



Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Croft Nursing Home
Name of provider:	Croft Nursing Home Limited
Address of centre:	2 Goldenbridge Walk, Inchicore, Dublin 8
Type of inspection:	Unannounced
Date of inspection:	27 August 2021
Centre ID:	OSV-0000028
Fieldwork ID:	MON-0034058

About the designated centre

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

The Croft Nursing Home is located just a few miles from Dublin city centre and within walking distance of Inchicore village. The home is a single-storey building providing accommodation for 37 long stay beds. Accommodation is configured to address the needs of all potential residents and includes superior single, companion and shared accommodation with assisted bath and shower rooms. There are a number of lounges and reading areas located throughout the building. The centre also has access to a secure garden area for residents to use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	36
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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
Friday 27 August 2021	08:25hrs to 18:40hrs	Margaret Keaveney	Lead
Friday 27 August 2021	08:25hrs to 18:40hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

The overall feedback from residents was that the centre was a nice place to live, with plenty of communal and private space and easy access to the garden. Although the residents received good care and were well supported by staff, adequate systems were not in place for the effective oversight of fire safety, medication management, staff training and appropriate record keeping. This will be further discussed in the report below.

On arrival to the centre, inspectors were met by a staff member who ensured that all necessary infection prevention and control measures, including hand hygiene and temperature checking, were completed prior to inspectors accessing the centre. This procedure was seen to be implemented for all visitors to the centre.

The centre was laid out over one floor and was clean with bright communal areas, however inspectors saw that repainting and repairs were required in some areas. The centre was an older building with narrow corridors leading to communal areas and resident's bedrooms that did not allow for residents using mobility aids to pass each other easily. However, residents overcame this by standing aside and residents moved freely throughout the centre. Some inappropriate storage was seen in communal bathrooms and the conservatory, for example cleaning and mobility equipment, which impacted residents' access to these areas.

Inspectors observed that residents were free to choose how to live their lives in the centre. Residents were observed to look well and were well dressed. Many residents were seen partaking in activities in a large day room, and there was a dedicated sensory room which residents were observed to enjoy. Inspectors saw that residents had unrestricted access to the garden either alone or accompanied by staff. The garden contained raised flowerbeds for residents to tend to, and a smoking area for residents' use.

A dedicated activities coordinator led a number of lively, fun filled activities during the inspection, such as card playing and a sing song session with residents singing their favourite songs. Inspectors observed that staff encouraged residents to partake in the singsong and some good humoured banter was heard. Residents told the inspector that they enjoyed the activities on offer, in particular the live music and bingo sessions with prizes. Inspectors saw one-to-one sessions taking place for those who did not enjoy or could participate in group activities.

Many of the residents spoken with were very complimentary about the food and the choice. Residents were observed to take their meals in the dining room, day room or in their bedrooms. The dining room was pleasantly decorated with dressed tables and a large noticeboard that displayed the menus of the day. Inspectors observed that residents enjoyed the variety of nutritious snacks and refreshments on offer throughout the day. Resident's bedrooms were seen to be personalised with soft furnishings, ornaments and family photographs, and that there was adequate

storage for all residents' belongings and equipment in both single and shared bedrooms.

Residents told inspectors that they were delighted that they can receive visitors again and inspectors observed many visitors meeting with residents throughout the day, having complied with all infection control procedures on their arrival. The provider had three areas for residents and their visitors to meet in; however, inspectors noted that one area was a hallway with seating which made it difficult to maintain privacy. Residents were supported to maintain community links individually with residents seen to go out with family members during the inspection day, while other residents told inspectors that they were free to leave the centre and enjoy a short walk along the canal to local shops.

Residents were encouraged to participate in and influence the running of the centre, and could voice their opinions on the quality of the service provided by attending residents' meetings and through the annual satisfaction surveys. Resident meetings were chaired by an independent advocate who attended the centre regularly, and one resident was a spokesperson for residents to ensure resident voices were heard.

Overall residents spoken to were very complimentary about the staff. Residents told inspectors that they felt safe living in the centre. They said that staff were kind and listened to them. Inspectors observed appropriate, respectful and friendly interactions between residents and staff during the inspection, and it was clear that staff knew the residents well. Residents' privacy and dignity was respected by staff. Staff were observed to knock on residents' bedroom doors and await an invitation before entering and they ensured doors were closed when giving personal care.

Overall, the residents expressed feeling content in the centre. The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place, and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

There was a well-defined management structure in place in the centre and the management team were well known to residents, their visitors and the staff. However, inspectors found that the management systems in place were not sufficiently robust to ensure that the service provided to residents was safe, appropriate and effectively monitored, as they did not identify a number of areas of concern that required immediate improvement, for example in fire safety and medication management. This was an un-announced inspection to follow up on information that had been received by the Office of the Chief Inspector of Social Services. A number of issues raised in the information received were upheld and significant improvements were required to bring the designated centre into regulatory compliance. Five regulations were found to be non-compliant during this inspection, namely governance and management, fire precautions, medicines and

pharmaceutical services, staff training and records. An urgent action plan on fire safety and medication management concerns was issued to the provider following the inspection, in order for the provider to give assurances that immediate measures were being taken to protect residents. These assurances were received by inspectors within the time frame required.

Croft Nursing Home Limited is the registered provider for Croft Nursing Home and this designated centre is one of a number of nursing homes managed by the registered provider. There were clear structures around how the centre was being run with regular meetings held to oversee and discuss the day to day operation of the centre, with regular audit and quality assurance systems in place to monitor key performance areas.

The centres' safety statement had not been reviewed since September 2019, however there was an emergency plan in place to guide staff on handling emergency situations, such as the loss of power. The centre also had a COVID-19 contingency and preparedness plan which outlined their response to the risks posed by COVID-19, such as the arrangements for isolating suspect or positive residents and the management of staff absences. The provider had completed an annual review report for 2020, and had arrangements in place to gather the views of residents which were represented in the annual review. The overall response was that residents and relatives were happy with the care provided.

The staffing numbers and skill mix in the centre were adequate. This enabled staff to meet the assessed needs of the residents, and to ensure the safe delivery of resident care and services. A dedicated activities coordinator was rostered to work Monday to Friday, with care staff attending to residents' social needs at the weekend.

Staff had access to the required training to enable them to care for residents safely, however records reviewed by inspectors showed that a number of staff required refresher mandatory training in fire safety and infection control training. The provider had identified the gaps in fire safety training and inspectors were provided with evidence that there was refresher training in fire safety was scheduled for the following week. Training in the safe management of medicines also required particular attention as the relevant policies and professional guidelines were not followed.

The person in charge had a formal induction programme in place, however regular staff appraisals were not available to inspectors. The assistant director of nursing informed inspectors that all staff had recently been issued with a self-assessment form and appraisal meetings with staff and the management team were due to be scheduled.

Inspectors observed that residents' records were not securely stored to ensure residents' privacy were maintained. A sample of staff files reviewed were not kept in accordance with schedule two of the regulations, for example evidence of qualifications and references were missing, and did not provide assurance that the provider had a robust recruitment system in place.

Records showed that complaints received were addressed in a timely way and that those who made a complaint was advised of the outcome and their satisfaction with how the complaint had been managed was recorded. There were three complaints on-going at the time of inspection and these were being managed in line with the centres policy. Complaints were reviewed at a monthly management meeting, and changes were implemented where learning was identified to prevent similar complaints happening again. For example, changes to menu options. The person in charge was appointed to the role of complaints officer and there was a person nominated to ensure that all complaints were appropriately responded to.

A sample of contracts of care were reviewed. Each set out the terms and conditions of the residents' residency in the centre and were signed by the resident or their next-of-kin. The contracts included details of the additional fees to be charged to residents in receipt of the 'Fair Deal Scheme'. However, inspectors observed that contracts had not been updated as residents' terms and conditions in the centre had changed, for example room occupancy.

Regulation 15: Staffing

The number and skill mix of staff was appropriate to the assessed needs of residents and the design and layout of the centre.

Rosters reviewed showed that there was one or more qualified nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

A number of staff were not up-to-date with mandatory training such as fire safety, hand hygiene and the donning and doffing of personal protective equipment. Inspectors saw evidence of poor practices in mask wearing, as a result of insufficient training, throughout the inspection.

Staff nurses required refresher training in the management of medicines as the relevant policies and professional guidelines on medication management were not being followed in the centre.

Staff appraisals had not been completed on an annual basis to ensure that staff were appropriately supervised and developed in their roles.

Judgment: Not compliant

Regulation 21: Records

Records required in Schedules 2 and 3 were not maintained in line with the regulation.

Inspectors identified the following issues with records reviewed were identified:

- Two staff records did not contain documentary evidence of qualifications
- Two staff records did not contain a full employment history
- Two staff records did not contain two written references
- Resident records were not securely stored in the clinical room

Judgment: Not compliant

Regulation 23: Governance and management

Urgent improvements were required to ensure that the centre was providing safe and effective services consistently to residents. The provider did not have effective oversight systems to manage the following issues found by inspectors:

- Poor medication management practices that did not assure inspectors that residents' medications were safely administered and securely stored.
- The fire safety precautions and evacuation procedures in place that did not assure inspectors that residents' needs would be met in the event of a fire.
- Incomplete staff records did not assure inspectors that there was a robust recruitment process in place to ensure that residents were being cared for by staff with the relevant qualifications and experience.
- The provider had not identified a number of storage and maintenance issues in shared toilets and bathrooms and the conservatory that impacted on residents' safe use of these areas.
- Ineffective oversight and review of residents' contracts for provision of services.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed four contracts of care and observed that each required updating to accurately reflect residents' conditions living in the centre. For example;

- One record did not state the room occupancy.

- Two records had not been updated with the correct room number and occupancy, following the residents move from single to twin occupancy rooms.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had a complaints policy in place, and the complaints procedure was prominently displayed at the entrance to the centre and contained all information required by the regulations.

The inspectors reviewed the complaints logs and noted that all complaints logged had been investigated, with the outcome and the complainants' satisfaction recorded for all closed complaints.

Judgment: Compliant

Quality and safety

Overall, there were examples of good quality care being provided to residents which ensured that they were supported and encouraged to live a good life in the centre. However, there were a number of immediate improvements needed to ensure residents' safety living in the centre, which included fire safety measures and in medicines and pharmaceutical services. Other areas that required improvement were in the areas of individual assessment and care planning, managing behaviours that challenge, premises and infection control.

There were systems in place for the assessment, planning, implementation and review of health and social care needs of residents. Inspectors found that the nursing and medical care needs of residents were assessed and appropriate interventions and treatment was being given. While nursing staff knew residents well, directions in care plans were not clear as some contained both historical and more up-to-date guidance on residents' care. This made it difficult for staff to identify resident's current care and support needs. The person in charge had already identified issues with the structure of care plans and inspectors saw evidence in two care plans where they were seen to be well laid out using the new structure.

A selection of end-of-life care plans were reviewed and were found to be respectful to resident's final wishes. Care plans detailing residents preferences regarding their social, cultural, religious and psychological needs were in place and written in a sensitive manner.

Records showed that the centre was working towards a restraint free environment where nursing staff had successfully trialled a range of alternative equipment. The use of restrictive practice was reviewed regularly by the person in charge and assistant director of nursing. Consent was sought from residents or their family, if appropriate, before they were used.

Efforts were made to identify and alleviate the underlying causes of responsive behaviours (behavioural and psychological symptoms of dementia). Care plans in relation to responsive behaviours showed techniques that would help to distract and reassure the resident at the time. However, they did not always show triggers for responsive behaviours. Clear guidance was also required in care plans to direct staff to use behaviour monitoring charts and show when prn medications (as required) were to be used when other strategies for responsive behaviour had not been effective.

Residents spoken with were satisfied with the arrangements in place for the laundering and storage of their clothing and personal possessions. The person in charge of the laundry told inspectors that residents' clothing was labelled on their admission to the centre. There was ample storage in the residents' rooms for their clothing and personal possessions. Residents also had a lockable unit in their rooms for valuables.

Records seen showed that the centre was a pension agent for a number of residents. Resident monies were kept in client account separate to the providers business account. Documents supplied by the provider showed that this arrangement was well managed, with evidence available to show the deposits, withdrawals and residents current balances.

There was a good menu choice available to residents for all meals. Inspectors observed that residents could choose when and where to dine. Mealtimes were seen to be social occasions. Snacks and refreshments were provided outside of mealtimes and the inspector saw that adequate staff were available to assist residents with refreshments and at mealtimes.

Most residents reported that there were good opportunities for social engagement within the centre. This included one-to-one activities in their rooms or quiet areas in the centre, small group activities in communal areas and trips out to the enclosed garden. Residents were seen to be supported to join activities in communal areas. Where residents didn't want to join the activities their choice was respected.

The centre had an up-to-date risk management policy in place, which met the requirements of the regulation. The provider had developed a risk register that identified clinical, health and safety and COVID-19 specific hazards and risks. The health and safety statement was reviewed and the emergency plan was up to date.

Infection prevention and control strategies had been implemented to effectively manage or prevent infection in the centre. These included implementation of transmission-based precautions for residents, for example personal protective equipment (PPE) which were mostly used in accordance with national guidelines and

the monitoring of visitors, staff and residents for signs of COVID-19 infection.

A COVID-19 vaccination program had taken place, with vaccines available to both residents and staff. There had been a high uptake of the vaccines among residents and staff. This year's influenza vaccination program was being organised between the provider and the GP. While there was evidence of good infection prevention and control practice, examples seen showed there was inappropriate storage and use of equipment and wearing of face masks which are further detailed under Regulation 27: Infection Control.

The provider had a number of arrangements in place to protect residents against fire risks. There was a fire safety policy and clear fire procedure in place which had been developed following consultation with an external fire safety specialist. Fire safety training was provided to staff annually and staff spoken with were knowledgeable on coordinating the evacuation of residents in the event of a fire. However, urgent improvements were required to ensure adequate precautions were in place to protect residents against the risk of fire, for example personal emergency evacuation plans were unclear and fire doors required repair. The provider submitted documents evidencing that these improvements were made in the time frame set by inspectors. This is further discussed below under regulation 28 Fire precautions.

A number of serious concerns were found in relation to medicine management. The failings in medicine management indicated that the medicine storage, supervision of practice and staff training methods were not sufficiently robust, could potentially create a risk to the health and safety of residents. This is further discussed in Regulation 29 Medicines and pharmaceutical services.

Regulation 11: Visits

Visiting was facilitated in many areas in the centre and was well managed in line with national guidelines.

Judgment: Compliant

Regulation 12: Personal possessions

There was an organised laundry system in place.

The provider was a pension agent for a number of residents. Inspectors saw evidence of a well-managed and transparent system, which provided residents with access to and control over their funds available.

Judgment: Compliant

Regulation 13: End of life

Evidence was seen that end of life care decisions were made in consultation with doctors and the residents or their representatives. There were arrangements detailed in residents care plans which described where they wished to spend their final days.

Judgment: Compliant

Regulation 17: Premises

A number of improvements were required to ensure the safety of residents living in the centre:

- There was no call bell in the outdoor smoking area, should residents need to call for assistance.
- Flooring in two corridors and chair coverings were damaged. This would not support effective cleaning.
- There was inappropriate storage of items in shared bathrooms, such as personal hygiene items on the floor, residents' mobility equipment and a foam mattress.
- Inappropriate storage of new cleaning equipment in the conservatory area, which had arrived two weeks prior to the inspection.
- Paintwork on wooden seats and one wall was peeling in the garden area. The paintwork on a number of bedroom doors was chipped and damaged.
- Fixtures and fittings in shared toilets were observed to be broken and worn which could pose an infection prevention and control risk as they could not be effectively cleaned. For example;
 - Broken seal between the toilet and floor tiles
 - Paint on radiator covers was chipped in two shared toilets
 - Tape was covering a handrail in one shared toilet
 - Holes in wall tiles of one assisted shower room

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Inspectors saw that residents' nutritional needs were assessed by a dietitian and specialist advice was communicated effectively to the chef and catering staff.

Residents who had special dietary requirements were provided with meals suited to their needs.

Judgment: Compliant

Regulation 26: Risk management

The risk management policy met the requirements of the regulations and addressed specific issues such as unexplained absence of any resident, self-harm and the prevention of abuse. The provider had arrangements in place for recording and learning from serious incidents or adverse events involving residents.

Judgment: Compliant

Regulation 27: Infection control

There were issues important to good infection prevention and control practices which required improvement. For example:

- Staff hand hygiene practices required review as two staff were seen to wear nail varnish, two wore stoned rings and one a watch. This meant that they could not effectively clean their hands.
- Alcohol-based hand rub was required in the sluice room to support compliance with good hand hygiene practice.
- While resident equipment appeared clean, there were no cleaning check lists in place to ensure that cleaning took place and could be effectively monitored.
- Grouting around tiles in sluice room was not clean and one tile was cracked.
- Inspectors observed many instances when staff frequently touched the front of their mask or did not wear them correctly. This could result in transmission of infections.
- There was no dedicated hand wash sink in the clinical room and only one dedicated hand wash sink within the entire centre which did not comply with current recommended specifications.
- Sharps boxes were stored on the floor of the unlocked clinical room and temporary closure mechanisms were not engaged.
- Lifting slings for residents were not designated for single resident use and could result in cross infection.
- Floor brushes seen were heavily worn and not clean.

Storage practices in the centre required review from an infection prevention and control perspective. For example:

- Cleaning trollies, solutions and equipment were stored in the sluice room which could result in cross contamination.
- Clean linen trollies were stored uncovered on corridors or assisted bathrooms where resident were seen to use frequently.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Immediate improvements were required to ensure adequate precautions were in place to protect residents against the risk of fire. During the inspection, inspectors observed the following and brought them to the attention of the management team:

- The door closers of eight bedroom doors were checked, four of which did not close fully when triggered.
- A fire door closer was missing from a door leading into a communal area.
- One side of an internal double door into a communal area was bolted shut. This could impact on the timely evacuation of residents during a fire, as only one half of the fire door could open in the event of the fire alarm being triggered.
- Intumescent strips (strips which expand in heat, seal doors and contain fire) were missing in parts along a door leading into a communal area, and there was a gap between the door and the floor.
- There was a hole in one bedroom door, which meant that the door was not fire resistant and did not protect the residents occupying that bedroom from fire. This could also impact the privacy and dignity of the resident occupying the room.
- There were no fire extinguishers or fire blankets in the smoking area
- Historical personal emergency evacuation plans (PEEPs) for residents were kept with more up-to-date PEEPs. This introduced the risk that the most appropriate PEEP for a resident would not be followed by staff in the event of a fire.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Due to the number of serious issues of concern in relation to medicine management, inspectors issued an urgent action plan to the provider. Immediate improvements were required to ensure that medication were stored and administered in a safe manner, such as:

- There was evidence of unsafe storage of medication in drug trollies,

cupboards and fridges, such as keys were left in the drug trolley while it was unattended and cupboards were found to be unlocked.

- Drug trollies were not secured when in the clinical room.
- Resident picture identification was not present in four medication order sheets seen by inspectors.
- The name of a medication was not identified on the drug order sheet that had been given to a residents over a number of weeks. Only prescribed medication should be administered by nursing staff.
- Eight examples were seen when controlled drugs were not signed as being checked by two staff before administration.
- One medicines storage fridge was not clean, there was white residue on the one shelf.
- There were gaps in temperature monitoring records for the medication fridge to ensure that medication was stored at the correct temperature.
- Blood glucose monitoring machines were not regularly calibrated to ensure accurate readings.
- Blood glucose monitoring equipment were not designated for single resident use. The use of these devices require a risk assessment to ensure they do not pose a risk of cross contamination.
- Oxygen cylinders were not secured to prevent them from falling over.

These findings indicated a serious concern that the system was not appropriate or safe, particularly in relation to controlled drugs which are administered under very specific professional guidelines for nurses on the management of controlled drugs.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Improvements were needed in care planning, such as:

- The documentation of residents' current needs was unclear and could not be easily followed as historical information had not been removed.
- Some information contained in care plans was outdated and incorrect, such as wound care plans for one resident and nutritional supplements ordered by a dietitian was not reflected in the current nutrition care plan.
- Incidents such as falls were also recorded in care plans. This meant clear and up-to-date information about residents needs was not easily accessible which could lead to incorrect care and support being delivered.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate medical care. There was a general practitioner linked to the centre, and access to a doctor during out of hours. Referrals were made to appropriate allied health professionals when required, with recommendations from specialists mostly reflected in resident care plans. Residents were seen to access hospital care when required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Recording of prn medication (as required medication) needed improvement. Examples were seen where there was no clear guidance for staff when to give the prn medication or to use behaviour monitoring charts in care plans.

One smoking plan did not inform staff that the resident often refused to adhere to fire safety measures. Clear details of possible triggers for responsive behaviours are required to support resident's well-being.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems and procedures in place to ensure residents were safeguarded and protected from abuse. Staff were facilitated to attend training in recognising and responding to a suspicion, incident or disclosure of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

There was a range of activities available to residents to ensure that all residents had access to enough opportunities to participate in activities in accordance with their interests and capacities. There were regular resident meetings.

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 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Croft Nursing Home OSV-000028

Inspection ID: MON-0034058

Date of inspection: 27/08/2021

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	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>A full audit review of training has taken place: All staff have completed their training in IPC including hand hygiene, donning and doffing. This training will be repeated yearly. The PIC will include weekly reminder sessions with all staff re IPC control measures. All staff will have Fire Safety training completed by the 12th October 2021.</p> <p>All staff nurses have completed refresher training on medication management with our external pharmacist and HSEland. The PIC will complete a weekly Training matrix review and book training as required for staff as indicated by dates in the matrix. The RPR team will complete a monthly review to ensure compliance.</p> <p>Staff appraisals will begin for all staff on the 28th September and will be completed by the 31st December 2021. In 2022 the Group HR Manager is completing a full review of our performance management process to assure that all staff are suitably supervised and are developed with their role.</p>	
Regulation 21: Records	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:</p> <p>A full review of all staff records has been completed. All staff files contain evidence of their qualifications, full employment history, and two written references. The PIC will complete a review of all new hires to ensure full compliance under schedule 2 and 3. Resident’s records are stored in a locked press. Staff nurses will ensure the notes remain secure and the PIC is completing random audits of same to ensure compliance.</p>	

Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>To assure the inspector the provider has and is in the process of the following quality improvement plans to ensure effective services are consistent for residents and that there is an effective oversight of these supports and systems in place.</p> <p>Staff recruitment: The Group HR Manager will support the PIC on behalf of the provider to ensure that all staff that are caring for the residents have the suitable qualifications and experience to meet the identified needs of the residents.</p> <p>A full review of the use of storage has taken place and internal storage areas for specific functions have been identified and will be fully operational by the 11th October 2021. The PIC and home maintenance personnel have completed a full review. All actions as per day of inspection are completed. The PIC and homes maintenance personnel will complete a weekly home review to ensure any issues found are addressed immediately.</p> <p>Contracts of care are completed prior to admission to the home. The PIC if required to transfer a resident to a different room will prepare an amendment note to the contract of care to ensure the correct room number and number of occupants in the room is correct. The RPR will complete a monthly review of the Residents contracts of care to ensure they reflect the requirements as set out in regulation 24.</p> <p>The following has been completed to ensure that Medication Management practices are safely administered and stored securely :</p> <p>Storage of Medications supplied to a resident is as follows.</p> <ul style="list-style-type: none"> • The Nurses Station contains the two drug medication trolleys, Medication storage presses, Medication fridge and MDA storage. • The door to the Nurses station will remain closed and locked with Key pad code entry system in place. • The two medication trolleys when not in use will be locked to the wall within a locked Store Press. When the Drug trolley is in use the nurse will dispense the medications from it and Lock it when they go to a resident. • The Nurse on duty will carry the keys at all times and handover to change of shift nurse at report time. • The Medications, when supplied to the home will not be stored on the floor but immediately put away in the dedicated medication storage press. This press is to be locked at all times when not in use. • The new Medication fridge is to be temperature checked twice daily, recorded and any issues reported immediately via our incident reporting process FLOWFORMA. The fridge was replaced on the 28th August 2021. Any action required must be addressed that day. The pharmacy can provide support 7 days a week and will provide a fridge if required on the same day an issue is identified. The fridge is marked clearly as the medication only 	

fridge. A daily cleaning schedule is in place and signed off by the staff nurse daily and reviewed and signed off by the PIC when on duty.

- The MDA storage area is reviewed twice a day by two nurses. The MDA count is completed by two nurses twice a day. The nurses sign the MDA register and the cupboard review check twice daily.
- A medication stock check takes place daily and any unused medication is returned to the pharmacy. Returns are recorded in the Pharmacy Returns book. This is reviewed at the audits.
- All the staff nurses have repeated the medication management training on HSEland and the pharmacist is providing training on the 15th September.
- We have reviewed our medication policies to ensure they provide guidance and support to the nursing staff to ensure their compliance and ours.
- The PIC will complete a bi monthly audit on the above to ensure ongoing compliance. Any issues identified will be actioned and learnings communicated to staff. The pharmacy will complete an audit on a four monthly basis to ensure on going compliance. The results of both the PIC audit and Pharmacy audit will reviewed by the RPR and any additional supports or resources will be provided to ensure compliance and safety. The PIC is now ensuring that the administration of medicinal products is in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the use of the product.
- The resident's prescription was reviewed with the GP and pharmacist and the full protocol re dispensing of the required dosage of identified medication was put in place. A new prescription was written by the GP and reviewed by the pharmacist. INR as per GP direction is reserved every two weeks. The results are sent to the GP via "SOCRATES". The GP reviews the INR levels and will send a new prescription with prescribed dose. The Kardex and MAR sheet will be updated by the pharmacy.
- The PIC will complete a review audit of this process on a fortnightly basis and send results to RPR to ensure any supports or resources required to ensure compliance and safety are given.
- Residents prescribed any diabetic medication now have in place their own dedicated glucometers and medication. The Glucometers are calibrated weekly and reviewed by PIC weekly.
- Residents MAR sheets have all been reviewed and updated to include all information required and a recent photo of the resident.
- All the staff nurses have repeated the medication management training on HSEland and the pharmacist is providing training on the 15th September.
- We have reviewed our medication policies to ensure they provide guidance and support to the nursing staff to ensure their compliance and ours.
- The PIC will complete a bi monthly audit on the above to ensure ongoing compliance. Any issues identified will be actioned and learnings communicated to staff. The pharmacy will complete an audit on a four monthly basis to ensure on going compliance. The results of both the PIC audit and Pharmacy audit will reviewed by the RPR and any additional supports or resources will be provided to ensure compliance and safety. To assure that fire precautions and evacuation procedures in place will meet the residents need in the event of fire the following is completed. In addition a Fire Safety Engineer completed a full fire risk assessment inspection, copy of which has been sent to the inspector which includes a SMART plan for any action identified to be completed. A fire extinguisher is now available by the outside Smoking area. Smoking aprons for each individual resident are available in the smoking area.

- Staff will supervise the smoking area when resident are there. Call bell available.
- All doors have been reviewed by homes maintenance personnel with an outside contractor to ensure all door closures are in working order and the door closes tightly. The PIC and homes maintenance person will complete a weekly review and any issues found will the recorded on our Incident reporting structure and sent to RPR so that resources and support can be provided to ensure compliance and safety.
- The homes maintenance personnel will ensure on a daily basis that all escape routes and fire doors are in working order.
- Emergency light bulbs that were not working on the day of inspection have all been replaced and will be replace on any occasion promptly when not working.
- The conservatory door has been repaired and has a door closing mechanism attached.
- Room 20: The Hole which was identified occurred as the resident removed the privacy lock. This has been replaced. The Staff will complete daily checks to ensure it remains in place.
- A comprehensive Fire drill took place in area identified with night time staffing levels. The PIC will conduct these weekly until all staff have taken part in this Night time simulation. The RPR has reserved the Services of a Fire engineer assessor to provide additional advice and support to the home.
- All emergency lighting was reviewed and broken bulbs replaced. A daily review is now in place to ensure that when a bulb goes it is replaced immediately.
- External fire evacuation routes are clear of clutter and doors are in working order.
- All PEEPS have been updated with the current resident profile with current photos and reflect the resident's mobility and cognitive understanding during an evacuation. The Care plans on PEEPS have also been reviewed. They will be reviewed 3 monthly or at any change in condition. The PEEP review will take place during the MDT team health and safety meeting. The minutes of the meeting are sent to the RPR so that any supports required are given.
- All PEEPS have been updated with the current resident profile with current photos and reflect the resident's mobility and cognitive understanding during an evacuation. The Care plans on PEEPS have also been reviewed. They will be reviewed 3 monthly or at any change in condition. The PEEP review will take place during the MDT team health and safety meeting. The minutes of the meeting are sent to the RPR so that any supports required are given.
- The following checks are now in place for reviewing fire precautions: Daily checks include: Emergency lighting, Emergency doors, Bedroom doors, escape routes.
- Weekly fire drill of a night time scenario are ongoing until all staff have completed it. Following that Drills will take place twice a month. 1 day time scenario and 1 night time scenario.
- Care plans for Residents that smoke are now all in place and guide staff in meeting the safety needs of residents if they smoke.
- Staff supervise the smoking area and a call bell is available to alert if any needs are required to be met.
- The smoking bins and ash trays to be emptied 3 times a day.

Regulation 24: Contract for the provision of services	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:</p> <p>Contracts of care are completed prior to admission to the home. The PIC if required to transfer a resident to a different room will prepare an amendment note to the contract of care to ensure the correct room number and number of occupants in the room is correct. The RPR will complete a monthly review of the Residents contracts of care to ensure they reflect the requirements as set out in regulation 24.</p>	
Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <p>The following improvements required have been actioned: A call bell is available in the residents' smoking area. The flooring in the two corridors has been reviewed and will be repaired/replaced as required.</p> <p>A full review of the use of storage has taken place and internal storage areas for specific functions have been identified and will be fully operational by the 11th October 2021. The PIC and home maintenance personnel have completed a full review. All actions as per day of inspection are completed. The PIC and homes maintenance personnel will complete a weekly home review to ensure any issues found are addressed immediately. This review will ensure all fitting and fixates are in working order and that communal space is used as per its purpose. In the continued absence of the Group Facilities Manager (was due to return 18/07,09/08, 30/08, 06/09, now off to 31/12) due to illness, a contract facilities supervisor is being sourced through an independent Facilities Management Company in the interim pending the return of the Group FM.</p>	
Regulation 27: Infection control	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Infection control:</p> <p>To ensure all staff observe and participate in good infection control prevention practices the following is in place :</p> <ul style="list-style-type: none"> • The PIC has ensured that all staff have completed IPC training, Hand hygiene training and Donning and doffing training. The PIC meeting weekly with the staff and reminder and update sessions occur then. Hand hygiene audits will be completed by the PIC and ADON on regular basis with staff to ensure compliance with good practice. • An alcohol hand rub unit is now available in the sluice room. 	

- A detailed allocation and cleaning schedule for equipment is in place. This is signed off on completion of task by allocated staff member and reviewed and confirmed by PIC/ADON.
- A full review of the use of storage has taken place and internal storage areas for specific functions have been identified and will be fully operational by the 11th October 2021.
- The PIC has sourced a covered trolley for care items and laundry.

Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:

An independent Fire Safety Engineer has completed a full fire risk assessment review of the home. The report and action plan required has been forwarded to the inspector for review. This plan includes a SMART plan to ensure all issues identified are actioned.

The provider has the following in place :

- A fire extinguisher is now available by the outside Smoking area as required by inspector although this is not a requirement under Section B of the building code or under the Fire Services Act. Smoking aprons for each individual resident are available in the smoking area.
- Staff will supervise the smoking area when resident are there. Call bell is also available.
- All doors have been reviewed by homes maintenance personnel with an outside contractor to ensure all door closures are in working order and the doors close tightly. The PIC and home's maintenance person will complete a weekly review and any issues found will be recorded on our Incident reporting structure and dealt with in a timely manner to ensure compliance and safety.
- The homes maintenance personnel will ensure on a daily basis that all escape routes and fire doors are clear of obstruction and are in working order.
- Emergency light bulbs that were not working on the day of inspection have all been replaced (on that day) and are subject to daily checks
- The conservatory door has been repaired and has a door closing mechanism attached however, this is not a fire door and per the fire assessor and therefore having one side secured is not a violation of Section B of the Building Code or the Fire Services Act
- Room 20: The Hole which was identified by the inspector occurred as the resident removed the privacy lock. The lock was replaced (was previously replaced also) by maintenance but immediately removed by the resident. The Staff will complete daily checks to ensure it remains in place however, if replacing the lock causes continued, and significant anxiety to resident, the PIC/RPR will have to respect residents wishes.
- A comprehensive Fire drill took place in area identified with night time staffing levels. The PIC will conduct these weekly until all staff have taken part in this Night time simulation. As stated above the RPR has engaged (as requested) the Services of a Fire Engineer assessor to provide additional advice with respect to the findings of the inspector. the detailed report accompanies this submission and will be actioned within the recommended timelines

1. Three(3) P4 recommendations were identified which require actioning within six(6)

Months (21st March 2022)

2. Eight(8) P5 recommendations were identified which require actioning within one (1) year (21st September 2022)

- All emergency lighting has been reviewed and are fully functional. A daily review is now in place to ensure failed bulbs are replaced immediately.
- External fire evacuation routes are clear of clutter and all doors are in working order.
- All PEEPS have been updated with the current resident profile with current photos and reflect the resident's mobility and cognitive understanding during an evacuation. The Care plans on PEEPS have also been reviewed. They will be reviewed 3 monthly or at any change in condition. The PEEP review will take place during the MDT team health and safety meeting. The minutes of the meeting are sent to the RPR so that any supports required are given.
- The following checks are in place for reviewing fire precautions: Daily checks include: Emergency lighting, Emergency doors, Bedroom doors, escape routes.
- Weekly fire drill of a night time scenario are ongoing until all staff have completed it. Following that Drills will take place twice a month. 1 day time scenario and 1 night time scenario.
- Care plans for Residents that smoke are now all in place and guide staff in meeting the safety needs of residents if they smoke.
- Staff supervise the smoking area and a call bell is available to alert if any needs are required to be met.
- The smoking bins and ash trays are emptied 3 times a day.

Regulation 29: Medicines and pharmaceutical services

Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

The following has been completed to ensure that Medication Management practices are safely administered and stored securely:

Storage of Medications supplied to a resident is as follows.

- The Nurses Station contains the two drug medication trolleys, Medication storage presses, Medication fridge and MDA storage.
- The door to the Nurses station will remain closed and locked with Key pad code entry system in place.
- The two medication trolleys when not in use will be locked to the wall within a locked Store Press. When the Drug trolley is in use the nurse will dispense the medications from it and Lock it when they go to a resident.
- The Nurse on duty will carry the keys at all times and handover to change of shift nurse at report time.
- The Medications, when supplied to the home will not be stored on the floor but immediately put away in the dedicated medication storage press. This press is to be locked at all times when not in use.

- The new Medication fridge is to be temperature checked twice daily, recorded and any issues reported immediately via our incident reporting process FLOWFORMA. The fridge was replaced on the 28th August 2021. Any action required must be addressed that day. The pharmacy can provide support 7 days a week and will provide a fridge if required on the same day an issue is identified. The fridge is marked clearly as the medication only fridge. A daily cleaning schedule is in place and signed off by the staff nurse daily and reviewed and signed off by the PIC when on duty.
- The MDA storage area is reviewed twice a day by two nurses. The MDA count is completed by two nurses twice a day. The nurses sign the MDA register and the cupboard review check twice daily.
- A medication stock check takes place daily and any unused medication is returned to the pharmacy. Returns are recorded in the Pharmacy Returns book. This is reviewed at the audits.
- All the staff nurses have repeated the medication management training on HSEland and the pharmacist is providing training on the 15th September.
- We have reviewed our medication policies to ensure they provide guidance and support to the nursing staff to ensure their compliance and ours.
- The PIC will complete a bi monthly audit on the above to ensure ongoing compliance. Any issues identified will be actioned and learnings communicated to staff. The pharmacy will complete an audit on a four monthly basis to ensure on going compliance. The results of both the PIC audit and Pharmacy audit will reviewed by the RPR and any additional supports or resources will be provided to ensure compliance and safety. The PIC is now ensuring that the administration of medicinal products is in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the use of the product.
- The resident's prescription was reviewed with the GP and pharmacist and the full protocol re dispensing of the required dosage of identified medication was put in place. A new prescription was written by the GP and reviewed by the pharmacist. INR as per GP direction is reserved every two weeks. The results are sent to the GP via "SOCRATES". The GP reviews the INR levels and will send a new prescription with prescribed dose. The Kardex and MAR sheet will be updated by the pharmacy.
- The PIC will complete a review audit of this process on a fortnightly basis and send results to RPR to ensure any supports or resources required to ensure compliance and safety are given.
- Residents prescribed any diabetic medication now have in place their own dedicated glucometers and medication. The Glucometers are calibrated weekly and reviewed by PIC weekly.
- Residents MAR sheets have all been reviewed and updated to include all information required and a recent photo of the resident.
- All the staff nurses have repeated the medication management training on HSEland and the pharmacist is providing training on the 15th September.
- We have reviewed our medication policies to ensure they provide guidance and support to the nursing staff to ensure their compliance and ours.
- The PIC will complete a bi monthly audit on the above to ensure ongoing compliance. Any issues identified will be actioned and learnings communicated to staff. The pharmacy will complete an audit on a four monthly basis to ensure on going compliance. The results of both the PIC audit and Pharmacy audit will reviewed by the RPR and any additional supports or resources will be provided to ensure compliance and safety.
- The oxygen cylinders are stored appropriately.

Regulation 5: Individual assessment and care plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</p> <p>The PIC is completing a full review of all residents care plans, she is supported in this by the ADON and CNM. The review will ensure that all residents' needs are clear and identify their individual care requirements and will guide and support staff to meet these needs. Information no longer required will be archived. Dedicated care plans will be in place following incidents or changes in condition to ensure that they reflect the care given and care assessed. A monthly random review audit on sample of care plans will be undertaken by the RPR team to ensure continues compliance and improvements. The changes made to a care plan will be reviewed with the resident and or the nominated NOK. 3 monthly reviews of all care plans in place for each resident will take place with either the resident or their nominated NOK.</p>	
Regulation 7: Managing behaviour that is challenging	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:</p> <p>Staff training to take place re the management of the administration of PRN medication. There is a detailed policy and supporting SOP in place that guides staff in the plan to meet the needs of residents with a responsive behaviour pattern. ABC charts are available and are to be used together with the resident individual behavior support care plan to minimize the use of PRN medication to manage a responsive behaviour. Any use of a PRN medication is to be reported on the homes incident reporting platform FLOWFORMA. The PIC is to review each incident and ensure the ABC chart was completed and plan followed and all actions completed before the administration of a medication. Once the PIC has completed this review a further review will be completed by the RPR team, Clinical Governance Manager. Learning from these reviews will be communicated back to staff to ensure better practice and outcome for residents if required. The smoking care plan for identified resident has been updated and communicated to all staff and family.</p>	



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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	12/10/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/12/2021
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	11/10/2021
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	Not Compliant	Orange	04/10/2021

	Inspector.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	04/10/2021
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	30/03/2022
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	04/10/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	11/10/2021

	associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	31/08/2021
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	01/09/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	06/09/2021
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 followed in the	Not Compliant	Red	31/08/2021

	case of fire.			
Regulation 29(3)	The person in charge shall ensure that, where a pharmacist provides a record of medication related interventions in respect of a resident, such record shall be kept in a safe and accessible place in the designated centre concerned.	Not Compliant	Orange	15/09/2021
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Red	31/08/2021
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Red	31/08/2021
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs	Substantially Compliant	Yellow	29/11/2021

	of each resident when these have been assessed in accordance with paragraph (2).			
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	29/11/2021
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	04/10/2021
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time	Substantially Compliant	Yellow	04/10/2021

	to time.			
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