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:	Maryfield Nursing Home
Name of provider:	West of Ireland Alzheimer Foundation
Address of centre:	Farnablake East, Athenry, Galway
Type of inspection:	Unannounced
Date of inspection:	03 November 2021
Centre ID:	OSV-0000359
Fieldwork ID:	MON-0034431

About the designated centre

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

Maryfield Nursing Home is a designated centre that provides long term and respite care for 24 male or female residents who have dementia or a related condition. The centre is located in a rural setting approximately two kilometres from the town of Athenry and 25 kilometres from Galway city. The centre is purpose built. It is single storey and residents' accommodation is provided in 12 single and six double rooms. There is adequate sitting and dining space to accommodate all residents in comfort. A safe garden area is also available. The environment has been enhanced by the use of dementia friendly features that include signage, good levels of natural lighting and a homelike layout.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21

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 3 November 2021	09:00hrs to 18:00hrs	Una Fitzgerald	Lead
Wednesday 3 November 2021	09:00hrs to 18:00hrs	Claire McGinley	Support

What residents told us and what inspectors observed

Overall, inspectors found that the residents received a good standard of care and support that met their assessed needs. Residents' medical and healthcare needs were being met. Inspectors observed a relaxed and welcoming atmosphere. The centre is a dementia specific facility and inspectors spent periods of time observing resident and staff engagement. Residents appeared content in the environment.

This was an unannounced inspection. On arrival, the person in charge guided the inspectors through the infection prevention and control measures necessary on entering the designated centre. These processes included hand hygiene, face covering, and a temperature check. On the day of inspection all residents had completed the vaccination programme and had receive their booster vaccine. At the time of inspection no resident within this centre had had COVID-19. Resident representative meetings evidenced that residents and relatives had been kept up to date regarding the visiting restrictions and the COVID-19 pandemic.

Most residents spent their day in the main communal dayroom which was supervised by a member of staff. The inspectors summarised from the answers to questions that the staff knew the residents care needs. The inspectors spent time observing residents and staff interactions. A small number of residents spoke with inspectors. While none of the residents met with were able to tell the inspectors their views on the quality and safety of the service, inspectors observed that the residents were at ease in the environment. Residents were observed to be well groomed. Inspectors observed their clothing was clean, nails were clean, hair was brushed and makeup was applied.

The overall atmosphere in the centre was observed to be calm. In the main, residents were not rushed. For example; inspectors observed two staff assist a resident to walk from their bedroom to the main communal sitting room. Staff were heard offering encouragement and when the resident became agitated and voiced they had walked enough a wheelchair was provided.

As previously stated the centre provides care to residents with dementia. Inspectors observed that most residents did not routinely have a call bell in their bedrooms to enable them call for assistance. On discussion with staff the response was that, in the main, residents did not have capacity to use a call bell. Staff informed inspectors that when a resident was at high risk of falling intervention management strategies such as alarm mats were in place to reduce the risk of falling. Inspectors questioned that a resident may not require to get out of bed but may wish assistance with another activity. For example, requesting a drink. When this was discussed with the person in charge, inspectors were informed that the majority of residents spend their day time in the communal room which is supervised at all times. At night, staff complete frequent safety checks on all residents. The person in charge confirmed that if a resident has capacity to ring a bell one is freely available.

One area of concern observed by inspectors was the process in place for the provision showers for residents. Inspectors observed that residents are brought from their bedrooms wrapped in towels and when finished brought back to their bedrooms wrapped in towels for dressing. Inspectors observed that residents were inappropriately exposed while moving between rooms. On discussion with the person in charge a commitment was given to review this practice immediately to ensure that individual residents rights to maintain their privacy was not compromised.

Activities are scheduled seven days a week. All group activities such as bingo and baking had been discontinued during the pandemic. One to one activities such as hand massage had continued. Inspectors were told that a review of the risks and benefits of recommencing group activities was on the agenda for discussion now that all residents had received their booster vaccination.

The next two sections of the report present the findings of this inspection in relation to the capacity and capability in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Inspectors found that residents received a good standard of direct care that met their assessed needs. Parts of the premises were in a poor state of repair and there was an insufficient number of showers available for resident use. The inspectors acknowledge that a plan is in place for the installation of new showering facilities that have a completion date of 31/12/2021. Inspectors found that the governance and management support available to the person in charge to enable them have sufficient oversight and monitoring of the systems in place required improvement and strengthening.

West of Ireland Alzheimer Foundation is the registered provider of the centre. This was an unannounced inspection carried out over one day. The centre is registered to accommodate 24 residents in both single and double-occupancy bedrooms. As a result of the pandemic the centre is currently holding two bedrooms vacant to allow for the isolation of residents' in the event of a COVID-19 outbreak.

On the day of inspection, there were 21 residents accommodated in the centre. Inspectors reviewed the staffing rosters and found that the number and skill mix of staff on duty was appropriate to meet the direct care needs of the residents. The staff providing direct clinical care to the residents consisted of one registered nurse on duty at all times who reported directly to the person in charge. The nurse was supported by a team of healthcare assistants, activities staff and the centre had catering and housekeeping staff on duty daily.

There was evidence of good systems of communication that included monthly governance meetings with the provider, quality safety and risk management

meetings, staff meetings and clinical daily handover meetings. There was evidence that the management team discuss all clinical and operational matters on an ongoing basis. Minutes reviewed had identified that there were ongoing challenges with staff recruitment. On the day of inspection there were vacancies within the governance and management structure. Inspectors found that this vacancy was impacting on the monitoring of the service. The WTE registered nurse compliment was also in need of review. The person in charge confirmed that staff duty rotas was a constant concern and that considerable time was taken over with the management of same.

There was an audit schedule in place. Inspectors found that the audits reviewed required further development. Gaps found on this inspection had not been identified through the auditing systems. For example, an infection and prevention audit had been rated as 100% compliant. However, the audit did not identify the challenges and barriers to have effective cleaning of equipment that is not amenable for cleaning, such as heavily rusted equipment, exposed chipboard, fabric seating and worn armchair rests.

The care plan audits completed had not identified the gaps in documentation. Inspectors were informed that the nurse manager position that is currently vacant had held a large portion of the responsibility for the auditing in the centre. Inspectors reviewed the audits completed prior to the departure of the nurse manager support and found that when the person in charge had had on site managerial support the audits completed had identified gaps. Inspectors found a direct connection with the level of monitoring with the exit of the managerial support for the person in charge.

Another example of the requirement to increase the support for the person in charge was staff supervision. When asked about staff supervision and performance monitoring, inspectors' were informed that the intention was to complete staff annual appraisals. These had not been completed due to resources and managerial support for the person in charge.

While it was evident that direct care was delivered to a high standard, inspectors found that further development of management systems in place to monitor the overall quality and safety of the service continued to require further strengthening. The systems in place are not sufficiently robust enough to ensure sufficient oversight. This was evidenced by:

- The auditing system in place as identified above did not capture the gaps in documentation found during this inspection. Therefore the auditing system was not effective in promoting quality improvements.
- The system of risk management required further review. While there was a detailed policy in place the risk register reviewed by inspectors required updating. For example. The risk on the limited availability of registered nurses.
- A review of the staffing numbers was required to ensure that there are sufficient registered nurses available in the centre. While inspectors acknowledge that recruitment is ongoing the appointment of a replacement in

the clinical nurse management structure is required. The staffing vacant positions were impacting on the person in charges ability to monitor the service.
- The COVID-19 staffing contingency plan required review to ensure sufficient nursing staffing resources were available in the event of a outbreak in the centre.
- Fire safety checks had not identified deficits with some of the fire doors.
- Inspectors found repeated non-compliances with the regulations reviewed and that the compliance plan response to the previous inspection findings from November 2019 had not been fully implemented.
- The annual review of the service did not evidence that residents or their representatives had been consulted with.

The provider was committed to providing ongoing training to staff. The training matrix reviewed evidenced full compliance with mandatory training required by the regulations. Staff had received mandatory training in safeguarding vulnerable adults from abuse, fire safety, people moving and handling, infection prevention and control and hand hygiene. The person in charge held responsibility for the ongoing supervision of staff. There was a process in place to ensure staff were inducted to their roles and this included on-line learning, supplemented by practical demonstrations, and mentoring by the staff team. As previously stated the process of completing annual staff appraisals was currently on hold due to resources.

Inspectors reviewed staff files and found that in the main staff files contained all of the documents required by the regulations. Any gaps were known to the administration staff and appropriate steps were in process.

The inspector reviewed the complaints log. The complaints procedure was displayed at the reception area in the centre. There was evidence that when a complaint is logged appropriate steps are taken as per the centre's policy. The documentation in place evidenced that the management engaged with the complainant to ensure that all reasonable measures were taken to ensure a satisfactory outcome.

Regulation 15: Staffing

The person in charge had ensured that there was a registered nurse on duty at all times.

The findings specific to the availability of registered nurses and the nurse management vacancies are actioned under Regulation 23 Governance and Management.

Judgment: Compliant

Regulation 16: Training and staff development

Training records provided to the inspector for review evidence that all staff had up to date mandatory training in safeguarding, fire safety and manual handling. Staff had also completed training relevant to infection, prevention and control.

Gaps in the completion of annual staff appraisals is actioned under Regulation 23 Governance and Management.

Judgment: Compliant

Regulation 23: Governance and management

The management team had systems in place to oversee the quality and safety of care in the centre. While these systems generally worked well, further oversight was required in relation to the staffing strategy, fire safety precautions, some aspects of infection prevention and control and maintenance of parts of the premises. The totality of the findings evidenced that the person in charge and the support structures in place required strengthening to ensure that the systems are effective and result in improved levels of compliance.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge was aware of the requirement to notify the Chief Inspector of all incidents as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy in place. The policy included the name of the person nominated to deal with complaints and an appeals procedure. There was a system in place to facilitate the recording of complaints. The inspector reviewed the complaints logged. At the time of inspection there were no open complaints. It was unclear who monitored the administration of complaints to ensure that the policy was adhered too. This was discussed during the inspection and an appropriate

person was appointed.

Judgment: Compliant

Quality and safety

Inspectors found that the direct provision of care was of a good standard and was based on an assessment of need. Inspectors found that the residents individual care needs, likes and dislikes were known to the staff. Inspectors sat in on daily handover and observed that the information sharing evidenced that person centred care was being delivered. Notwithstanding the positive findings the inspectors found that the documentation in place specifically on care plans did not always guide the care and direct staff. The risk therefore is that changes in treatment will be missed.

Residents' medical and health care needs were met. Staff spoken with were knowledgeable on the individual care needs of the residents under their care. Inspectors reviewed resident files. In the main, care plans were found to be individualised and person-centered. The documentation system in place was clearly laid out and the information was easily retrieved. Residents had access to medical and allied health care supports.

The provider had systems in place to monitor environmental restrictive practices. In the main, the centre was working towards a restraint-free environment in line with local and national policy. Records showed that where restraints specific to the use of bedrails were used these were implemented following robust risk assessments and alternatives were trialled prior to use.

Inspectors walked the premises. There was sufficient staffing to ensure that the premises were cleaned daily. As a result of the pandemic additional resources had been allocated to the cleaning of the centre. A deep cleaning schedule was in place for all curtains and resident private screening. There was a colour coded cloth and mop system in place that utilises one cloth per room to ensure that each area is cleaned with a new cloth/mop on every occasion. The inspectors spoke with staff who were very clear on the policy, procedures and practices in place.

Improvements had been made since the previous inspection, such as the continuance supply of hot water. However, as previously stated there were parts of the premises that were in a poor state of repair. There were multiple examples of resident equipment that was in need of attention and in many cases in need of replacement. This is detailed under Regulation 17 Premises.

Residents’ lives had been significantly impacted by the COVID-19 pandemic and consequent restrictions. A small number of staff had tested positive for COVID-19 during the pandemic. At the time of inspection no resident had tested positive for COVID-19. Inspectors observed that staff adhered to guidance in relation to hand hygiene, maintaining social distance and in wearing PPE in line with the national

guidelines. Staff reported that the training they had received had been of a good standard and they were able to implement it in practice. The management team were committed to ensuring all reasonable measures were in place to prevent introducing the COVID-19 virus into the centre. This included:

- a temperature and COVID-19 symptom check on arrival to the centre
- alcohol hand sanitizers were available throughout the centre.
- appropriate signage was in place to prompt all staff, visitors and residents to perform frequent hand hygiene.
- Individual resident slings for manual handling purposes.
- two bedrooms were being kept vacant for isolation purposes.

The laundry facilities and procedure were managed appropriately to ensure residents clothing was managed with care and minimised the risk of clothing becoming misplaced. Residents' laundry was managed on-site and each item of clothing was marked for identification.

Inspectors reviewed the documentation that supports the monitoring of fire safety in the centre. Daily checks of the fire panel and means of escape and weekly checks of fire doors were completed. Fire equipment such as fire extinguishers had been inspected by a competent person. However, no fire drill had been completed since April 2021. The monthly management meeting records reviewed from July and September 2021 highlighted the need to complete a simulated night time fire drill. To date this had not been completed. Inspectors acknowledge that the records of drills that were completed were detailed and learning had been identified. However, the length of time taken to evacuate one resident was up to six minutes which is in excess of recommended times. Staff spoken with were clear on what action to take in the event of the fire alarm being activated. Inspectors found that further improvements are required to bring the centre into full compliance with the regulations. The detail is outlined under regulation 28 Fire precautions.

Regulation 11: Visits

Residents were supported to maintain personal relationships with family and friends. The centre was facilitating visiting in line with the current COVID-19 Health Protection and Surveillance Centre (HPSC) guidance on visits to long term residential care facilities.

Judgment: Compliant

Regulation 17: Premises

The layout of the premises supported the needs of the residents and provided adequate indoor private and communal space and access to outdoor areas. Further

improvements were required in the maintenance of the premises. Inspectors found that internal renovations and redecoration were required to address areas of the building that had wear and tear in bedrooms and bathrooms. The provider confirmed that the installation of additional bathroom/showering facilities was in process that is required to ensure the premises comply with S.I. No 293/2016 – Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) (Amendment) Regulations 2016, by 1 January 2022.

Improved focus and assessment of the premises was required. This is further evidenced by:

- Floor coverings in areas were damaged and torn. This inhibited effective cleaning
- Some walls and skirting had chipped paint and staining and were visibly damaged
- Resident wardrobes and bedroom sink surrounds were in a poor state and had exposed chipboard and many were in need of replacement.
- Equipment used to support residents required cleaning and in some cases upgrading. For example; some shower chairs and commode chairs required replacement due to staining and rust.
- Some wooden bed rails were damaged.

Judgment: Not compliant

Regulation 26: Risk management

The risk policy contained all of the requirements set out under Regulation 26(1). The local risk register was kept under review by the person in charge. The risk register identified risks and included the additional control measures in place to minimise the risk.

Judgment: Compliant

Regulation 27: Infection control

Further oversight was required to cleaning of some parts on the premises and to some equipment used by residents:

- resident equipment that was stored away for use was not clean and ready for use with the next resident
- The inspectors observed that some armchairs in the centre are worn in parts and this had an effect on the ability to clean to the standards required during a national pandemic

- Some items of resident equipment were not visibly clean
- Resident personal toiletries were found in communal bathrooms

Judgment: Substantially compliant

Regulation 28: Fire precautions

A range of simulated fire drills had taken place. However the management team had not carried out a simulated drill of the largest compartment taking in to consideration night time staffing levels and residents needs. Therefore, assurance was not available that their evacuation strategy could be managed in a timely manner.

The weekly fire door checks had been completed but had not identified that there was a significant gap when some of the doors shut. For example; In one door inspectors had a clear view through the gap. Therefore, this gap compromised the fire doors function of containing smoke.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of resident files and found evidence that residents had a comprehensive assessment of their needs prior to admission to ensure the service could meet the assessed needs of the residents.

Care plans reviewed by inspectors were not consistently updated with changes in a residents' condition. For example,

- one resident admitted did not have a comprehensive admission assessment of needs completed and consequently, a corresponding care plan addressing some of these aspects of care was not developed.
- the specific personal care needs of residents were not always recorded. For example, shower records did not align with the guidance contained in the residents care plan.
- a resident had developed an infection and was commenced on antibiotic treatment. The care plan was not updated to reflect the care needs.

While inspectors acknowledge that the needs of residents were known to the staff, the detail required to direct the care was not always recorded. This is a risk to residents care. Care plan consultation with the resident and their family or representatives was not evidenced in the resident's records reviewed by inspectors. This is a repeated non compliance.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had appropriate access to their general practitioner (GP) and were further supported by a team of allied health care professionals including physiotherapy, dietitian, dentist and opticians. In addition, inspectors found that advise received was followed which had a positive outcome for residents.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors found that residents privacy was not sufficiently maintained with the processes in place for residents when assessing the showering facilities. Inspectors observed resident's being wheeled from their bedrooms into the communal shower room wrapped in towels. The resident's were not sufficiently covered to ensure their dignity was not compromised.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Maryfield Nursing Home OSV-0000359

Inspection ID: MON-0034431

Date of inspection: 03/11/2021

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Sufficient Resources: A nurse has been recruited and commenced employment in November 2021. Another nurse has been identified who has the qualifications and experience to undertake the role assisting the Person in Charge with Governance and Management. Review of Audit Tools is currently being undertaken to ensure effective monitoring of the quality of care. Annual Review of Quality and Safety of Care is undertaken in consultation with residents and / or their representatives. This will be detailed in the Annual Review document going forward.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Walls and skirting will be repainted • Repair and replacement of wardrobes and sink surrounds will be undertaken in residents' bedrooms. The magnitude of these works is being assessed by a carpenter on the 2nd of December. However, he has indicated he will not be able to undertake any work prior to Christmas. • Replacement shower chairs and commode chairs have been ordered to replace those with staining / rust. A deep clean of all equipment is close to completion and will be completed by December 8th.	

• An assessment of all beds / bedrails was undertaken by an external supplier on the 29th of November. They will revert with a cost and timeline for replacing damaged bedrails. • Floor Coverings – gaps in floor covering resulting from installation of pipes will be repaired.

Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: • Staff have been reminded of the importance of cleaning of all equipment following use to ensure that it is clean and ready for use with next resident. Monitoring of this will form part of IPC Audits going forward. • New armchairs have been ordered to replace those with wear and tear damage. • Staff were reminded of the importance of checking bathrooms following use to ensure that residents personal toiletries were returned to their rooms.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire Drills of the largest compartment was undertaken on the 4th of November and the 7th of November 2021 utilizing nighttime staffing levels and measures have been put in place to ensure to adherence to the fire drill schedule in the future. A review of fire doors has been undertaken by an external company. A report of their findings is awaited, and remedial action required will be undertaken as a matter of urgency.	
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: The importance of changes in a resident's condition being updated in the resident's care	

plan has been highlighted to nursing staff along with the importance of evidencing consultation with the residents and their family. A review of all care plans is under way to rectify deficiencies and will be completed by the 17th of December 2021.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Staff have been reminded of their obligations to ensure that the dignity of residents is not compromised at any time. Training has been provided on precautions to be taken during transfer of residents to / from communal bathrooms.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(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.	Not Compliant	Orange	28/02/2022
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	15/01/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Not Compliant	Orange	24/12/2021

	consistent and effectively monitored.			
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Substantially Compliant	Yellow	31/01/2022
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 staff.	Substantially Compliant	Yellow	10/12/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/01/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be	Not Compliant	Orange	07/11/2021

	followed in the case of fire.			
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	23/11/2021
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	17/12/2021
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	07/11/2021