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:	CareChoice Ballynoe
Name of provider:	Carechoice Ballynoe Limited
Address of centre:	Whites Cross, Cork
Type of inspection:	Unannounced
Date of inspection:	27 April 2021
Centre ID:	OSV-0000210
Fieldwork ID:	MON-0032090

About the designated centre

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

Carechoice Ballynoe (known as Ballynoe) is a designated centre which is part of the Carechoice group. It is located in a rural setting of Whites Cross and is a short distance from the suburban areas of Ballyvolane and Blackpool, Cork city. It is registered to accommodate 51 residents. Ballynoe is a two-storey facility with lift and stairs to enable access to the upstairs accommodation. It is set out in three corridors on the ground floor called after local place names of Glen, Shandon and Lee, and Honan on the first floor. Bedroom accommodation comprises five single rooms with wash-hand basins, six twin rooms and 34 single rooms with en suite facilities of toilet and wash-hand basin; 15 residents are accommodated upstairs. Additional shower, bath and toilet facilities are available throughout the centre. Communal areas comprise a comfortable sitting room, Morrissey Bistro dining room, large day room and a large quiet room with comfortable seating. The hairdressing salon is located near the main day room. There is a substantial internal courtyard with lovely seating and many residents have patio-door access to this from their bedrooms; there is a second smaller secure courtyard accessible from the quiet room. At the entrance to the centre there is a mature garden that can be viewed and enjoyed from the sitting room, dining room and some bedrooms. Carechoice Ballynoe provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

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
Tuesday 27 April 2021	09:00hrs to 19:00hrs	Breeda Desmond	Lead
Tuesday 27 April 2021	09:00hrs to 19:00hrs	Mary O'Mahony	Support

What residents told us and what inspectors observed

Inspectors arrived to the centre in the morning for an unannounced inspection and staff guided the inspector through the infection prevention and control measures necessary on entering the designated centre. These included a signing in process, disclosure of medical wellness or otherwise, hand hygiene, face covering, and temperature check.

This was a two storey facility with resident accommodation on both floors, with lift and stairs access to the first floor. The upstairs remained closed following the COVID-19 outbreak and the person in charge informed inspectors that redecorating the upstairs was part of their 3-phase refurbishment plan to upgrade the premises. A review of equipment including residents' furniture was planned as part of the refurbishment programme to ensure that furniture and fittings were fit for their intended purpose and would comply with the national standards for infection prevention and control.

Overall, inspectors observed improvement in the centre since the last inspection in February 2021 as items such as residents' personal belongings and personal protective equipment (PPE) were no longer stored in the day room or other communal area; they were stored appropriately in designated rooms and presses.

Inspectors spoke with several residents in the day room and in their bedrooms throughout the day. Feedback from residents was positive about the care they received. Residents said that staff were kind and helpful, and that 'every one is so good and 'better than the next'. They reported that visiting had re-started and were so delighted to see their families and grandchildren again. Their 'own' staff were back and staff knew their ways, likes, preferences and their families, which made 'everything easier'. Residents were complimentary about the quality of their meals, but agreed with the inspectors regarding the waiting times for dinner to be served in the dining room. Residents reported that there was a good variety of activities and that the activities co-ordinator was exceptional.

The main entrance was wheelchair accessible. There was COVID-19 advisory signage, hand sanitiser, electronic temperature check and hand-wash facilities inside the main entrance. Entrance to the centre was locked to facilitate COVID-19 precautionary measures on entering the building to ensure the safety of residents and staff.

The main day room was located to the right of reception. This was a large room laid out in four pods with seating arranged to facilitate social distancing while at the same time enabling residents to sit and relax and meet up with their friends to chat.

Nursing offices were by reception and the dining room was found to the left of reception. There were two smaller sitting rooms; one of which had an outdoor visitors' snug with seating and this also supported window visits. Residents

accommodation was beyond reception in adjoining corridors.

Residents' bedroom accommodation comprised 15 single occupancy bedrooms upstairs (which was currently closed), 19 single bedrooms and six twin bedrooms downstairs. Bedrooms were personalised and decorated in accordance with residents wishes. Storage for residents' personal possessions comprised double wardrobes, chest of drawers and bedside lockers. Privacy screens in shared rooms were effective and ensured residents' privacy. The doors to residents' bedrooms were decorated like a front door with wrought iron-like number and door knocker and coloured differently as an aid to residents to identify their own 'front door'.

Wall-mounted hand sanitisers were displayed throughout the centre and staff were observed to comply with best practice hand hygiene. Staff and visitors were observed completing hand washing on entry to the building as well. Throughout the inspection staff were observed to adhere with social distancing and maintain their work teams of A and B in line with Health Protection Surveillance Centre (HPSC) guidance. Separate staff changing rooms and canteen facilities were available for the two staff teams. Storage of personal protective equipment (PPE) was in designated spaces which did not impact residents' space or areas where there was a potential for cross contamination. Most clinical sinks had hands-free tap mechanism, however, one sink required the taps to be upgraded to hands-free in line with National Standards.

Overall, the premises was bright and clean and the atmosphere was calm and relaxed. Personal care was being delivered in many of the bedrooms and observation showed that this was delivered in a kind and respectful manner. During the morning and afternoon walkabouts, most residents were in the day room while a few residents remained in their bedrooms. Mass and rosary were streamed live in the day room in accordance with residents request. Following this, morning snacks were offered of tea, juices or soup. An exercise session was facilitated by the activities co-ordinator where residents were given soft cylindrical foam which they used as part of their exercise programme. Residents were observed to enjoy this with an occasional dueling match which brought laughter and fun to the activity. The activities programme was varied and changed as required, for example, garden activities were scheduled for the afternoon of the inspection but the weather changed and there were dreadful showers, so a movie was screened. There was a large telescopic screen in the day room which enabled movies to be shown 'on the big screen'; and the ice-cream trolley added to the enjoyment. A monthly newsletter was produced giving residents the news and goings-on in the centre with photographs of activities such as art and flower arranging, staff, birthdays, and Easter celebrations for example in the April edition. The activities and recreation calendar was displayed with activities scheduled for morning and afternoon with some evening programmes.

Observations on inspection showed that staff had good insight into responding to and managing communication needs and provided support in a respectful professional manner. For example, taking residents for walks and orientating them to the time, day and place they were to allay confusion and anxiety.

Appropriate signage was in place indicating storage of oxygen in a secure location. Medications were seen to be administered before or after dinner so that mealtime was protected for residents. Residents were asked their menu choice for their lunch. Appropriate assistance was provided to residents and the mealtime was unhurried. However, there was significant delays for residents in the dining room being served their meal. Resident were seated in the dining room from 12:40hrs however, they were not served until 13:15hrs. Fluids of teas, juices and soup and snacks were offered to residents mid-morning and tea, juices and snacks offered in the afternoon. This was facilitated in a relaxed and social manner with positive engagement by staff. Residents gave positive feedback of the quality and standard of meals provided; the inspector saw that meals were well presented.

There were two enclosed garden areas for residents to enjoy. The main garden was bright and colourful and had comfortable seating, tables and parasols. There were raised garden beds around the perimeter, all painted different colours; some were planted up and the activities co-ordinator explained that more planting was due to be completed. In the smaller garden, residents had planted herbs and vegetables. There were small pots around the base of the parasols painted by residents which were very pretty and brightened up the tables. The residents' smoking area was located within this enclosed garden. It had a fire blanket, apron and metal receptacle for disposing of cigarettes and matches.

During the walkabout, it was noted that some fire doors were not aligned and could not close; the heat and smoke seals to others were not effective. This was brought to the attention of management who immediately undertook an examination of all fire doors; following this the maintenance manager was on site and re-aligned doors, magnets and replaced heat and smoke seals to ensure fire safety. While medication trolleys were securely maintained to a wall, this was in a fire evacuation pathway and the trolleys partially obstructed the escape route; the inspector asked that these be removed to a more safe location which did not impeded a possible evacuation, should the need arise.

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

CareChoice Ballynoe was a residential care setting operated by the CareChoice Ballynoe Limited. It was registered to accommodate 51 residents. While the service demonstrated some improvement since the inspection of February 2021 where the registered provider responded to the findings and implemented several improvements, there continued to be areas of non compliance, some repeated non compliance, despite the additional support of a director of nursing to the management structure on site. Even though data was gathered as part of their

quality management system, it was not evident that this information was analysed, trended or utilised appropriately to improve the service; or insight into the potential for this information to influence and improve service delivery.

The organisational structure comprised the chief executive officer (CEO), board of directors, director of quality and innovation, and regional director of operations. Other supports included human resources and finance departments. On site, the person in charge was full time in post and was supported by the director of nursing, three clinical nurse managers (CNMs), senior nurses, care staff and administration. The CareChoice group had appointed a director of nursing (DON), to support persons in charge within the group, as required. As this centre was subject to a significant COVID-19 outbreak, the director of nursing was seconded to CareChoice Ballynoe to support the organisational structure and the person in charge. The DON was on site since February 2021 and continued to support the person in charge in the daily running of the service.

This unannounced risk inspection was undertaken to follow up on the non compliance findings of the inspection on 11 February 2021. While improvement was noted with regulations relating to medication management, risk management, infection prevention and control (IP&C), visits and maintaining residents' personal possessions, the judgment of non compliance remained for governance and management, training and staff development, records, and notifications; additional non compliance was identified regarding fire safety and the complaints procedure.

Similar to the previous inspection failings relating to governance and management, and issues found on this inspection:

- statutory notifications were not timely submitted in line with regulatory requirements
- oversight of auditing and monitoring the service was not effective as audit findings were not analysed, trended, actioned, followed up or information sharing with staff was not evident
- the post COVID-19 outbreak review report had not been finalised following the significant outbreak and learning had not been actioned to date
- reporting structure and deputising governance arrangements were unclear
- lack of robust recruitment practices
- lack of oversight of HR practices relating to staff appraisals, performance management and supervision
- management of complaints was not in line with the centre's complaints policy and procedure.

The inspection in February had identified that notifications (other than the NF02) were not submitted within the time-lines specified in the regulations. This continued to be a finding on this inspection, with eight notifications submitted late.

The centre had remained free of COVID-19 throughout 2020, but had experienced a COVID-19 outbreak in January 2021, which was declared over by Public Health 28 March 2021. Inspectors were mindful that this was a stressful, upsetting and challenging period for residents, their families and staff and that the service was

only just emerging from that worrying time. All CareChoice staff had returned to work and the centre was no longer reliant on agency staff or staff from other centres within the CareChoice group. This positively impacted the well-being of residents as staff knew residents, their ways and preferences.

In response to the findings of the February inspection, the registered provider had updated the COVID-19 contingency plan; communication pathways were established with families to ensure next-of-kin were informed of the changing needs of residents; evidence of this was seen in care documentation examined. The HPSC national guidance recommends that a post COVID-19 outbreak review would be undertaken to identify areas for learning and improvement. However, the COVID-19 outbreak in the centre had not been fully reviewed to analyse the findings and possibly identify trends to establish learnings and positively influence their quality improvement strategy. This was requested by the regulator following the outbreak and again on this inspection, and to date, it was not available.

On the day on inspection there were adequate staff to the size and layout of the centre and the assessed needs of residents including housekeeping staff, laundry, catering, care staff and activities co-ordinator. Staff confirmed that they had additional training to support them relating to COVID-19 pandemic such as infection prevention and control, hand hygiene, donning and doffing PPE. The duty roster for several weeks showed that ongoing training was provided and scheduled for a variety of topics such as fire safety, challenging behaviour, medication management, safeguarding and restrictive practice.

The audit schedule for 2021 was evidenced and showed clinical, observational and practice audits to provide oversight of the service. The CNM demonstrated good insight into the audit process and its value and how it influenced quality improvement. A CNM from another centre of the CareChoice group undertook an audit of medication management as part of their quality improvement. As with many of their audit results, areas for improvement were identified. Inspectors were informed that audit results formed part of the monthly management meetings, however, there was lack of evidence on the ground of how these influenced quality improvement. While documents were shown to inspectors as minutes of monthly management meetings, they were not reflective of minutes of meetings, but reports. These were not dated, they did not reflect the attendees, and did not provide an overview of discussions; issues raised were not followed up on subsequent meetings. These records did not demonstrate appropriate oversight and did not provide assurances to ensure the service was effectively monitored.

A clear reporting structure and deputising arrangements were not evident on inspection. Current management vacancy and arrangements in place to cover should the person in charge be absent, were not outlined.

A sample of staff files were reviewed. The registered provider had not ensured that Schedule 2 documents (documents to be held in respect of the person in charge and each member of staff) were in place for all staff prior to their commencement of employment, as part of their safeguarding arrangements. For example, the provider had not assured that written references were in place from the employee's last

previous employer in two files examined. One staff did not have a vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021. The provider gave assurances that he would follow this up and that the person would not work in the centre until the vetting disclosure was in place. Issues identified in one staff appraisal were not followed up by the person in charge to be assured that appropriate supervision arrangements were in place.

The complaints' records were examined. Inspection findings demonstrated that the centre was not operating in line with their own complaints policy. 14 complaints were documented between 08 February - 06 April 2021, 10 of which remained open and not progressed. While actioning had commenced, the progress and outcomes were not up-to-date on the I.T. care system. There was lack of evidence that a comprehensive review of complaints was undertaken to identify key issues or trend the information fed back about the service, to enable learning and improvement as part of a quality improvement plan.

The risk register was updated since the last inspection and had identified risks associated with the impact of COVID-19 and additional control measures to mitigate identified risks. For example, risk associated with increased visiting to the centre.

In conclusion, staff positively engaged with residents in a kind, gentle and relaxed manner and quality of care was good. Notwithstanding the additional supports that were in place during and following the COVID-19 outbreak, and acknowledging improvements in some areas since the last inspection, there continued to be areas of concern relating to the governance and management of the service.

Regulation 14: Persons in charge

The person in charge was a registered nurse who was full time in post and had the necessary experience and qualifications as required in the regulations.

Judgment: Compliant

Regulation 15: Staffing

The staff roster showed that the number and skill mix of staff was appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Appropriate supervision arrangements were not in place. Issues identified in a staff appraisal were not followed up to be assured that care was safe and consistent.

Judgment: Substantially compliant

Regulation 21: Records

As part of their protection arrangements to safeguard residents, robust oversight of Schedule 2 documentation (staff files) was not evidenced in three of the four staff files examined, as follows:

- two staff files did not have written references from the employee's last previous employer
- two written references as detailed in the regulations were not in place for one staff prior to their commencement of employment
- one file had one written reference on file rather than two
- one staff did not have a vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021.

Judgment: Not compliant

Regulation 23: Governance and management

Management systems in place did not provide assurances that the service was safe, appropriate, consistent and effectively monitored as:

- statutory notifications were not submitted in line with regulatory requirements
- oversight of auditing and monitoring the service was not effective
- the outbreak review following the significant COVID-19 outbreak was not available
- the management structure and reporting structure were not clearly defined
- they had not ensured that their complaints procedure was implemented in practice
- recruitment practices were not robust
- oversight of HR practices relating to staff appraisals, performance and staff supervision was not robust.

Judgment: Not compliant

Regulation 3: Statement of purpose

Current deputising arrangements for times when the person in charge was absent from the centre, as described in the regulations, were not detailed in the statement of purpose.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspection in February had identified that notifications (other than the NF02) were not submitted within the time-line specified in the regulations. This continued to be a finding on this inspection as eight notifications were submitted outside of the statutory time-frames.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had not ensured that their complaints procedure was implemented in practice and that complaints were maintained in line with regulatory requirements:

- not all complaints were investigated promptly
- the status of 10 complaints were not updated on the I.T. care system
- actions taken on foot of a complaint were not recorded on the I.T. care system for 10 complaints
- the appeals process was not communicated to one complainant
- whether the complainant was satisfied with the outcome in one complaint
- a review of complaints was not demonstrated to enable learning and improvement as part of their quality improvement strategy.

Despite inspectors numerous requests for any other records related to complaints, none were provided.

Judgment: Not compliant

Quality and safety

The inspector observed that the care and support given to residents was respectful, relaxed and unhurried; staff were kind and were familiar with residents preferences and choices and facilitated these in a friendly manner. Staff positively and actively engaged with residents including residents with complex communication needs.

Visiting had recommenced and visits were scheduled by the administrator in the centre and were facilitated in the afternoons over a seven-day period. Inspectors saw visitors to the centre and appropriate IP&C precautions were adhered with coming and going from the centre.

Activities were varied and included one-to-one therapy and group sessions. The weekly activities programmes showed that there was a varied schedule with items such as gardening and planting herbs and vegetables, morning review of the newspaper, hand massage, hair up-styling, knitting club, morning mass and rosary. Minutes of residents' meetings showed that these were well attended and lots of areas were discussed relating to their quality of care and quality of life; issues were followed up in subsequent meetings.

The GP attended the centre and documentation showed that medications were regularly reviewed along with assessment of the resident. The GP had his own user code for the on-line care documentation system and could remotely access residents' notes to update or activate prescriptions. Residents had timely access to psychiatry of old age, surgical reviews, dietician, speech and language therapist, geriatrician and palliative care. The physiotherapist was part-time in the centre and completed 'fit for life' assessment and care plan to enable residents maintain their current level of mobility as well as strengthen their muscle tone.

Pre-admission assessments were undertaken by the interim director of nursing to ensure that the service could provide appropriate care to the person being admitted. As part of this pre-admission assessment the family completed a 'brief life history', this was then followed up by the activities person to further enhance the information available so that staff could actively engage with residents, chat about their interests and include their interests in the activities programme.

Notes of two recently admitted residents showed that a comprehensive inventory of personal property was recorded including photographs of jewellery and mobile phones upon admission.

On admission, a three-day food and fluid chart was maintained of the resident to get a base line of the residents intake; this informed the care plan nutritional assessment and care plan and the plan of care was adjusted accordingly. The daily narrative was comprehensive in the care documentation examined. Sometimes there were several entries during the day which provided a holistic picture of the care required and given.

A sample of care plan documentation was reviewed. Residents had evidence-based risk assessments to guide care and documentation showed that residents were consulted with regarding their care; these assessments were completed in line with

regulatory requirements. Care plans were updated every four months, however, they were not updated with the changing needs of residents. For example, the care plan for one resident's care needs had significantly increased in the previous fortnight, but their associated care plans did not reflect the additional care needs. Advanced care directives 'Let Me Decide' were in place for residents and documentation showed that these discussions were with the resident, next of kin and GP. While the end of life care plan was in place it was not updated with the information available in the palliative care assessment.

Of the sample of care documentation seen, some residents had signed their own consent forms for items such as photographs, vaccinations and participation in care planning, while others were signed by their next of kin regarding information sharing.

Staff spoken with and practice observed showed that staff had good insight into residents' specific care needs relating to behaviours and measures put in place to support residents. Those residents requiring behavioural support plans had them in place and observational charts were initiated when required to help identify possible sources of upset, confusion or anxiety.

The national transfer letter was part of the on-line care documentation available to staff to complete when an resident was transferred out of the centre so they could be appropriately cared for by the receiving facility. Residents notes showed that comprehensive documentation accompanied the resident upon their return to the centre from another care service.

There was a daily safety pause to remind staff of issues such as residents at risk of falls, skin integrity, absconsion, responsive behaviours, and reminders when visitors came to the centre regarding IP&C precautions.

Controlled drug records were securely maintained. The daily controlled drug check book and administration record log were updated since the last inspection; the CNM reported that these new ledgers were much better and enabled robust records to be maintained. Issues that were identified on the last inspection relating to medication management were remedied; the attending GP reviewed all prescriptions and updated them accordingly. Weekly medication audits were undertaken and an additional external audit was completed by the CNM from another centre in the CareChoice group as part of their quality improvement.

Household staff described best practice regarding cleaning regimes and the use of colour-coded cloths and solutions. Bottles of residents' shampoo and shower gels were seen in a communal shower which was not in compliance with IP&C precautions.

Laundry was segregated at source and laundry staff described best practice work-flows in the laundry to prevent cross infection in line with the national standards for infection control. The laundry was neat and tidy and clothes were segregated appropriately. Other precautions in place for infected laundry included the use of alginate bags; clinical waste procedures were seen to be robust. Dani centres were located around the centre for staff to easily access personal protective equipment

(PPE). The sluice rooms and clinical rooms were secure access to prevent unauthorised access to hazardous waste and clinical products. A flushing regime was seen for areas not in regular use to mitigate the risk of legionella.

There was a daily risk register which included risks that were identified following incidents and accidents for example. There was a corporate risk register that was centre specific and included risks associated with COVID-19 pandemic. While there was risk identified with the usage of CCTV it did not correlate with the CCTV policy as detailed by the person in charge.

Documentation relating to fire safety required review as there were both soft and hard copy records, and it was difficult to determine if records were appropriately and comprehensively maintained. While there were paper-based monthly templates available, records input to the templates straddled months, and there were gaps in the hard copy records seen; other records then were on computer. Similar findings were seen regarding records of weekly emergency lighting checks, fire hydrant monthly flushing and monthly fire door checks. An immediate action was given on inspection relating to some fire doors. The maintenance manager came on site and re-aligned fire doors, replaced heat and smoke seals and repaired faulty magnets. However, some of these issues identified on inspection requiring immediate attention were not recorded in the daily fire safety checks seen. There were colour-coded floor plans displaying fire alarm zones with a point of reference highlighted, however, evacuation pathways were not detailed to ensure persons had access to the building layout and escape routes available.

Regulation 11: Visits

Visits were facilitated in line with current HPSC guidance.

Judgment: Compliant

Regulation 12: Personal possessions

Storage for personal possessions included a double wardrobe, chest of drawers and bedside locker for each resident.

Judgment: Compliant

Regulation 13: End of life

While the end of life care plan was in place it was not updated with the information

available in the palliative care assessment.

Judgment: Substantially compliant

Regulation 17: Premises

There were inadequate shower facilities for the number of residents in this centre. The provider had a plan in place to address this shortfall, however, due to COVID-19 it was necessary for the completion date for the additional showers to be pushed out from March 2021 to September 2021.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents had access to fresh drinking water throughout the day. Meals were pleasantly presented and catered for the dietary needs of residents. However, serving of meals required attention as residents were seated in the dining room from 12:40hrs and but not served their meal until 13:15hrs - waiting time of 35 minutes.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

The national transfer letter was available as part of the suite of templates on the computer care documentation. Transfer letters were evidenced on inspection to be assured that information was available when a resident required acute care or transfer to another institution so they could be appropriately cared for by the receiving facility. Following discharge back to the centre, comprehensive information was available when the resident returned to the centre.

Judgment: Compliant

Regulation 26: Risk management

A current risk management policy and safety statement were available. There was a daily risk register which included risks that were identified following incidents and

accidents for example. There was a corporate risk register that was centre specific and included risks associated with COVID-19 pandemic.

Judgment: Compliant

Regulation 27: Infection control

HPSC guidance recommended that a post COVID outbreak review be undertaken to identify areas for learning and improvement, however, this report was not available to date.

Bottles of residents' shampoo and shower gels were seen in a communal shower which was not in compliance with IP&C precautions.

Most clinical sinks had hands-free tap mechanism, however, one sink required the taps to be upgraded to hands-free in line with National Standards.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Hard and soft records of the daily, weekly and monthly fire safety precautions checks were maintained, however, neither were comprehensive.

Issues identified on inspection requiring immediate attention such as the mal-alignment of doors preventing them from closing, or the placement of the medication trolleys obstructing fire doors, were not recorded in the daily fire safety checks seen.

There were colour-coded floor plans displaying fire alarm zones with a point of reference highlighted, however, evacuation pathways were not detailed to ensure persons had access to the building layout and escape routes available.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Issues identified on the last inspection were remedied. Medications and associated documentation were maintained in line with legislation and professional guidelines. New controlled drug ledgers were introduced since the last inspection to enable

more robust records and mitigate risk of potential errors or near miss episodes.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plans were updated every four months, however, they were not updated contemporaneously with the changing needs of residents. For example, the care plan for one resident's care needs had significantly increased in the previous fortnight, but their associated care plans did not reflect the additional care needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had regular access to on-site GP consultation. Residents medications were reviewed as part of their consultation with their GP and ongoing monitoring and responses to medication were seen. In the sample of residents' care documentation examined, appropriate records were seen regarding wound care and supports for communication needs.

Judgment: Compliant

Regulation 8: Protection

Safeguarding training was provided to staff and the duty roster showed that further safeguarding training was scheduled in the next few weeks; observations demonstrated that residents were treated with respect and a social model of care was promoted.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had access to meaningful activities; the activities co-ordinator knew residents interests and encouraged people to take part in the activity programme.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for CareChoice Ballynoe OSV-0000210

Inspection ID: MON-0032090

Date of inspection: 27/04/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The current and proposed actions: Staff appraisals are completed annually for staff by their Line Manager, these are held on the electronic HR system. The staff appraisal which the inspector refers to in the report has since been reviewed, actioned and closed. The DON and HR representative for the home review staff appraisals on completion, and an action plan is generated for areas of staff personal development identified, these are then are actioned and reviewed within an agreed timeframe. • Review: The Management team in conjunction with HR are reviewing the Annual Performance Management Process and same is being updated. This will be implemented in Ballynoe by the end of June 2021. • Training: Training will be provided for the Management and Line Managers in using the new procedure by end June 2021. • Audit & review: An audit of employee files has been completed and a detailed re-review on all performance appraisals in underway with any identified corrective action plan put in place with all areas addressed.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The current and proposed actions:	

• References: References are sought for all new starts, one from the most recent employer. Where possible this will be a direct line manager. Where possible, references will be verified by the HR team by telephone call. This call will be logged on file. If there are any issues in relation to receiving references, details of number of attempts to attain references are noted on file and a discussion takes place with DON and HR. The file that is referred to by the Inspector had 2 references in place, both from the employees most recent employer with a that employers company stamp.
The process for receiving and reviewing references has been enhanced to now include a new verification document for all new employees.

• Garda Vetting: This is completed for newly recruited staff before commencement of work. Garda Vetting is uploaded to the HR electronic system at the onboarding stage. An administrative oversight occurred with one new staff member in terms of vetting disclosures. Whilst this person was completing induction for 2 days there was staff shadowing and supervision in place. This is now rectified.

A verification checklist document has been implemented for all new starts and will prevent this from reoccurring. Further internal controls have been implemented in the HR system which will now prevent any newly recruited staff being registered on clock in system without garda vetting in place.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. Notifications
The PIC has completed further training on governance and management of notification process on 21st May 2021.

All incidents and complaints will be reviewed on a daily basis by the clinical management team to determine the requirement for notification submission. This will be supported by the Regional Quality Manager and the RDO as part of a weekly review.

Further training on notifications will be provided to the Clinical Nurse Managers in June 2021. All members of the Clinical Management team are provided with a copy of the HIQA notification handbook for reference and discussion.

2. Audit Oversight
As identified by the inspector on the day the "audit schedule for 2021 was evidenced and showed clinical, observational and practice audits to provide oversight of the service. The CNM demonstrated good insight into the audit process and its value and how it influenced quality improvement."

The annual, monthly and weekly audit schedule is in progress. Audits are completed by the clinical management team and further training on auditing and developing action plans has been provided in May 2021.

All audits will be reviewed by the PIC & the clinical management team with support from the Regional Quality Manager with results and action plans developed discussed with the relevant department team members in the home. Review of audit trends will be completed by the PIC and the clinical management team. The Regional Quality Manager will monitor completion of audits and actions that arise. The RDO will receive confirmation of work completed at the monthly operations meeting.

3. Outbreak Review
The Covid Outbreak review was commenced in March 2021 in conjunction with the DON and is at its final draft. This review will be discussed as part of the Crises Management team meetings with any actions determined.

The outbreak review will be retained in Ballynoe and the PIC with support from the clinical management team will address any internal actions identified.

The final outbreak review findings will be discussed and actioned at senior management level in CareChoice in conjunction with the CareChoice Quality & Compliance Department.

4. SOP deputizing arrangements
At the time of the inspection the SOP referred to an ADON being the nominated person o deputize for the DON/PIC, a senior CNM who was working in Ballynoe since 2007 was completing many of the ADON tasks at that time and available to deputize for the DON as required.

CareChoice Ballynoe is actively recruiting a permanent ADON and once appointed this person will deputize for the DON in their absence.

The SOP reflects same.

5. Complaints management
Whilst it is recognized that during the Covid outbreak there was a delay in recording some of the complaints on the electronic system, all complaints were responded to immediately, documented, and investigated. These complaints were also reviewed by the Regional Quality Manager and DON in March.

A review of all records pertaining to these complaints is underway, complaint files are being audited with support from the Regional Quality Manager and RDO. Actions identified will be completed to include review of complaints status, actions, implementation of the appeals process and the relevant outcome.

A review of complaints will include identifying trends, developing and implementing appropriate action plan.

Training on complaints management is being provided to all nursing staff, administration

staff and clinical management team in Ballynoe.

6. Recruitment practices (records)
The DON and HR work closely to identify recruitment needs in the nursing home. References are sought for all new starts, one from the most recent employer. Where possible this will be a direct line manager. Where possible, references will be verified by the HR team by telephone call. This call will be logged on file. If there are any issues in relation to receiving references, details of number of attempts to attain references to be noted on file and discussion to take place with DON.

As part of the recruitment process a new verification document has been implemented for all new recruits.

Garda Vetting is completed for New Hire's before commencement of work. The Garda Vetting document is uploaded to the HR file at onboarding stage. An administrative oversight occurred with one new staff member in terms of vetting disclosures. During this time whilst this person was completing induction for 2 days there was staff shadowing and supervision in place. This is now rectified. A verification checklist document has been implemented for all new starts and will prevent this from reoccurring. The HR system will now prevent new hires being registered on clock in system without garda vetting in place.

7. HR practices (appraisals, performance & supervision)

Staff appraisals are completed annually for staff by their Line Manager, these are held on the electronic HR system.

The DON and HR representative for the home review on completion, and an action plan is generated for issues identified, these are then are actioned within an agreed timeframe.

The Annual Performance Management Process is underway and is being updated. This will be implemented in CareChoice Ballynoe by the end of June 2021.

Training will be arranged for Management and Line Managers in using the new procedure by end June 2021.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
At the time of the inspection the SOP referred to an ADON being the nominated person o deputize for the DON/PIC, a senior CNM who was working in Ballynoe since 2007 was

completing many of the ADON tasks at that time and available to deputize for the DON as required.

CareChoice Ballynoe is actively recruiting a permanent ADON and once appointed this person will deputize for the DON in their absence.

The nursing home is being supported by 2 CNM's who work supernumerary with 1 CNM onsite daily to support the clinical management of the nursing home. An experienced ADON from another CareChoice Nursing home is in place in the interim.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The RPR recognizes that a number of notifications were submitted outside of the required timeframe and assures that this is now rectified.

Education
• The PIC has since reread HIQA's Notification Handbook and undertakes to complete all notifications within the designated timeframe going forward.
• The PIC has attended a one-day course on 'Governance of the Nursing Home, the Role of the Registered Provider, PIC and beyond', which includes SI No 415 of 2013 Health Act 2007 regulations, National Standards and HIQA Guidance documents.

Supervision
• The Quality Dept has commenced reviewing the timeframe of incidents that arise and the notification of same and will highlight late notifications to the PIC and their Line manager so they may be addressed. This will be completed as part of the monthly Quality review with the Regional manager and PIC. Notifications form part of the monthly operations meeting and will be discussed accordingly.

Audit & Review
• All notifications are being reviewed monthly by the PIC and Quality Dept, actions arising are completed by the PIC.
• Notifications are further reviewed during the Monthly Operations meeting.
• A report on all notifications is made available to CareChoice Senior Management team for review monthly.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The current and proposed actions: • Upon receipt of complaint, initial correspondence and phone calls were maintained, some of this was maintained on a hard copy to include Senior Management team notes. These have subsequently been added to the electronic system and complaints files reviewed. • The complaints in question remain open and the complainant's satisfaction shall be recorded on closure. A review is underway of any closed complaints and the status of complaints is being updated. • As part of the current review of all complaints, any identified actions which may have been omitted will be recorded and completed. • CareChoice Complaints procedure is available on all units, and the complaints information leaflet is available both in the home and on the website. Complainants were informed of the appeals process during communication meetings and telephone correspondence. • A review of all open and closed commenced in March with the DON / Regional Director of Operations and the Regional Quality Manager and this will be fully completed in June with oversight from the RDO and Director of Quality & Compliance. On completion of the review a quality improvement plan shall be documented and actioned.	
Regulation 13: End of life	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: End of life: The nursing home facilitates the "Let me Decide" programme for residents. Staff have been education on implementing this programme. All residents have a documented end of life careplan and a review of these careplans has been completed to include cross referencing of the residents let me decide documentation, information on residents' preferences on end of life care have been added where required. • Review: Residents careplans will be reviewed at a minimum 4 monthly and or if the resident's health status changes in line with regulation. Education on assessment and care planning has been completed by nursing staff and ongoing support is provided the clinical management. • Audit & Supervision: In addition, the nursing team will continue to receive support in assessment & care planning from the Regional Quality Manager. Weekly Audits of resident's assessment and careplans are completed and feedback provided to the assigned nurse. Any identified actions will be reviewed by the Clinical Management team	

& DON/ADON to ensure that the residents care plans are reflective of their wishes and needs.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The RPR was in regular contact with the Inspector and completed an Application to Vary as required, to reschedule the completion of the works required that had been delayed due to Level 5 and Outbreak restrictions.
This work will be completed by September 2021 in line with as per the new timeframe agreed with the Inspector.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• Review: A review of the Dining Experience within the home is underway, as part of this process residents are accompanied to the dining room prior to their meal to socialize, smell the food cooking and to choose from the menu.

As part of a review of the dining experience the Group Catering & Household Manager is completing a dining audit and attended the home's resident committee to obtain feedback from the residents on their dining experience. Following this the outcome will be reviewed and an action plan implemented.

The clinical management team also complete QUIS assessments during mealtimes and any identified actions will be discussed and reviewed with staff.

• Training: As part of the person-centered personal care training in June 2021, staff will be educated to ensure that residents are provided with a choice of time to attend the dining room for meals as per their preferences. This will also be included as point of note in staff huddles by the DON & CNM's.

• Supervision: Mealtimes are supervised by members of the clinical management team on a daily basis to ensure that the timeframe that residents are in the dining room prior to their meals is not too lengthy for them.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• At the time of the inspection a detailed outbreak review was underway by the DON and Regional Operations Director, this will be completed by the end of June and a quality improvement plan will be documented and actions addressed.

• Communal shower rooms have been reviewed and residents' toiletries have been removed. Signage to that affect has been erected. Staff have been reminded that this is not appropriate, and the clinical management team are monitoring daily.

• A review of sinks within the home has been completed and where a replacement is required this has been ordered and will be replaced by end of June 2021.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• The nursing home maintains daily, weekly and monthly fire safety records. These are both in paper and electronic format, with a plan to move exclusively to electronic records in 2021.

• There is a comprehensive fire management strategy in place which was developed in conjunction with the H&S person and a Fire Prevention Advisor. This includes a risk register and a number of Training sessions which were delivered out to the following staff members DON, Maintenance, Fire trainers, Admin staff in February and March 2021. As part of the fire strategy plan a review of fire doors was completed by external contractor in February 2020. The home continued to engage with the contractors, unfortunately due to Level 5 and outbreak restrictions works were scheduled to be completed in May. Emergency remedial works was completed on fire doors in May 2020 and in September 2020, a survey of planned maintenance on fire Doors was completed. Ongoing internal works and repairs have been completed as identified in 2020/2021. The full schedule of works by the contractors is now being completed and due to finish in June 2021. The nursing home acknowledges that on the day of inspection the issues identified by the inspector related to the closing of the doors had not been recorded at that time and this was rectified with immediate action to resolve the issue taken.

Education: Training will continue to be provided by the Health & Safety Officer and Facilities Manager to the maintenance team in ensuring that all issues are recorded daily and communicated to the facilities manager and the PIC/DON.

Fire training is provided to all staff to include the importance of the daily safety checks and this will continue to be communicated in staff huddles.

HIQA provided new Guidance on Fire Safety in Jan 2021, a review has been completed an Carechoice Ballynoe and an action plan in place. In relation to the floor plans, these are currently being upgraded to provide detailed pathways of escape routes in the building.

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:
Residents careplans will be reviewed at a minimum 4 monthly and/or if the residents health status changes in line with regulation.
• Education: Careplan education has been completed by nursing staff and the nursing team have been provided with an assessment and care plan toolkit as a reference guide. The nursing team will continue to receive support in assessment & care planning from the Regional Quality Manager.
• Review: A review of resident careplans has been completed, and all have been updated to reflect resident current care needs.

• As part of daily handover, member of the clinical management team will promptly review any residents care plans where the resident health needs have changed.

Weekly Audits of residents assessment and careplans are also completed and feedback provided to the assigned nurse. Any identified actions will be reviewed by the Clinical Management team to ensure that the residents care plans are reflective of their wishes and needs.

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)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Substantially Compliant	Yellow	30/06/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/2021
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	30/09/2021

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	
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/08/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	01/07/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by	Substantially Compliant	Yellow	30/06/2021

	staff.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/06/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/06/2021
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	30/06/2021
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	01/06/2021
Regulation 31(4)	Where no report is required under paragraphs (1) or (3), the registered provider concerned shall report that to the Chief Inspector at the end of each 6 month period.	Not Compliant	Orange	01/06/2021
Regulation 34(1)(d)	The registered provider shall	Not Compliant	Orange	31/07/2021

	provide an 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.	Not Compliant	Orange	31/07/2021
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.	Not Compliant	Orange	31/07/2021

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.	Not Compliant	Orange	31/07/2021
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 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.	Not Compliant	Orange	31/07/2021
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.	Not Compliant	Orange	31/07/2021
Regulation 34(3)(b)	The registered provider shall	Not Compliant	Orange	31/07/2021

	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).			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/07/2021