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:	Moorehall Lodge Drogheda
Name of provider:	Moorehall Healthcare (Drogheda) Limited
Address of centre:	Dublin Road, Drogheda, Meath
Type of inspection:	Unannounced
Date of inspection:	25 May 2022
Centre ID:	OSV-0000737
Fieldwork ID:	MON-0035602

About the designated centre

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

The designated centre provides twenty-four hour support and nursing care to 121 male and female older persons, requiring both long-term (continuing and dementia care) and short-term (assessment, rehabilitation convalescence and respite) care. The philosophy of care adopted is the "Butterfly Model" which emphasises creating an environment and culture which focuses on quality of life, breaking down institutional barriers and task driven care, while promoting the principle that feelings matter most therefore the emphasis on relationships forming the core approach. The 'household model' has been developed to deliver care and services in accordance with the philosophy. The designated centre is a purpose-built three storey building situated on the outskirts of a town. It is divided into households; Rosnaree and Newgrange households, located on the ground floor, Millmount and Mellifont households situated on the first floor and Oldbridge and Beaulieu households on the second floor. Each household has its own front door, kitchen, open plan sitting and dining room.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	119

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 25 May 2022	10:00hrs to 17:00hrs	Sinead Lynch	Lead
Wednesday 25 May 2022	10:00hrs to 17:00hrs	Sheila McKevitt	Support

What residents told us and what inspectors observed

Inspectors spoke with a number of residents in each of the units during the course of this inspection. Their views on what life was like living in the centre were mixed. Residents said it was a good place to live when there were enough staff on duty, and then life in the centre was good. However, a number of residents and their relatives told inspectors that the quality of care provided was not satisfactory in their view and they felt that basic nursing care was not being delivered in a timely manner due to the ongoing staff shortages.

Residents said that everyday they were short-staffed and those staff on unexpected leave for whatever reason were not always replaced. Some residents and visitors told inspectors that on these days residents did not always get the care they required or requested. For example, one resident described that on occasions staff asked them to stay in bed longer until there were enough staff available to assist them. As a result of insufficient staffing levels, the resident did not have their hygiene care needs delivered in line with their preferences and as per their care plan.

The residents next-of-kin said they had brought this to the attention of the person in charge and since this their care needs were being addressed now but still not in a timely manner on the days when there were staff shortages.

Another resident spoken with, who was accompanied by a relative, said that they were getting their shower at 6.30am, otherwise staff would not have had time to assist them later in the morning. They said, that this was an ongoing problem in the centre and that they are 'always short of staff'.

Another resident who communicated with the inspectors said that communication with unfamiliar staff was 'frustrating', and that often both parties found it difficult to understand each other.

Residents said the food was good, there was always a choice and it was well-presented and hot on delivery. They enjoyed all their meals and were offered drinks and snacks in between their main meals. They had access to drinking water at all times both in their bedrooms and the communal rooms.

Inspectors observed that residents had access to their call bell in their bedrooms. Residents said that their call bell was answered when they rang it, but sometimes they had to wait for a while for the staff to come back and provide the care they needed. Inspectors saw activities occurring in some units. Residents appeared to be actively participating in the activities and to be really enjoying them. Residents spoken with said they enjoyed the activities when they took place and described the staff delivering them as excellent. One resident said they would like to have more male-focused activities such as woodwork or mechanical work so they could use

their hands.

Residents were involved and consulted in the running of the centre. For example, regular resident meetings were held and resident satisfaction questionnaires were completed to help inform ongoing improvement and required changes in the centre.

The centre appeared clean and non cluttered. The corridors were found to be bright and airy. The residents had access to the outdoor wheelchair accessible grounds which had adequate seating available.

Staff and residents could be seen interacting in a calm and friendly manner. The staff were seen to know what the residents likes and dislikes were. Friendly banter was taking place in the sitting room between a staff member and the residents.

The reception area was very welcoming while the receptionist was available to answer any queries that visitors had. The new signage gave clear direction to residents and visitors in the centre.

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 the quality and safety of the service being delivered.

Capacity and capability

The registered provider demonstrated their efforts to provide a safe service for the residents in the centre although some further improvements were required. While continuity with staffing was a problem on the day of the inspection the provider was responsive and working to address the staffing shortages. The registered provider had identified the issues and made efforts to mitigate the staffing issues.

This unannounced risk inspection was carried out to assess the progress made by the provider to come into regulatory compliance. While significant progress has been made in regards to records, the premises and responsive behaviours, (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), staffing shortages continued to have a negative impact on the service provisions and the quality of care provided.

Inspectors found that the centre was not appropriately resourced with staff. On the day of the inspection the centre was short staffed with four unplanned staff absences which were not replaced with agency, this is discussed further in the report under regulation 15 - Staffing. The ongoing staff shortages had a negative impact on the quality of care the residents received.

Inspectors were informed that the management had just completed a large recruitment process. Staff files were seen of those new staff due to start in the

coming weeks and these met the regulatory requirements. The person in charge was recently appointed to the centre and met the requirements of the regulations and were supported by the director of operations and an assistant director of nursing. There are also two full-time experienced care managers as additional support to the person in charge.

However, based on the findings on the day, the inspectors concluded that an additional review of staff and governance in the centre was required to ensure appropriate resources were in place so that all residents received a high standard of person-centred care at all times. The registered provider submitted further assurances to inspectors following the inspection. This included additional information on staffing levels and admissions to the centre.

Inspectors acknowledged the improvements made by the provider since the last inspection, however the current management systems required further strengthening. For example, a review of complaints did not assure inspectors that complaints were investigated in line with policy. Furthermore enhanced clinical oversight and supervision of staff was required.

There was an audit system in place to assist the provider in overseeing the service. There was a comprehensive annual review available which showed the residents involvement in the day to day running of the service.

Records reviewed included all accidents and incidents that took place in the centre which was a comprehensive record, and all had been notified to the Chief Inspector as required by the regulations. There was a directory of residents available in the centre which was well maintained. The statement of purpose required updating to reflect the actual number and skill mix of staff in the centre.

A copy of the complaint procedure was placed in a prominent position in the centre. Residents spoken to were aware of who to go to if they wanted to make a complaint.

Regulation 14: Persons in charge

The person in charge had the necessary experience and qualification as required by the regulations. He was a registered nurse who worked full time in the centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider did not have the number and skill mix of staff appropriate to the needs of the residents on the day of the inspection. The centre had a

recruitment process in place to fill the current vacancies in both the health care and homemaker role. However, on the day of the inspection there were 4 staff members (3.5 WTE (whole time equivalent)) absent and none of these posts could be filled on that day.

Judgment: Not compliant

Regulation 19: Directory of residents

The centre had an established and well maintained directory of residents that was made available to the inspectors on the day.

Judgment: Compliant

Regulation 21: Records

The staff records were well organised and contained the information required under Schedule 2 of the regulations.

The inspectors reviewed a sample of staff files and observed that they contained all the required documentation required by the Regulations. Gardai Siochana vetting was in place for all staff, nursing registration numbers were available and up-to-date for all staff nurses

Judgment: Compliant

Regulation 22: Insurance

The registered provider had a contract of insurance in place against injury to residents

Judgment: Compliant

Regulation 23: Governance and management

The registered provider did not have appropriate resources in place to ensure the effective delivery of care in accordance with the statement of purpose.

There was insufficient clinical and operational oversight of resources, as on the morning of the inspection the management team were not aware that there were four absences which had not been replaced. Unplanned absences were not consistently replaced and as a result residents did not avail of the planned schedule of activities.

Management systems to oversee the care and service provided were not sufficiently developed to ensure effective, consistent and safe delivery of service at all times.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A sample of contracts for the provision of care were reviewed. Each was signed by the resident or their next of kin. Arrangements under the fair deal scheme were in place. The weekly charge was included and outlined the arrangement for health and social care professional services for those entitled to these services for free.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose required updating to include:

- The total staffing complement

- The arrangements made for dealing with complaints

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents and notifications as set out in Schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required time frame.

Judgment: Compliant

Regulation 34: Complaints procedure

All complaints were logged but they were not investigated promptly and there was little or no evidence of the investigation process. Furthermore, in a number of complaints reviewed, the outcome was not available as required by the regulations.

Judgment: Substantially compliant

Quality and safety

Overall, residents received a good standard of care. Residents' health, social care and spiritual needs were catered for. However, further improvements were required in relation to residents' nursing assessments, access to a general practitioner (GP) and access to activities to ensure all residents received a high standard of quality care at all times.

The premises appeared clean, tidy and de-cluttered. The corridors were free from obstruction and hand rails kept clear which enabled residents to mobilise independently throughout each unit. Signage had improved throughout the centre. The improved signage also facilitated them finding their way around independently.

Visitors were being welcomed into the centre and this was having a positive impact on residents. Visitors spoken with raised the issue of staff shortages with inspectors and confirmed what residents told inspectors in relation to the negative impact staff shortages had on the quality of care residents received.

There was an activities schedule which residents had access to in their bedroom and in the main communal rooms in each unit. The homemaker had responsibility for the delivery of activities in each unit. This worked well when there was a full compliment of staff on duty, however when there were staff shortages the homemaker assisted the health care assistants with direct care duties and hence activities were not delivered as per the schedule. As a result, activities did not occur as per planned activity schedule and there were days in which residents lacked social stimulation as there was limited activities available.

In addition to that, assistance with care needs was delayed on some days, and for example, residents had to spend longer in bed in the morning that they preferred.

Residents assessments were reviewed. Inspectors observed gaps in residents' care records. Some were completed in detail, others were not and for these residents a true clear picture of the residents' health, personal and social care needs was not available. This had the potential to negatively impact on the standard of care being received by residents as their needs were not effectively communicated among the nursing and care team

Regulation 11: Visits

The inspectors saw that the visiting policy reflected the current Public Health guidelines. There were no restrictions for visitors in the centre. There was adequate space for residents to meet their visitors in areas other than their bedrooms if they wished to do so. The recommended safety check and sign-in process was in place at the reception desk.

Judgment: Compliant

Regulation 12: Personal possessions

Resident had adequate space available to them to store their personal possessions. They had a lockable space in their bedside locker.

Judgment: Compliant

Regulation 13: End of life

Residents had access to end of life care provided by the staff, their general practitioner and where required the local palliative care team. Residents had access to services which provided emotional, social, psychological and spiritual care to residents when at this stage of their life.

Judgment: Compliant

Regulation 17: Premises

The premises was clean and tidy. Many areas including the store rooms and clinical rooms had been de-cluttered. New signage had been installed which facilitated residents to easily identify rooms within their home.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents had access to fresh drinking water in their bedroom and in the communal rooms. Residents informed inspectors that there was a good choice of food available to them and that they can access food and snacks whenever they want.

Judgment: Compliant

Regulation 20: Information for residents

There was a residents guide available for residents reference. It met the legislative requirements.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A sample of residents nursing assessments and care plans were reviewed. Residents had a comprehensive nursing assessment, a number of risk assessments completed which were updated on a four monthly basis. However, the comprehensive nursing assessment was not always completed in full and therefore it was difficult to get a clear picture of the resident's health status and healthcare needs.

Judgment: Substantially compliant

Regulation 6: Health care

Access to the general practitioner (GP) required review to ensure that residents admitted for long-term care were seen by their GP within a timely manner.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Residents' risk assessments and care plans identified potential triggers for responsive behaviours, (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The care records were consistent and provided staff with a clear plan of how to intervene with person centred de-escalation techniques for the

resident when they became agitated or distressed.

Judgment: Compliant

Regulation 9: Residents' rights

Residents access to activities was not always facilitated as confirmed by residents themselves and inspectors' observations. When staff were off on unexpected leave the homemaker responsible for delivering activities in each unit was required to assist the care team in providing care to residents. This occurred a number of times each week hence it was evident that residents did not consistently have access to the scheduled daily activities.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Moorehall Lodge Drogheda OSV-0000737

Inspection ID: MON-0035602

Date of inspection: 25/05/2022

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:
On the day of the inspection and in the follow up correspondence ,the authority was informed of the level of recruitment and investment in regular agency staff to address staffing challenges within Moorehall Lodge Drogheda.
Following the inspection Moorehall Lodge Drogheda as part of the Virtue Group have negotiated a contract for additional staff which will provide a relief panel to respond to short term absences in the home.
An aggressive recruitment drive has been ongoing in conjunction with the Virtue Director of HR including a constant and continuous local and overseas recruitment pipeline.
There were 7 HCA that had been recruited locally and overseas on the day of inspection and were awaiting to be fully compliant with Schedule 2 prior to commencing employment in the home.
Since the day of inspection, a total of 9 WTE healthcare staff have commenced employment in Moorehall Lodge Drogheda, completing both their theory and practical induction.

There are currently a further 8 WTE HCAs in the local and overseas recruitment pipelines of which 4 Health Care assistants are expected to commence their employment week commencing 18th July 2022 and the remaining 4 WTE Senior Health care assistants due to commence by 11th August 2022.

4 WTE Nurses have successfully completed their RCSI exam in July 2022, of which 1 WTE has received their PIN number and has commenced practical induction and 3 WTE Nurses are currently awaiting their PIN numbers. The 4 WTE nurses have been recruited as part of the forward planning for nurses commencing maternity leave during Quarter 4 of 2022.

There are currently 4 WTE agency Health Care Assistants who have been working in MHLD and will be retained until all newly recruited staff have completed their induction whilst ensuring that there are relief staff available on roster to cover unplanned absences.

Our current planned rosters have no unfilled shifts, in the event of unplanned absences they will be filled by our regular agency staff.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The staff reporting procedure of sickness and absence was reviewed and amended. The amended reporting procedure ensures that the management team in MHLD are aware of any staff absences and are informed of any unfilled shifts on the roster on any given day in real time.
Part of the action plan for Regulation 23 is mentioned above in Regulation 15.
The Assistant Director of Nursing and two Care Managers have responsibility for the day-to-day clinical oversight, supervision and delivery of care to our residents. Each manager is allocated two households.
There has been the addition of both Advanced Care Practitioners and Senior Health care assistants in each household to ensure a robust skill mix on duty at all times.
There are 2 additional Senior staff Nurses in place to support the management team with the clinical monitoring and oversight of the delivery of care.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Total staffing complement will be updated in the Statement of Purpose by 22nd July 2022.
A review of complaints management policy and procedure was completed and was subsequently updated which will be reflected in the updated Statement of purpose by 22nd July 2022.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints policy has been updated and rolled out to all members of staff.
A training and information session was provided by the Group Director of Quality Safety and Risk to the management team on 30/05/2022 which included the complaints investigation process.
The Director of Operations has oversight of the complaints management process ensuring that any complaints are appropriately responded to in the prescribed time frame

Any complaints if received are all acknowledged and investigated within the timeframe. The investigation process will be included and recorded in the Complaints management folder including the outcome of the investigation of complaints.

The outcomes of some of the complaints that were not recorded on the day of inspection are now entered onto the Complaints register on 30/05/2022.

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:
All residents admitted to Moorehall Lodge Drogheda will have their comprehensive assessments completed in full within 24 hours of admission.

This is checked daily as part of the Care Managers Daily Quality Assurance Checks.
All newly employed and existing staff nurses have or are scheduled to receive training on the legislation in relation to Nurses documentation including the completion of comprehensive assessments within the regulatory timeframe.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
All newly admitted residents for long term care will be reviewed by the GP within 48 hours of admission to Moorehall Lodge Drogheda.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
This is covered partly in Regulation 15 under staffing.
There are external providers including Arts and Crafts, Chair Yoga, Reflexology, Musicians and Tricycle rickshaw ensuring that there are social and recreational activities occurring daily in Moorehall Lodge Drogheda.
With the increase in current staffing levels, each household has appropriate staffing to ensure that any unplanned absence will not impact the resident access to daily activities.
The ADON and the Care managers will assess the needs of each household to ensure absences are appropriately covered and relief staff contacted where needed.
This will ensure consistency and secure access to both external activities and internal activities for our residents.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
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	30/07/2022
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	30/06/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure	Substantially Compliant	Yellow	30/06/2022

	that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	22/07/2022
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	22/07/2022
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	30/05/2022
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	Substantially Compliant	Yellow	30/05/2022

	complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(1)(g)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.	Substantially Compliant	Yellow	30/05/2022
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	30/05/2022
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken	Substantially Compliant	Yellow	30/05/2022

	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	30/05/2022
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/06/2022
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before	Substantially Compliant	Yellow	01/07/2022

	or on the person's admission to a designated centre.			
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.	Substantially Compliant	Yellow	30/06/2022
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	30/06/2022
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	30/07/2022