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:	Beech Park Nursing Home
Name of provider:	Dunmurry West Care Homes Ltd.
Address of centre:	Dunmurry East, Kildare Town, Kildare
Type of inspection:	Unannounced
Date of inspection:	25 June 2024
Centre ID:	OSV-0000012
Fieldwork ID:	MON-0043584

About the designated centre

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

Beech Park Nursing Home is a purpose-built, single-storey residential service for older persons. The centre is situated in a rural setting outside Kildare town. The centre provides accommodation for a maximum of 47 male and female residents aged over 18 years of age. Residents accommodation is provided in 33 single bedrooms, 12 of which have full en suite facilities and 21 have en suite toilet and wash basin facilities and seven twin bedrooms. Full en suite facilities are provided in four of the twin bedrooms and a wash basin is available in the other three twin bedrooms. Toilets and showers are located within close proximity to bedrooms and communal sitting and dining areas. The centre provides long-term, respite and convalescence care for residents with chronic illness, dementia and palliative care needs. The provider employs a staff team in the centre to meet residents' needs consisting of registered nurses, care assistants, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	46

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 25 June 2024	08:00hrs to 16:30hrs	Sinead Lynch	Lead
Monday 8 July 2024	08:30hrs to 15:30hrs	Sinead Lynch	Lead
Tuesday 25 June 2024	08:00hrs to 16:30hrs	Aoife Byrne	Support
Monday 8 July 2024	08:30hrs to 15:30hrs	Aoife Byrne	Support

What residents told us and what inspectors observed

Overall, during this two day inspection the inspectors observed that staff were working hard to deliver a good quality of care to the residents. However, inspectors observed that due to constraints in the staffing levels this proved difficult. There were 46% of residents assessed as maximum dependency living in the centre and the staffing complement was not sufficient to ensure residents were attended to in a prompt manner. On some occasions on day one of the inspection the inspectors had to ring the call bell for residents or call on staff members to assist residents.

On day one of the inspection, when the inspectors arrived at the centre they were informed that there was a power cut impacting the area, and the national electricity services were actively working to address this. Inspectors observed the staff practices and residents' lived experience in the centre. As a result of the power failure all fire doors had automatically closed. There was one communal area where the doors were all closed and a resident was sitting alone. The inspectors had to obtain the assistance of staff as the resident was requesting a drink. The registered provider sourced a generator at 11.00am and the power was restored at 14.00hrs. Inspectors returned for a second day of inspection and observed that staffing levels continued to be insufficient to meet the needs of all residents.

One visitor who the inspectors spoke with raised concerns about the continuous high turnover of management staff which they described as 'difficult'. They said that 'one gets used to one manager and within a few months there is a new manager'. They also said that nurses and care staff work so hard to attend to the residents and that they are 'great'.

Residents also spoke very positively about the staff. One resident said 'they are great and they try their best' while another said 'I ring the bell and it sometimes take ages to answer, but I know they are so busy'. A number of negative reviews were provided to the inspectors by residents related to not enough staff and how staff are 'run ragged'.

Staff were observed to be very busy on both days of the inspection but were observed to be very kind towards residents. They always knocked on the door and informed the resident who they were before entering.

Inspectors observed that supervision of residents was not sufficient to ensure residents' needs were met. 17 residents were observed sitting in a day room being supervised by one health care assistant, however this level of supervision was not adequate to ensure the needs of the residents could be safely met. For example; one resident did not have access to their mobility aid when they attempted to mobilise and another resident was observed mobilising with inappropriately fitted foot wear. There was no other staff member available to assist these two residents, hence their risk of falling or sustaining an injury was increased.

There were activities made available to residents and residents were complimentary about these activities. In the afternoon, inspectors observed the residents enjoying bingo with the activities co-ordinator. Residents were engaging well in the activity.

There was a laundry service made available to residents. The majority of residents were very complimentary about the service. While there had been issues with clothes getting mixed up in the laundry in the past, the provider had put a plan in place and there had been no recent concerns.

Residents were provided with nutritious meals and residents that spoke with the inspectors spoke highly about the food. Residents were offered choice and there was a selection of drinks made available in the dining room at meal times. However, inspectors observed that healthcare staff wore hair nets and aprons while assisting residents with their meals. This removed the homely feel in the dining room.

The centre was laid out on ground floor level and was pleasantly decorated. The centre met the residents needs' where there was sufficient private and communal space for residents to utilise. An enclosed courtyard was available which was easily accessible by the residents. There were raised planters and residents were involved in the planting and maintaining process.

The following two sections, capacity and capability and quality and safety will outline the quality of the care and services provided for the residents. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

This was an unannounced inspection carried out over two days. The inspectors spoke with many residents and visitors over the two days of the inspection. The feedback was mixed, both positive and negative.

Since the previous inspection in February 2024, there was a decline observed in the management systems in the centre with insufficient oversight of care delivery and of the service provided to the residents. Specifically the governance and management arrangements in the centre had failed to ensure that in the event of an emergency staff would be guided by the centre's policies and procedures and that the Chief Inspector of Social Services was timely notified of all reportable incidents. Further detail is available under each regulation.

The centre is owned and operated by Dunmurry West Care Homes Limited and is part of the Beechfield group. A new person in charge had been appointed since the last inspection and they were working on a full-time basis. At the time of inspection there was a vacancy for the role of the assistant director of nursing (ADON). This role was filled but the person had not yet commenced in this role. The person in

charge reports to the provider and an operations manager. They also received support and guidance from the group quality and clinical practice lead.

The provider had a suite of audits in place. However, these audits were not consistently effective at highlighting areas for improvement and had not identified some of the significant findings of this inspection. The audits in some areas were not complete and did not provide appropriate timely action plans. There was minimal learning and where poor findings were identified they were not followed up with cohesive action plans to address them.

The provider had completed an annual review. This annual review did not include consultation with residents. There was no quality improvement plan for the centre. The provider said they were actively working on a new template for the annual review which would involve residents and their opinions and feedback on the running of the centre.

There was a suite of policies available in the centre. However, these did not guide practice in relation to responding to emergencies and fire safety. The incorrect contact numbers were displayed in this policy for emergency services. The management team to be contacted no longer worked in the centre. The complaints policy did not guide staff in relation to how to make a complaint or how to support residents to make a complaint. The contact details for the complaints officer and review officer were left blank.

Oversight of notifications of incidents was not sufficiently robust as inspectors found a number of incidents that had not been notified to the Chief Inspector, as further outlined under Regulation 31: Notification of incidents.

There was a statement of purpose in place and displayed in the centre. However, this did not detail the required up-to-date information, as outlined under Regulation 3: Statement of purpose.

The number and skill-mix of staff on duty was not in line with the statement of purpose. The dependency levels of the residents indicated that their needs were greater than what the current staffing levels could provide. On day one, the inspectors requested that the registered provider review their staffing levels to ensure they could meet the needs of the residents living in the centre. This was evidenced by the numerous occasions the inspectors had to ring residents' call bells to seek assistance or assist residents with drinks on day one of the inspection. On day two of the inspection the person in charge informed the inspectors that the provider had agreed to increase the healthcare support staff by 12 hours a day. However, this had not yet been put in place as they had to recruit more staff to support this increase.

There was training provided to staff. However, on the day of inspection there were gaps seen. There were two staff who had been working in the centre who had not completed safeguarding vulnerable adults. These staff were immediately removed from duty as directed by the provider where they took the course immediately.

There were other gaps in training which are detailed under Regulation 16: Training and staff development.

Residents' records were not stored securely. On day one of the inspection there was an unsecured box of deceased residents' medical and nursing notes in the oratory. There was an immediate action given to the provider and these were removed and placed in a secure storage room. On day two of the inspection the residents' files continued to be easily accessible, as the nurses station door was unlocked and the cupboard that was holding residents files was not locked and left wide open. The provider gave assurances on the day that this would be fixed and secured within 24 hours.

Regulation 14: Persons in charge

The person in charge had the relevant knowledge and experience as required in the regulations. The person in charge had commenced in this role three months prior to the inspection.

Judgment: Compliant

Regulation 15: Staffing

Inspectors were not assured that the provider had the required numbers of staff available with the required skill-mix having regard to the size and layout of the centre and the assessed needs of the residents. This was evidenced by:

- Some staff were required to work in household cleaning and then move into the laundry and were observed to move between these roles during the day. This practice posed a risk of cross-infection.
- With 43% of the residents assessed as maximum dependent, a review of healthcare support staffing levels was required. This was observed on day one of the inspection when inspectors had to repeatedly assist residents with drinks in their bedrooms or call for assistance for residents.
- There was a poor level of supervision in the communal day room. One health care assistant was observed to be the only staff member with 17 residents who required assistance. One resident was requesting their mobility aide while another resident was attempting to mobilise although their footwear was not appropriately fitted and may pose a risk of falls.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge did not ensure that staff had access to appropriate training. For example:

- Two staff members had not completed mandatory safe guarding training. Inspectors acknowledge that the provider took prompt action during the day and ensured they received the required training.
- Four staff had not completed mandatory fire safety training.
- One staff member had not completed infection prevention and control training.

Judgment: Not compliant

Regulation 21: Records

Resident records were not stored securely and safely and in line with the regulations as follows:

- Full nursing files and medical notes for residents who had passed away were found in unsecured boxes in the oratory. Therefore, they were accessible to all residents and visitors who used the oratory.
- A storage cupboard with current residents' files was open and easily accessible in the nurses' station which was observed unattended at times.

Judgment: Not compliant

Regulation 23: Governance and management

Management systems were inadequate or not in place to ensure the service provided was safe and appropriately monitored. This was evidenced by a failure to:

- On day one of the inspection there was an unexpected power outage. However, the centre could not be guided by the emergency policy as it detailed the plan for another centre. The contingency plan outlined in this policy could not be implemented as there was no generator available on site. On day two of this inspection the emergency policy had still not been updated to guide practice.
- Ensure that statutory notifications of key incidents and events were submitted to the Chief Inspector of Social Services within the required time-frame, in line with regulatory requirements.

- Audits were found to be incomplete and did not lead to the development of improvement plans or identify where improvements were required. For example; one audit on the use of antibiotics in the centre had eight questions left blank.
- Call bell audits did not identify what the residents said and what inspectors observed on the day, specifically the rationale for the delay in answering them or responding to residents needs.
- The governance and management arrangements in the centre did not ensure that policies in place were updated and sufficiently clear to provide effective guidance to staff on the service to be provided.

The centre was not adequately resourced to ensure the effective delivery of care in accordance with the statement of purpose. This was evidenced by the following:

- There was no assistant director of nursing working in the centre
- There was not sufficient staff in place in order to meet the residents assessed needs

There was an annual review in place, however, there was no quality improvement plan or resident involvement in its development. There was no evidence it was developed in consultation with residents and it was not made available to residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose relating to the designated centre. However, this did not match with the findings on the day of inspection. For example;

- The whole time equivalent (WTE) on the statement of purpose did not correlate with the working rosters.
- The arrangements for the management of the designated centre where the person in charge is absent was not correct.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had not notified the Chief Inspector of Social Services of the following incidents:

- Two incidents in respect of alleged misconduct of a staff member.

Judgment: Not compliant

Regulation 34: Complaints procedure

Notwithstanding the overall good management of complaints, the registered provider did not have an accessible and effective procedure for dealing with complaints. For example:

- The procedure was not centre specific and would not guide someone on how to make a complaint.
- There were blanks throughout the policy such as who the complaints officer and review officer were.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing the policies and procedures as set out in Schedule 5 of the regulations. However, these policies required review, for example:

- Responding to emergency policy required a full review in relation to; detailed emergency numbers that were not for this specific centre, detailing how to turn on the generator in the event of a power cut. However, the centre does not have a generator on site.
- The fire policy had a list of contact names and numbers to be contacted in the event of a fire. However, these staff members no longer worked in the centre. This was corrected on Day 2 of the inspection.

In the absence of clear policies and procedures, the provider and inspectors could not be assured that these policies were implemented in practice.

Judgment: Not compliant

Quality and safety

It was evident that the team of staff in Beech Park nursing home knew the residents well and worked hard to ensure that the basic needs of residents' were met.

However, the over all standard of care delivered required improvements to ensure they received a high standard of nursing care.

While there were clear efforts to provide good quality care to the residents and improve their quality of life and lived environment, further action was required in respect of infection prevention and control and care planning arrangements, to ensure residents' safety was maintained and maximised at all times. There were clear gaps in care and oversight of these areas and a strengthening of the management systems and oversight of staff practices was required as outlined in the capacity and capability section.

The inspectors reviewed a sample of residents' records and saw that residents were appropriately assessed using a variety of validated tools. This was completed within 48 hours of admission. Care plans were in place addressing the individual needs of the residents, and were updated within four months or more often where required. However further improvements were required to ensure care plans reflected residents' current condition and were implemented in practice. This is outlined further under Regulation 5: Individual assessment and care plan.

There was a residents guide made available for residents. This provided information for residents and visitors about the services and facilities available in the centre. However, this had not been updated in some time and would not guide someone on how to make a complaint or who to approach as the contact people no longer worked in the centre.

Improvements were required in relation to infection prevention and control. There were areas of the centre that could not be appropriately cleaned. This was due to damaged surfaces and floors. The provider acknowledged this and informed inspectors that this was detailed in a line of works due to take place this year. Infection prevention and control audits did not highlight the findings of the inspection. The provider assured the inspectors that there was a quality lead who would support the new person in charge and developing audits that would have timely action plans going forward.

Medicine management was observed to be in line with the requirements set out by the Nursing and Midwifery Board of Ireland (NMBI). The storage of medicine was safe and all medicines were reviewed by the general practitioner (GP) on a three monthly basis. The pharmacist provided a service where they were reviewing residents' medication and their contraindications to other medicines.

There was good GP service supporting the residents living in the centre. There was a record of all residents when they required the service and then follow-up when they were reviewed. The GP was available on the phone and to call to the centre. Where the GP referred residents to other services there was a clear and transparent referral and follow-up service.

Regulation 18: Food and nutrition

Residents were offered a varied choice at meal-times. They appeared to be served adequate quantities of food and drink at meal-times.

Judgment: Compliant

Regulation 20: Information for residents

There was a resident guide available in the centre. This guide was not updated and did not have the current person in charge of the centre included. The procedure respecting complaints had the complaints officer as the person in charge who had since left their role.

Judgment: Substantially compliant

Regulation 27: Infection control

Improvements were required in order to ensure procedures are consistent with the National standards for infection control in community services, 2018. For example,

- There was inappropriate storage in the sluice room on the draining board, where a high rise toilet seat, urinal and basin were placed. It could not be identified if these items had been cleaned or were due to be cleaned. This could increase the risk of infection spread.
- The flooring outside room 21 and in the equipment store was damaged and could not be adequately cleaned
- There was a hand rail which was chipped, this could not be appropriately cleaned.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge ensured that all medicinal products are administered in accordance with the directions fo the prescriber of the resident concerned.

The inspectors observed good practices in how the medicine was administered to residents. Medicine was administered appropriately, as prescribed and dispensed.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Comprehensive assessments were completed and in line with the regulations. Care plans were largely person-centred, however improvements were required. For example:

- Advice from a diabetic nurse was not consistently followed through. One resident was to have eight hourly blood sugars tested as per professional's recommendations but no blood sugars levels were documented in the last three months.
- Care plans did not provide a clear picture of residents' current needs and condition. Some had outdated information and appeared to be used in a fashion similar to the recording of daily progress notes.
- There was a lack of coherence to some care plans, which posed the risk that they would not provide staff with clear guidance on the care to be provided. For example, one resident had updates on their urology outpatients appointment documented in their mobility care plan.

Judgment: Not compliant

Regulation 6: Health care

There was evidence of access to medical practitioners, through residents own GP's and out of hours services when required. Systems were in place for residents to access other healthcare care professionals as required.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant

Compliance Plan for Beech Park Nursing Home OSV-0000012

Inspection ID: MON-0043584

Date of inspection: 08/07/2024

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The RPR and HR department has carried out a full review of the centre to assess and ensure appropriate staffing levels and skill-mix are in place so each residents needs are met. The RPR and HR department have suitable contingency arrangements in place to ensure continuity of care and support to residents in the event of a shortfall of staff. These arrangements include deploying staff who are suitably skilled and trained from other parts of the provider's organisation when required. There are now separate rosters in place for household and laundry departments. This will prevent a crossover of staff into these areas. A full review of staffing levels was carried out and they are in line with the SOP. The allocation of HCA's has been reviewed and they are attending to all residents needs as required. Management reviewed the allocation of staff, as a result an additional HCA is assigned to the communal day room to assist the activity coordinator.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Both staff members were removed from the roster on the day of the inspection. All staff members have now completed mandatory safe guarding training. All four staff members have completed the mandatory fire safety training.	

The one staff member has completed the infection prevention and control training.

A full review of the training matrix and staff files has been conducted by the HR department and PIC. All staff files are complaint with the regulations.

Systems to record and regularly monitor staff training are now in place. A training needs analysis will be recorded quarterly for all grades of staff. This will ensure staff receive on going training as part of their continuing professional training and development

The training needs analysis findings will form part of the clinical governance process.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
All medical notes for deceased residents were removed into secure storage on the day of inspection.

A new storage cupboard has been installed which the nurses can now lock. All nurses have been reminded to ensure the cupboard is to be locked when not in use.

The provider has ensured that there is effective systems and processes in place, including relevant policies and procedures, for the creation, maintenance, storage and destruction of records which are in line with all relevant legislation.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The emergency policy has been updated and guides the staff in the event of an emergency.

All statutory notifications are now submitted within the required time frame.

All audits are reviewed monthly by the DON/PIC. Any improvements required are actioned, these are then reviewed and verified by the operations team monthly and at the Clinical Governance meetings.

The Centre had identified the call bell system was not sufficient. The installation of a new

call bell system was already planned. The new call bell system was being installed on the second day of inspection. The DON/PIC is now able to review the number of call bells and the response time. Staff have been trained on the new call bell system.

While waiting for the commencement of the new Assistant Director of Nursing, the Group Quality and Clinical Practice Lead is supporting the DON in clinical oversight. A new Assistant Director of Nursing has commenced in the home on the 12th August. They are being supported by the DON and Group Quality and Clinical Practice Lead.

The home currently has its staffing levels as per the SOP. Any vacancies that arrive, HR actively recruits to fill these vacancies as early as possible.

Resident satisfaction surveys were completed which will be included in the next Annual review. Quality Improvement Plan will be developed based on the resident's feedback from the satisfaction surveys and resident committee meetings.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
A full review of the homes rosters was completed. The working rosters now correlate with the Statement of Purpose WTE's.

While waiting for the commencement of the new Assistant Director of Nursing, the Group Quality and Clinical Practice Lead is supporting the DON in clinical oversight. A new Assistant Director of Nursing has commenced in the home on the 12th August. They are being supported by the DON and Group Quality and Clinical Practice Lead.
There is now a clearly defined management structure that identifies the lines of authority and accountability in the Nursing Home.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Chief Inspector has now been notified of the alleged misconduct of a staff member.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaint procedure is now centre specific and guides individuals on how to make a complaint.

The Policy has been updated and is now identifying the complaints officer and review officer.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
A full review of policies and procedures was carried out by the SMT. The Emergency policy has been reviewed and was updated after day one of the inspection.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
The resident guide has been updated to include the new PIC.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A new draining rack has been installed in the sluice room.

The damaged floors and surfaces were identified by the management prior to inspection

which was detailed in a line of works due for completion this year.

The hand rail has been repaired.

An infection prevention and control link practitioner is available in the Nursing Home to guide and support staff in safe infection prevention and control practices and oversees performance.

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:
All residents with history of diabetes have been reviewed to ensure their care plan reflects the monitoring of blood sugar levels. The residents care plan in question was investigated and found out that the resident is not diabetic, however the diabetic nurse's recommendation was for a temporary period, and it was no longer relevant to the resident's current condition. The resident's care plan has been updated.

One-to-one training on Care Plan has been provided to all staff nurses to provide a clear picture of residents' current needs and condition.

The care plan with urology information is now documented in the right care plan.

A new monthly care plan audit has been implemented within the home.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/07/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/07/2024
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure respecting complaints, including external complaints processes such as the Ombudsman.	Substantially Compliant	Yellow	31/07/2024
Regulation 21(6)	Records specified in paragraph (1)	Not Compliant	Orange	31/07/2024

	shall be kept in such manner as to be safe and accessible.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/07/2024
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 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Orange	30/09/2024
Regulation 23(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the Chief Inspector.	Not Compliant	Orange	30/09/2024
Regulation 27	The registered provider shall	Substantially Compliant	Yellow	30/09/2024

	ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/07/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	31/07/2024
Regulation 34(1)(a)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable	Substantially Compliant	Yellow	31/07/2024

	after the admission of the resident to the designated centre concerned.			
Regulation 34(2)(a)	The registered provider shall ensure that the complaints procedure provides for the nomination of a complaints officer to investigate complaints.	Substantially Compliant	Yellow	31/07/2024
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).	Substantially Compliant	Yellow	31/07/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	31/08/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care	Not Compliant	Orange	30/09/2024

	plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			