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:	Cara Care Centre
Name of provider:	TLC Northwood Limited
Address of centre:	Northwood Park, Santry, Dublin 9
Type of inspection:	Unannounced
Date of inspection:	28 November 2018
Centre ID:	OSV-0000735
Fieldwork ID:	MON-0023505

About the designated centre

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

Cara Care Centre is a five storey, purpose built nursing home. It is located in Northwood Park in Santry. It is located close to shops and amenities. There are 61 single en suite bedrooms and 21 double ensuite bedrooms. There are facilities in place for social, recreational and religious activities, and there is a pleasant zen garden available for residents to use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	103

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
28 November 2018	08:45hrs to 18:00hrs	Sarah Carter	Lead
28 November 2018	08:45hrs to 18:00hrs	Michael Dunne	Support

Views of people who use the service

Inspectors met with residents on an individual basis and also during group activities. Residents who spoke with inspectors reported high levels of satisfaction with the care and services provided to them in the designated centre. Residents reported that they felt safe and that they could approach any staff member if they had a concern.

All residents spoken with gave positive accounts about staff; they said that they were caring and that all staff ensured that their needs were met in a supportive manner.

Residents were complimentary about the food and stated that they were able to access drinks and snacks outside of meal times. They confirmed that the menus were varied and that the food was of good quality.

Residents were happy with their room environments and said that they were comfortable. Residents reported that staff made sure their room was clean and comfortable. Residents told inspectors that they can personalise their room environment according to their own taste.

All residents spoken with were content with the variety of activities provided. Inspectors observed a group activity where residents were supported and encouraged to participate. Inspectors observed many pieces of art completed by residents on display.

Residents informed inspectors about a Japanese zen garden that they enjoy using and were very happy with this outside space.

Visitors who spoke with inspectors also expressed their satisfaction with the care their relatives received.

Capacity and capability

While there were sufficient staff, and there was a person in charge and a deputy in place to cover in their absence, inspectors were not assured that the designated centre had robust systems in place to ensure the safety of the residents.

The centre had a statement of purpose in place however it required amendment to ensure the usage of rooms was accurately described. This was brought to the attention of the centre's management team who amended the document on the day

and they were advised to submit same to the office of the chief inspector for consideration.

The centre had a clear management structure in place. The person in charge (PIC) was a registered general nurse and had worked at the centre for some time. The PIC was supported in terms of clinical supervision by two assistant directors of nursing (ADON) and there were four clinical nurse managers (CNM). One ADON was present on the day of the inspection and the PIC was on leave. The PIC did arrive at the centre during the course of the inspection and was available for part of the inspection process. The director of clinical services and the registered provider representative, who is the chief executive officer (CEO), were also available for the inspection.

Inspectors observed that there were sufficient numbers of staff with the required skill mix on duty to meet the needs of the residents. Rosters were also reviewed. The centre also had access to its own bank of locums to cover for staff when their regular staff were off.

The records of staff training and information about dates attended were available to Inspectors to review. Records indicated that staff had received appropriate training in a range of areas to support residents needs with the exception of managing residents with behaviours that challenge (which is discussed in the quality and safety section of this report).

The centre has a procedure in place to guide anyone who wished to make a complaint and this was displayed within the centre. This complaints policy was made available at the end of the inspection for review. Residents spoken with confirmed that complaints and concerns were dealt with in a timely manner. The centre gathered and compiled records on complaints and also on concerns. While evidence was seen of the recording of complaints, it was not clear what steps were taken or what learning occurred as a result of processing these listed complaints.

The centre had a range of systems in place to monitor the effective delivery of care to the residents. Inspectors saw information records on monthly falls audits, care plans, risk assessments, incident reports, team meetings, maintenance records and information on complaints and concerns. In some cases information was shared on 2017 data, and some 2018 data was not consistently available to inspectors. There were a range of clinical audits being completed weekly and monthly, however it was not clear within the documents shared with the inspectors if any learning or action plans were shared with staff on foot of these audits. Staff meeting minutes were reviewed and did not contain evidence of discussions or learning from audit results. A previous inspection noted that the management system for allocating staff break times needed to be reviewed as there was insufficient staff cover on the floor to meet the needs of the residents at break times. This issue had not been fully addressed as nursing staff were difficult to locate during a period of time during the course of this inspection.

Inspectors reviewed a number of recorded incidents with regard to healthcare and notifications. Inspectors found that incidents were recorded, investigated and

reviewed in a timely manner but it was not clear if subsequent learning enhanced resident's care. Inspectors also noted that the centre was not notifying the office of the chief inspector correctly of their level of restrictive practices.

Overall inspectors were not assured that systems were in place to record adverse incidents and that learning was taking place as a result of the processes that the management team used to investigate and review. This will also be described further in the next section of the report when describing risk management.

Regulation 15: Staffing

There was sufficient staff members on duty on the day of this inspection. There was an adequate skill mix available to meet the needs of residents. Rosters were reviewed and inspectors were assured the staffing levels were consistent over the different days of the week.

Judgment: Compliant

Regulation 16: Training and staff development

The staff training records that were shared with inspectors showed that staff had mandatory training in the required areas.

Judgment: Compliant

Regulation 21: Records

As per the requirement of schedule 4; the registered provider was not sufficiently recording the correct number of restrictive practices and notifying the office of the chief inspector as required.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were sufficient resources in place to meet residents needs.

There was a clearly defined management structure and roles and responsibilities of the management staff were clearly defined.

However the governance systems were not sufficiently robust to identify and learn from incidents within the centre. The governance systems had not satisfactorily addressed staffing during staff break times, the gathering of clear data, and the sharing of learning following audits or investigations with staff.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was found to not correctly describe the service and facilities in the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had a complaints procedure and it was well advertised in the centre. There was a nominated complaints officer, and a process was outlined for appeals. The complaints log for 2017 was shared with inspectors.

The registered provider was failing to record follow up actions and measures that were required to improve the services after complaints or concerns were investigated.

It was not clear if a person, separate to the appointed complaints officer, was allocated to overseeing responses to complaints and the maintenance of complaints records.

Judgment: Substantially compliant

Quality and safety

Good care was provided in the centre. Residents reported that they were comfortable the centre and that the premises met their needs. Residents spoke highly of the staff who cared for them. Inspectors observed good communication

between staff and residents. Staff interacted with residents in a person centred manner and it was evident that staff were aware of individual resident's likes and dislikes in the interactions observed on the day.

The inspectors reviewed resident records. Evidence was seen that a pre-admission assessment was carried out before residents were offered a place at the centre. On admission a comprehensive assessment was carried out and where residents had health and social care needs identified, care plans were developed.

Residents had access to a GP who visited the centre three times a week; the ADON informed the inspectors that there were monthly visits taking place from a dietician, speech and language therapist and a tissue viability nurse. The centre also employed its own physiotherapist who was available to residents in the centre Monday to Friday. There was evidence in the samples of care records reviewed that residents had received specialist interventions and that recommendations from specialists were reflected in the residents current care plans. The centre had in place a range of audits to review the delivery of care to the residents group; audit systems and the dissemination of their results are discussed in the previous section of this report.

Restrictive practices were in use in the centre to enable residents who required that support. Evidence was seen by the inspectors of regular assessment taking place that indicated the rationale for the use of restrictive practices. However the requirement for specific pieces of equipment following these assessments was not consistently recorded in residents care plans. The total amount of restrictive practices in use in the centre, were not being correctly notified to the office of the chief inspector and inspectors also noted that approximately half the staff had not received training in managing challenging behaviours.

As discussed in the section of the report on residents views, residents said they felt safe in the centre. Inspectors found that residents had their rights safeguarded on a day-to-day basis by good care. The financial process around handling residents finances remained unchanged from the previous inspection. Inspectors found that the notifications were being made as required to the office of the chief inspector, however no evidence was shared with the inspectors to show that learning had taken place following safeguarding investigations or measures had been developed to prevent incidents re-occurring.

Residents were complimentary about the food they ate in the centre. There was evidence that residents had a choice at mealtimes and where residents had special dietary requirements they were being provided by the centre. There was access to drinks and snacks outside of mealtimes. Dining area had had some refurbishment since the last inspection report, and the temperature in the rooms could now be adequately controlled.

There was evidence that the centre was well presented, it was clean and bright and each floor had private space where visitors could meet with residents. Residents could also access a garden area and there is also a shelter available for residents who wished to smoke. Residents were encouraged to personalise their bedrooms

with their personal belongings and items created from the activity programme. As a result resident bedrooms reflected the interest of the residents who lived there. There was an activity programme in place and inspectors saw evidence where residents were encouraged to attend and to participate. Residents were facilitated to leave the centre and engage with their family and friends in the community.

On review of storage facilities in the centre, iinspectors found inadequate storage of oxygen cylinders in a treatment room which required immediate attention. In addition a review of the layout of the treatment rooms and some sluice rooms were required to ensure staff had easy access to hand-washing facilities. There were storage facilities located on each floor however Inspector's noted that all hydrotherapy bathrooms were now being used as storage facilities. The change in use of these rooms had not been notified to the Chief Inspector and this is referenced in the previous section of this report in relation to the centres statement of purpose.

Maintenance records provided to inspectors were from 2017 and updated records for 2018 were made available following further requests by inspectors. Maintenance records indicated that recommendations had been made by external contractors three months previously in relation to maintaining important equipment in the building; however no evidence was seen indicating there was an action plan in relation to this. Maintenance records also did not reflect issues identified by the inspectors on the day; including broken locks on a treatment room on the ground floor. This issue was addressed immediately by the staff team.

Inspectors noted that the centre had deficiencies in their risk management processes. Inspectors were not assured that the risk management policy and procedures was detailed enough to guide staff to manage risk in the centre. The risk management policy was provided towards the end of the inspection and was reviewed immediately following the inspection.The policy did not fully reflect the requirements of the regulation.

It was noted that the risk register which was made available to the inspectors earlier on the inspection had been amended to include the risk of self-harm as the inspection drew to a close. However the risk register given to inspectors was not reflective of all risks within the centre and was not reflective of the risk management policy.

Regulation 17: Premises

Overall the premises was clean and well presented, signage was in place and was adequate.

Issues were identified in relation to the maintenance and storage of equipment. Maintenance contracts were in place, however records and actions relating

to identified faults with key equipment in the building were not being followed up. Some minor maintenance issues were noted by the inspectors which had not been logged. Rooms had been re-purposed as storage facilities and the statement of purpose had not been updated to reflect this. Access to wash hand basins and the safe storage of oxygen cylinders were restricted in treatment and sluice rooms due to poor storage practices.

Judgment: Substantially compliant

Regulation 26: Risk management

A risk management policy was in place, however it did not adequately describe the controls in place to manage the specified risks as required in this regulation.

The policy did not address how to respond to major emergencies, and did not reference or guide staff toward any policy that addressed major emergencies.

Arrangements to identify, record, investigate and learn from serious incidents were not clear to inspectors following reviews of paperwork and discussions with staff.

Judgment: Not compliant

Regulation 27: Infection control

The registered provider had ensured that there was sufficient resources in place to minimise the risk of infection.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plans were reviewed regularly, and were mostly detailed with information that staff would requires to care for, and meet residents needs. In a small sample care plans lacked specific details, and this detail related to the use of restrictive practices. Assessments had taken place to indicate the need for the restrictive practice, but the plans did not detail their use. For example, some residents who regularly used equipment that restricted their movement for various reasons, did not have these requirements written in the relevant section of their care plans.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had a choice to use their own GP and the centre provided regular GP services. Evidence was seen of residents accessing specialist personnel and services as required. Care plans had been updated to reflect specialist recommendations.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Restrictive practices were in use in the centre, and had been assessed and their use was recorded on a register. However care plans did not consistently guide the staff on their use.

Approximately half the staff had received training in managing behaviours that challenge.

Judgment: Substantially compliant

Regulation 8: Protection

Staff were sufficently trained and knowledgeable. However post incident learning and investigation was not sufficiently robust.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents had access to sufficient amenities for recreations. Residents had sufficient levels of privacy in their bedrooms. There was access to TVs, radios and newspapers.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cara Care Centre OSV-0000735

Inspection ID: MON-0023505

Date of inspection: 28/11/2018

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • With immediate effect, all restrictive equipment or devices in use in the centre will be notified to HIQA in accordance with our obligations under Regulations 21 and 31. Those devices assessed as restraint will be indicated clearly in the notification. • With immediate effect, all restrictive devices used will be clearly documented in the residents' care plans and assessed regularly (at least 3 monthly) in accordance with TLC's Restraint Policy.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Staff breaks- From 7th January 2019, all staff breaks across all floors will commence earlier and will be staggered to ensure adequate staff cover on each floor. Clinical nurse managers will provide cover for all staff nurse breaks. Incident management and learning- From 7th January 2019, the weekly management meeting in the centre will be enhanced to review all complaints, incidents, accidents, investigations, falls, maintenance log and risk register from the preceding week. This meeting will document the learning and actions to be taken to minimise risk of re-occurrence and minutes will be circulated to all floors and will be reviewed at handover with staff on each floor. The actions agreed at each meeting will be reviewed at the beginning of the next	

meeting.
The meeting will be attended by the Director of Nursing, Assistant Director of Nursing and Clinical Nurse Manager, Household Manager, Physiotherapist and Maintenance Manager.

Commencing 28th January and on the last week of each month going forward, each floor will have a monthly meeting chaired by the Clinical Nurse Manager to review each floor's incidents, investigation outcomes (where appropriate) complaints, accidents, falls, clinical audit results and learning. These meetings will be documented and shared with all staff on the floor. The CNM will be responsible for following up on actions agreed and this will be monitored by the Director of Nursing.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose has been reviewed to include changes in the use of hydrotherapy rooms. A soft copy has been attached to this action plan.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Follow up actions and service improvement- The enhanced weekly management meeting as described above, which will commence on week commencing 7th January 2019, will review and consider all complaints and concerns from the previous week. The learning from each complaint or concern will be documented and shared with all staff, through the minutes, which will be reviewed at handover on each floor. The follow up actions will be the responsibility of the CNM on the relevant floor and this will be monitored by the Director of Nursing.

With effect from 1st January 2019, a monthly review of all complaints and concerns received and their management and documentation will be conducted by the Director of Clinical Services and actions arising will be communicated to the Director of Nursing and follow up will be monitored by the Director of Clinical Services.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Maintenance systems- A new maintenance log has been commenced with immediate effect. All issues reported are logged onto the system at reception and this tracker will be reviewed daily by maintenance and monitored weekly at the management meeting, as outlined above, from 7th January 2019. Contact with external contactors and their outstanding recommendations will also be reviewed as part of that weekly meeting
Storage of oxygen and other equipment has been reviewed and addressed to ensure safe storage and also access for staff to wash hand basins.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Risk management policy- This policy has been reviewed and updated to reflect the requirements of Regulation 26 and to refer to TLC's Emergency Plan Policy, which has also been reviewed. A soft copy of both policies is attached.

An investigation template for use in the review of serious incidents, investigations and complaints has been introduced with immediate effect. This template will ensure the learning from each incident investigated is identified and shared with staff to minimise reoccurrence. The Director of Nursing will monitor compliance with this at the weekly management meeting and actions identified will be documented.

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:
With immediate effect, all restrictive devices used will be clearly documented in the residents' care plans and assessed regularly (at least 3 monthly) in accordance with TLC's Restraint Policy.

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: With immediate effect, all restrictive devices used will be clearly documented in the residents' care plans and assessed regularly (at least 3 monthly) in accordance with TLC's Restraint Policy. By 31st March 2019 all staff will have received training in Supporting Residents with Responsive Behaviour.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: An investigation template for use in the review of serious incidents, investigations and complaints has been introduced with immediate effect. This template will ensure the learning from each incident investigated is identified and shared with staff to minimise reoccurrence. The Director of Nursing will monitor compliance with this at the weekly management meeting and actions required will be documented.	

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 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	02/01/2019
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	02/01/2019
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and	Substantially Compliant	Yellow	31/01/2019

	4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
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	31/01/2019
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	02/01/2019
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	02/01/2019
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and	Not Compliant	Orange	02/01/2019

	actions in place to control abuse.			
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Not Compliant	Orange	02/01/2019
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Not Compliant	Orange	02/01/2019
Regulation 26(2)	The registered provider shall ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.	Not Compliant	Orange	02/01/2019
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	02/01/2019
Regulation 34(1)(d)	The registered provider shall provide an	Substantially Compliant	Yellow	02/01/2019

	accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.			
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.	Substantially Compliant	Yellow	02/01/2019
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	02/01/2019
Regulation 34(2)	The registered provider shall	Substantially Compliant	Yellow	02/01/2019

	ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to.	Substantially Compliant	Yellow	02/01/2019
Regulation 34(3)(b)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that the person nominated under paragraph (1)(c) maintains the records specified under in paragraph (1)(f).	Substantially Compliant	Yellow	02/01/2019
Regulation 5(4)	The person in charge shall formally review, at	Substantially Compliant	Yellow	02/01/2019

	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.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	02/01/2019
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	02/01/2019