number of residents remaining in their bedrooms daily and the activity arrangements so as a more effective use of rooms and communal areas could support a more balanced activity experience to facilitate all residents.

Resident and relative forums were held regularly to promote engagement and aid communication. Minutes included action plans developed to record and resolve issues raised. However, inspectors noted some issues had been raised repeatedly in the last number of months in different forums which indicated that further work was required to ensure concerns are resolved in a timely manner and evaluated thereafter.

Regulation 13: End of life

Inspectors were informed by staff that appropriate care and comfort to address the individual needs of residents was provided when residents were approaching their end of life. However, residents' preferences in shared bedrooms (31) had not been obtained in respect of having a private room.

Judgment: Substantially compliant

Regulation 17: Premises

This regulation was not fully reviewed on this inspection. The matters from the previous inspection were followed up and in doing so some other areas for improvement were identified.

While the design and layout of the residential service was suitable for its stated purpose, some areas for improvement were identified in relation to storage arrangements, waste management, malodour in parts and noise levels in open plan areas.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The matters arising from the previous inspection were followed up in relation to the use of plastic utensils and cups. While this had been addressed further improvement was needed in relation to the overall dining experience for residents attending the restaurant and those dining in their bedrooms.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a policy in place for risk management. Risk assessments had been carried out in response to risks identified throughout the centre, and individual residents' care plans had been updated as required.

There were arrangements in place for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Judgment: Compliant

Regulation 28: Fire precautions

Adequate precautions against the risk of fire were in place and maintained.

Fire safety precautions, means of escape and evacuation procedures including simulated drills to identify difficulties and inform staff, aid learning and promote health and safety were maintained.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Access to a GP, pharmacy and allied healthcare professionals was confirmed by staff and noted in the records reviewed.

Assessment and care planning formed part of the care model and nursing process. However, residents' assessed needs and arrangements to meet these assessed needs were not sufficiently set out in individual plans. Consultation with the

residents in relation to treatment interventions and care planning was not evident in some records available. Treatment and care plans were not routinely subject to a review as required and in the sample examined some reviews exceeded four months. Safety checks and observational records were not consistently completed as required. Care planning particularly required improvement in relation to the management of wounds, responsive behaviour, and seizure activity, end of life care decisions, dining and seating arrangements.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

A restraint-free environment was promoted within the centre. There was a policy in place to inform the use of restraint. A small proportion of residents within the centre used a form of restraint such as bedrails. There was evidence that decisions to implement any form of restraint were supported by a multidisciplinary team, and consented to by the resident where possible. However, inspectors found that while the use of restraint was reviewed regularly, records evidenced that such reviews were signed by the multidisciplinary team but not the resident. Alternatives such as crash mats and low-low beds were trialled prior to implementing restraint. Risk assessments had been carried out with residents prior to the implementation of restraint, and regular safety checks were documented.

Staff spoken with were knowledgeable of individual residents' support needs and while care plans had been developed to support some residents who exhibited responsive behaviours or behavioural and psychological signs of dementia (BPSD), a care plan for all residents with behavioural support needs was not in place to ensure that appropriate and effective supports or interventions were recorded and in place.This non-compliance is included in Regulation 5.

Judgment: Compliant

Regulation 8: Protection

There was a policy and procedure in place to safeguard residents from harm or from suffering abuse. The centre's management team demonstrated that arrangements were in place to investigate and respond to any allegations of abuse. Staff had completed training in the prevention, detection and response to abuse. Staff spoken with could describe how they would respond to an allegation, suspicion or disclosure of abuse.

The registered provider acted as pension agent for a number of residents. Inspectors reviewed the processes in place and found that the funds were managed

in accordance with guidelines published by the Department of Social Protection.

Judgment: Compliant

Regulation 9: Residents' rights

Staff endeavoured to promote residents' independence. Residents had access to independent advocacy services and were supported to engage with such services if desired.

A programme of activities was carried out in the various units of the centre and an activity co-ordinator was allocated to each building daily. Residents could avail of activities seven days a week.

Inspectors observed two group activities taking place during the inspection, and while these were enjoyed by those that were in attendance, it was noted that the majority of the other residents in those units were in their bedrooms during the inspection. A review of the arrangements for occupation and activity was required to ensure that all residents were supported to avail of opportunities for social engagement in line with their needs and preferences.

For the most part, residents' privacy and dignity was respected. Staff were discreet when providing care to residents. There were opportunities for residents to meet their visitors. A 'protected mealtimes' initiative was in place.

There was evidence that residents were consulted with regarding the running of the nursing home. Residents forums were held regularly, as well as a dedicated forum regarding the food served. Two relatives' forum had been held last year, and another had taken place in January 2019. Inspectors reviewed minutes of these and found that action plans were developed to resolve any issues raised. However, inspectors noted that despite this, some issues had been raised repeatedly in the last number of months in different forums. This indicated that further work was required to ensure that actions arising from these discussions are resolved quickly and satisfactorily. Minutes of these meetings were held at the reception of each unit to ensure residents could review them.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for TLC Centre Maynooth OSV-0000684

Inspection ID: MON-0023503

Date of inspection: 06/02/2019

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: • TLC Maynooth have recruited its full complement of Nurses. • Current vacancies will be filled by 30th April 2019.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Since the inspection a training plan has been put in place to ensure that all staff that handle food are HACCP trained. This training commenced on 12th February 2019 and all relevant catering staff will be trained by 31st March 2019. All other staff members who handle food will attend tool box talks on food hygiene by 31st May 2019. • TLC Maynooth has currently one BLS instructor in place to train staff. Since the inspection, a Clinical Nurse Manager commenced a BLS instructor's course on 23rd February 2019. All registered nurses will be refreshed in BLS training by 30th June 2019. • All department managers are responsible in ensuring that their staff are fully trained and up to date in their required fields. This will be monitored by the PIC, Director of Clinical Services and Provider at the monthly Clinical Governance Committee meetings, starting from 19th March 2019.	

Regulation 23: Governance and management	Substantially Compliant

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

• When CNMs are deployed as staff nurses, supervisory duties, to ensure the standard of care is maintained to residents, will be undertaken by ADONs and PIC.
• A training needs analysis for all nurses and education plan to address the identified needs will be completed by 30th April 2019.
• The Statement of Purpose and Function will be completed by the 31st March 2019 and a soft copy submitted to HIQA.
• The annual review of systems and practices has been completed since inspection. This is available for all residents and their families in all communal areas of the nursing home for review.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

• Weekly management meetings will commence on the week of the 12th March 2019. This will include a review of all complaints and concerns from the preceding week. This meeting will be attended by the Director of Nursing, Assistant Director of Nursing and Clinical Nurse Manager.
• The learning from each complaint or concern will be documented and shared with all staff, through the minutes, which will be reviewed at handover in each unit. The actions agreed at each meeting will be reviewed at the beginning of the next meeting.
• The follow up actions will be the responsibility of the CNM and this will be monitored by the PIC on a weekly basis commencing the week of the 12th March 2019.
• All complaints and concerns will be monitored, discussed and evaluated by the PIC, Director of Clinical Services and Provider at the monthly Clinical Governance Committee meetings, starting from 19th March 2019.
• The concerns record now has a further section to include the date of resolution and the satisfaction of the complainant. This will be monitored and updated at the weekly management meeting commencing the 12th March 2019.
• The Complaints policy was under review on the day of inspection, as noted by inspectors. A further review is currently being conducted to formalize the management of concerns within the policy. This will be completed by 27th March 2019.

Regulation 13: End of life	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:
• By the 30th April 2019, all residents will have their preference regarding their care at end of life recorded in their care plan and a plan documented to reflect the residents wishes.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Storage arrangements for oxygen cylinders has been reviewed and rectified since 7th February 2019.
• Waste management and bin storage has been reviewed. A key pad to allow access for staff to re-enter the building from the bin storage area has been requested. This was completed on the 07th March 2019.
• On the day of inspection there was already a plan in place to rectify the issue of malodors from certain areas. This issue has been rectified since inspection. Lino has been placed in two bedrooms and a sitting room. A monthly premises audit will be continued. The findings from this audit will be discussed at the monthly Clinical Governance meetings commencing 19th March 2019.
• Noise levels in open plan areas have been reviewed and reduced through the increased use of the multiple communal areas and activity rooms. This was commenced on the 18th February 2019 and will be monitored continuously to support a more balanced activity experience for our residents.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• A new resident friendly food satisfaction survey has been implemented. This captures the residents overall dining experience on a daily basis. This survey is being conducted after each meal with randomly selected residents and issues are addressed immediately, if required, with the resident. Overall feedback from the surveys are being brought to the monthly Clinical Governance meetings for discussion from the 19th March 2019. Feedback will also be brought to the Residents Food Group meetings for discussion.
• TLC Maynooth will always respect the wishes of our residents on where they would like to enjoy their meals. Documentation of resident's wishes will be documented and completed in their individualized care plans by the 30th April 2019.

• An enhanced system of food temperature checks has been implemented to included probing food on food trolleys in Kinvara to ensure that adequate temperatures are maintained when residents dine in their rooms. This enhanced check will be recorded and monitored continuously and will be reviewed for effectiveness by 30th April 2019.

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:
• The current process of auditing care plans is being reviewed and enhanced to ensure that a more realistic and effective system is in place. It will involve monthly reviews of care plans until a satisfactory level of person-centered care planning is achieved. This process will be reviewed by the 31st May 2019 to evaluate its effectiveness.
• Residents are encouraged to attend a care plan meeting at the time their care plan is due for review. If the resident declines this invitation, they are given the opportunity for their next of kin to attend on their behalf. Their choice on this is respected and documented accordingly. For those residents who are unable to express their wish, their next of kin are invited to the care plan meeting reviews. This approached will be monitored monthly by the PIC and reviewed by 31st July 2019.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The location of where activities take place has been reviewed and reconsidered since the 18th February 2019. There are additional communal rooms being used for activities at certain times of the day, especially in the evening.
• Enhanced supervision by nurse managers has commenced, this will monitor residents who spend prolonged time in their rooms. This supervision will ensure that residents' rights are being respected, and the wish or need for them to be in their rooms is documented clearly in their care plans. This will be reviewed in conjunction with the care planning auditing process by the 31st May 2019.
• Issues that were/are raised in different forums by residents and/or NOKs have been identified and are continuously being addressed. Feedback is given to the relevant parties as the actions are appropriately addressed. As part of the Complaint Policy review which will be complete by 27th March 2019, consideration will be given to the management of issues raised by family members and an enhanced system to address these will be put in place.

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 13(1)(d)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that where the resident indicates a preference as to his or her location (for example a preference to return home or for a private room), such preference shall be facilitated in so far as is reasonably practicable.	Substantially Compliant	Yellow	30/04/2019
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	Not Compliant	Orange	30/04/2019

	of the designated centre concerned.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/05/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2019
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	07/03/2019
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	30/04/2019
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.	Substantially Compliant	Yellow	31/03/2019
Regulation 23(c)	The registered	Substantially	Yellow	30/04/2019

	provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Compliant		
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Not Compliant	Orange	27/03/2019
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.	Substantially Compliant	Yellow	27/03/2019
Regulation 5(1)	The registered	Not Compliant	Orange	31/05/2019

	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).			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/05/2019
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.	Not Compliant	Orange	31/05/2019
Regulation 5(5)	A care plan, or a revised care plan, prepared under this Regulation shall be available to the resident concerned and may, with the consent of that	Not Compliant	Orange	31/07/2019

	resident or where the person-in-charge considers it appropriate, be made available to his or her family.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	18/02/2019
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/05/2019