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:	The Residence Portlaoise
Name of provider:	The Residence PL Limited
Address of centre:	Block B The Maltings, Harpur's Lane, Portlaoise, Laois
Type of inspection:	Unannounced
Date of inspection:	24 July 2024
Centre ID:	OSV-0008667
Fieldwork ID:	MON-0042335

About the designated centre

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

The Residence Portlaoise is a purpose-built nursing home which consists of 101 single registered bedrooms with en suite bathrooms. The Residence Portlaoise is situated a short distance from the town of Portlaoise, therefore the Nursing Home is serviced by restaurants, public houses, local library, community hall, places of worship and also has easy transport links. The Residence Portlaoise accommodates male and female residents over the age of 18 years for short term and long term care. It provides 24 hour nursing care and caters for older people who require nursing care, dementia care, palliative care, respite and post-operative care. There are a variety of communal day spaces provided including dining rooms, day rooms and visitor rooms available. Residents also have access to a large secure enclosed garden.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	39

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 24 July 2024	09:45hrs to 17:45hrs	Sean Ryan	Lead
Wednesday 24 July 2024	09:45hrs to 17:45hrs	Una Fitzgerald	Support

What residents told us and what inspectors observed

Residents living in The Residence Portlaoise were complimentary of the quality of care they received from staff, who they described as caring, patient and kind. Residents told the inspector that the management and staff valued their feedback and made them feel included in the decision about how the service is run, and how the quality of the service could be improved. Residents told the inspector that staff were attentive to their needs and made them feel safe living in the centre.

Inspectors met with the majority of residents and spoke to nine residents in detail about their experience of living in the centre. Some residents were unable to articulate their experience of living in the centre. However, those residents appeared comfortable and relaxed in their environment. Staff were observed spending time with those residents to ensure they were comfortable in their surroundings.

There was a busy atmosphere in the centre throughout the morning of the inspection. Some residents were observed enjoying each other's company in a variety of communal dayrooms located around the centre, while others were observed sitting in their bedroom, listening to the radio or watching television while waiting for assistance from staff. Staff were observed busily attending to residents requests for assistance promptly, and polite and respectful conversation was observed between residents and staff.

Inspectors observed a number of staff and resident interactions during the inspection. In general, residents were seen to be relaxed and comfortable in the company of staff. Staff were observed assisting residents with their care needs and overall, staff provided this support in a gentle and respectful manner. However, while the inspectors were walking through the centre they observed an interaction that was contrary to a person-centred approach to care. Inspectors observed that the manner in which staff interacted with a resident who requested support did not alleviate a resident's anxiety, request for assistance, or concerns.

The building was found to be well laid out to meet the needs of residents, to support their independence. There were appropriately placed handrails along corridors to support residents to mobilise safely and independently. Residents using mobility aides were able to move freely and safely through the centre. Residents' bedrooms provided residents with a homely environment and a number of residents had personalised their rooms with memorabilia.

The centre was visibly clean throughout, and inspectors observed appropriate infection prevention and control practices by staff. There were ample supply of wall-mounted hand sanitizers and hand wash basins strategically located throughout the home.

Residents were complimentary about the food served in the centre, and confirmed that they were always afforded choice. One resident told the inspector how they

looked forward to the different meal choices. Staff were observed to engage with residents during meal times and provide discreet assistance and support to residents, if necessary. The food served was observed to be of a high quality and was attractively presented. Residents in all areas had access to snacks and drinks, outside of regular mealtimes.

There was an information board at the main reception that displayed information on services available to residents. This included information on advocacy services, the details of the resident representative in the centre, and information of how to make a complaint. Residents confirmed that they could raise any concerns they may have with the quality of the service, and were confident that their concerns were listened to, and acted upon.

Residents were provided with opportunities to express their feedback about the quality of the service during formal resident forum meetings. There was evidence that residents feedback was acted upon to improve the service they received in areas such as the activities programme and menu choices. There was a nominated resident representative in the centre. The resident met with other residents prior to scheduled meetings with management personnel to ensure any concerns were brought to the attention of the management.

Residents were able to meet their friends and family in the privacy of their bedrooms, designated visiting areas, or sitting rooms, where appropriate. The inspectors spoke with a small number of visitors. They said that they were satisfied with the care their relatives received and that staff were kind in their interactions with their relatives.

The majority of residents spent their day in the communal dayroom on the ground floor. The inspectors spent time here, observing the interactions between the staff and residents. Staff were attentive to the needs of the residents. Residents told the inspectors that they could sit where they wished, and could leave the dayroom at any time to pursue activities in the privacy of their bedroom, and staff respected their choice.

A detailed activity schedule was displayed on the notice boards for residents to view and choose activities they wished to attend. Residents were complimentary about the quality of activities provided.

The following sections of this report details the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

This unannounced inspection was carried out by inspectors of social services to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).
- follow up on the actions taken by the provider to address non-compliant issues identified on an inspection of the centre on 11 March 2024.
- review information received by the office of the Chief Inspector.

Following an inspection in March 2024, the provider had taken action to ensure residents received care in an environment that protected them from the risk of fire, and to provide residents with appropriate and timely access to general practitioner services. However, the findings of this inspection were that there were aspects of the management systems that were not robust and did not provide adequate assurance that a safe and quality service was consistently provided. While the provider had developed systems to monitor aspects of the service such as the quality of resident care records and to oversee the nutritional care needs of residents, the provider had not ensured that those systems were consistently of effectively implemented. Additionally, systems in place to manage records and complaints was not effective.

The Residence PL Limited is the registered provider of The Residence Portlaoise. The organisational structure had changed since the last inspection through the appointment of two company directors. One of the directors represented the registered provider in engagement with the Chief Inspector. Further changes had occured to the regional management personnel through the appointment of a regional director and associate regional director, both of whom were persons participating in the management of the centre. The regional management personnel attended the centre on a weekly basis and were responsible for providing governance and support to the person in charge. Within the centre, the person in charge was supported clinically and administratively by an assistant director of nursing and a clinical nurse manager, in addition to a team of nursing, health care and support staff.

The provider had implemented some management systems to monitor aspects of the quality of the service. Key clinical indicators with regard to the quality of care provided to residents were collected on a weekly basis and collated to develop a monthly report that was submitted to the senior management personnel to support oversight of the service. This included the incidence of wounds, restrictive practices, falls, and other significant events. However, inspectors found that the information collated for this report was not always accurate and was therefore not effective in identifying deficits in the quality and safety of the service or escalating actual or potential risks in the centre to the registered provider. For example, information in relation to the incidence of pressure wounds, and residents at risk of malnutrition was not accurately maintained and did not reflect the actual number of residents with the aforementioned clinical risks. This impacted on the provider's ability to identify, trend, monitor and improve this aspect of the service.

There was an audit schedule in place which identified risk and areas of quality improvement. Audits had been completed in line with this schedule and this included audits of residents clinical care records. However, inspectors found that the monitoring of some aspects of the clinical care was poor. For example, a review of

residents care records found that residents who were assessed as being at risk of falls, and at risk of developing pressure related wounds did not always have an appropriate care plans developed to manage those risks. The system of clinical oversight, including the clinical audits, failed to identify these clinical risks to residents.

Risk management systems were underpinned by the centre's risk management policy. The policy detailed the systems in place to identify, record and manage risks that may impact on the safety and welfare of the residents. As part of the risk management systems, a risk register was maintained to record and categorise risks according to their level of risk, and priority. Where environmental risks to residents were identified, controls were put in place to minimise the risk impacting on residents. Risks were frequently reviewed by the management team to ensure the controls in place to manage risks to residents were effective.

There were systems in place to record and investigate adverse incidents and accidents involving residents.

Record management systems consisted of both electronic and a paper- based system. A sample of staff personnel files were reviewed and were found to contain all the information required by Schedule 2 of the regulations. This included a vetting disclosure for each member of staff in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021. However, some records, required to be maintained in respect of Schedule 3 and 4 of the regulations, were not appropriately maintained. This included records pertaining to the nursing care provided to residents, and records of adverse incidents involving residents. For example, not all recorded incidents contained the results of an investigation of the incident.

A centre-specific complaints policy detailed the procedure in relation to making a complaint and set out the time-line for complaints to be responded to, and the key personnel involved in the management of complaints. However, the management systems in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely manner and resulted in inconsistent recording of complaints. For example, there were two complaint reporting systems in use, and staff were unclear on which system to use. The lack of clear procedure on the appropriate complaint reporting system to record complaints impacted on the timely review and resolution of complaints. While inspectors were assured that action had been taken by the management personnel in response to complaints received, some complaints was not appropriately documented or managed within the complaints register, or in line with the centre's own complaints management policy.

The centre had sufficient resources to ensure effective delivery of care and support to residents. The centre had a stable team of staff. This ensured that residents benefited from continuity of care from staff who knew their individual needs. The team providing direct care to residents consisted of registered nurses, and a team of health care assistants. There were sufficient numbers of housekeeping, catering and

maintenance staff in place. There was a system in place to ensure clear and effective communication between the management and staff.

Records showed that staff were facilitated to attend training in fire safety, safeguarding of vulnerable people, and supporting residents living with dementia. Staff demonstrated an appropriate awareness of their training, with regard to fire safety procedures, and their role and responsibility in recognising and responding to allegations of abuse. Additionally, training had been provided to staff in relation to the management of residents at risk of a fall, and care planning.

Regulation 15: Staffing

On the day of inspection, there was adequate staff available to meet the needs of the current residents taking into consideration the size and layout of the building. There were satisfactory levels of health care staff on duty to support nursing staff. The staffing compliment included cleaning, catering, activities staff and administration staff.

Judgment: Compliant

Regulation 21: Records

The management of records was not in line with the regulatory requirements. For example;

- Records of specialist treatment, nutritional care and nursing care provided to residents were not accurately or appropriately maintained in line with the requirements of Schedule 3(4)(b). For example, records of care provided to residents at high risk of impaired skin integrity were not always maintained in line with the residents care plan. Records of nutritional care and residents dietary intake were not always appropriately maintained for residents assessed as being at risk of malnutrition.
- Nursing records were not completed in line with the requirements of Schedule 3(4)(c). For example, a review of residents' nursing records found that multiple nursing notes were duplicated from previous entries. This meant that the record was not person-centred, and did not provide assurance that the daily care needs of the residents had been met.
- Documentation and investigation of an incident in which a resident may have suffered potential abuse or harm was not documented in line with the centre's own policy, or contain the detail required by Schedule 3 (4)(j) of the regulations.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems in place to monitor the quality of the service did not fully ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced by;

- ineffective systems of audit and clinical oversight in place. For example, nutritional audits did not include an analysis of the findings. Therefore, there was no quality improvement plan developed to ensure residents' nutritional care needs, and nutritional risks were appropriately identified, monitored, and managed. This impacted on the systems of escalation in place to ensure an appropriate pathway of care was implemented in response to a resident's risk of malnutrition. Additionally, monthly reviews of falls consisted of statistical information regarding the number of falls, their time of occurrence and location. While a fall analysis report identified that the highest number of fall incidents occurred in resident bedrooms, there was no quality improvement plan developed in response to this finding. The quality improvement plan referred to increasing supervision in the communal dayroom only.
- poor oversight of nursing documentation. A review of the quality of resident's care plan found that care plans were not always based on the assessment of residents needs or risks. Care plans, particularly those relating to residents at risk of falls, impaired skin integrity, and at risk of malnutrition, were not always based on assessment and did not reflect the current care needs of the residents. Therefore, care plans lacked the required detail to ensure residents received safe and effective person-centred care.
- ineffective oversight of the complaints management system to ensure the quality of care of residents was monitored, reviewed and improved on an ongoing basis. This impacted on opportunities for learning and improving the service.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

All residents were issued with a contract for the provision of services. The contracts outlined the services to be provided and the fees, if any, to be charged for such services.

Judgment: Compliant

Regulation 34: Complaints procedure

A review of the complaints log in the centre found that complaints were inconsistently managed in line with the centres' own complaints policy or with the requirements under Regulation 34.

Some issues of concern in relation to the quality of care, medication management, and residents care needs not being met, had been brought to the attention of the management team but were not appropriately documented and managed within the centre's complaints register. Consequently, there was no record of how these issues were acknowledged, investigated or resolved to the satisfaction of the complainant.

Judgment: Substantially compliant

Quality and safety

Inspectors found that the interactions between residents and staff were kind and respectful throughout the inspection. Residents reported that the staff, and their environment made them feel safe living in the centre. The provider had taken action following the previous inspection to ensure residents received care in an environment that protected them from the risk of fire. Nonetheless, inspectors found that aspects of care delivery, with particular regard to residents assessments and care plans, and health care that were not in compliance with the regulations.

Residents' care plans and daily nursing notes were recorded on an electronic documentation system. An assessment of residents health and social care needs was completed on admission and ensured that residents' individual care and support needs were being identified and could be met. A sample of assessments and care plans were reviewed and found that, while each resident had a care plan in place, care plans were not always informed by an accurate and up-to-date assessment of the residents needs following an adverse incident such as a fall. Therefore, care plans did not reflect the current care needs of the residents. Furthermore, care plans were not reviewed following a change in the residents condition. Residents who had experienced weightloss did not have an appropriate assessment of their nutritional risk completed. Consequently, care plans were not reflective of the residents nutritional risk and care needs.

Residents were provided with appropriate and timely access to general practitioner services. This is a completed action since the last inspection. Arrangements were in place for residents to access the expertise of health and social care professionals such as dietetic services, speech and language, physiotherapy and occupational therapy through a system of referral. However, some residents assessed as being at risk of malnutrition, had not been referred for further expert assessment in a timely

manner to ensure best outcomes for residents. This is a repeat finding from a previous inspection.

The centre was actively promoting a restraint-free environment and the use of bed rails was appropriately monitored in the centre. Restrictive practices were only initiated following an appropriate risk assessment, and in consultation with the multidisciplinary team and the resident concerned. Residents who experienced responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) received non-restrictive care and support from staff that was kind, and respectful.

A review of fire precautions in the centre found that the provider had completed the actions set out in the compliance plan submitted following the previous inspection. Fire doors were observed to function in line with their intended purpose to contain the spread of smoke and fire. Fire exits were unobstructed and were controlled through the fire alarm system to ensure they opened in the vent of a fire emergency. Staff participated in fire evacuation drills to ensure the safe and timely evacuation of residents in the event of a fire emergency. The provider had arrangements in place to monitor fire safety in the centre.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

Procedures had been established to ensure that the transfer of residents from the designated centre occurred in line with the requirements of the regulations. This included consultation with residents and their representatives regarding transfers and discharges, and arrangements to ensure information pertinent to the care of residents were communicated to the receiving health care facility. This is a completed action from the previous inspection.

Residents were provided with daily newspapers and had access to radio, telephone and Internet if they wished. There were opportunities for residents to consult with management and staff on how the centre was organised through residents forum meetings and feedback surveys.

There was an activity schedule in place and most residents were observed to be facilitated with social engagement and appropriate activity throughout the day.

Visiting was observed to be unrestricted, and residents could receive visitors in either their private accommodation or a designated visitor area, if they wished.

Regulation 11: Visits

The registered provider had arrangements in place to facilitate residents to receive visitors in either their private accommodation, or in a designated visiting area. Visits to residents were not restricted.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Arrangements were in place to support the transition of residents from the designated centre to hospital or home in consultation with each resident, including the resident's general practitioner (GP). Information regarding the residents health and social care needs were provided to the resident concerned, hospital, general practitioner, family or carer.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A review of residents' assessments and care plans found that they were not in compliance with the requirements of the regulations.

- Care plans were not guided by a comprehensive assessment of the residents care needs. For example, some resident's care plans did not accurately reflect the needs of the residents and did not identify interventions in place to protect residents when a clinical risk had been identified. A resident assessed as being a high risk of falls did not have their care plan updated to include a fall prevention strategy despite multiple fall incidents being documented for this resident. Additionally, a number of residents who had experienced significant weight-loss did not have an accurate assessment of their weight and nutritional risk completed. Consequently, staff did not have accurate information to guide the care to be provided to the residents.
- Care plans were not reviewed or updated when a resident's condition changed. The care plan of residents assessed as being at high risk of impaired skin integrity had not been updated following a significant increase in their wound care needs and significant care interventions. Consequently, care plans did not provide staff with accurate information to guide the care to be provided to the resident.
- Care was not always provided to residents in line with their assessed needs and care plans. A care plan to manage a resident's continence was not appropriately implemented.

Judgment: Not compliant

Regulation 6: Health care

The registered provider did not ensure that all resident had appropriate access to medical and health care. This was evidenced by failure to provide residents with appropriate and timely referral to health care professionals for further assessment and expertise when clinically indicated, in line with the directive of health care professionals and the residents care plan.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Restrictive practices, such as bed rails, were managed in the centre through an ongoing initiatives to promote a restraint free environment. Restrictive practices were only initiated following an appropriate risk assessment, and in consultation with the multidisciplinary team and the resident concerned.

Residents who experienced responsive behaviours had appropriate assessments completed, and person-centred care plans were developed that detailed the supports and intervention to be implemented by staff to support a consistent approach to the care of the residents. Care plans included details of non-pharmacological interventions to support the resident to manage responsive behaviours. Interactions observed between staff and residents was observed to be person-centred and non-restrictive.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. Safeguarding training was up-to-date for all staff and a safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre. The provider did not act as a pension agent for any residents living in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

There were facilities for residents occupation and recreation, and opportunities to participate in activities in accordance with their interests and capacities. Residents expressed their satisfaction with the variety of activities on offer.

Residents has the opportunity to to be consulted about and participate in the organisation of the designated centre by participating in residents meetings and taking part in resident surveys.

Residents told inspectors they had a choice about how they spend their day.

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 15: Staffing	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Residence Portlaoise OSV-0008667

Inspection ID: MON-0042335

Date of inspection: 24/07/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: By the 30th September 2024, all nurses will have completed additional clinical training, including skin integrity, safeguarding and nutrition and the documentation required to evidence person-centred evidence- based care delivered. By 16th September 2024, a second Clinical Nurse Manager (CNM) will be recruited to provide further support and supervision of nursing staff. The Director of Nursing (DON) and the Regional Team will monitor and audit resident records on a monthly basis through clinical governance until required standard is achieved.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: By the 30/09/2024, all management staff will have received training on conducting effective audits and developing quality improvement plans. The Regional Director and Associate Regional Director will oversee that effective audits are conducted and quality improvement plans are implemented. This action will be reviewed monthly during Clinical Governance meetings. By the 30th September 2024, all nurses will have completed additional clinical training, including skin integrity, safeguarding and nutrition and the documentation required to evidence person-centred evidence- based care delivered. By 16th September 2024, a second Clinical Nurse Manager (CNM) will be recruited to provide further support and supervision of nursing staff. The Director of Nursing (DON)	

and the Regional Team will monitor and audit resident records on a monthly basis through clinical governance until required standard is achieved.
By the 30/09/2024, the management team will have completed refresher training on complaints management, relevant policies and procedures and quality improvement. This training will be conducted by the Regional Team and required improvements will be monitored monthly during governance meetings.

Regulation 34: Complaints procedure	Substantially Compliant

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

By the 30/09/2024, the management team will have completed refresher training on complaints management, relevant policies and procedures and quality improvement. This training will be conducted by the Regional Team and required improvements will be monitored monthly during governance meetings.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

By the 15/10/2024, all nurses will have completed additional training to improve resident assessments, care planning, and evaluation of care plans based on individualised resident need.

By 16th September 2024, a second Clinical Nurse Manager (CNM) will be recruited to provide further support and supervision of nursing staff. The Director of Nursing (DON) and the Regional Team will monitor and audit resident records on a monthly basis through clinical governance until required standard is achieved.

From 30th September 2024, resident care plans, specifically those relating to clinical risk areas will be audited monthly by the Director of Nursing (DON) and further reviewed at monthly Governance meetings by the Regional Team to ensure care plans accurately reflect residents' needs and are updated in a timely manner.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

By the 15/10/2024, all nurses will have completed additional training to improve resident assessments, care planning, and evaluation of care plans based on individualised resident need.

By 16th September 2024, a second Clinical Nurse Manager (CNM) will be recruited to provide further support and supervision of nursing staff. The Director of Nursing (DON) and the Regional Team will monitor and audit resident records on a monthly basis through clinical governance until required standard is achieved.

From 30th September 2024, resident care plans, specifically those relating to clinical risk areas will be audited monthly by the Director of Nursing (DON) and further reviewed at monthly Governance meetings by the Regional Team to ensure care plans accurately reflect residents' needs and to ensure all referrals are sent and residents are reviewed in a timely manner.

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 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.	Substantially Compliant	Yellow	30/09/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	30/09/2024
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	30/09/2024
Regulation 34(6)(a)	The registered provider shall ensure that all	Substantially Compliant	Yellow	30/09/2024

	complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
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	15/10/2024
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	15/10/2024

Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	15/10/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	15/10/2024
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais	Substantially Compliant	Yellow	15/10/2024

	from time to time, for a resident.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	15/10/2024