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:	St Brigid's Hospital
Name of provider:	Health Service Executive
Address of centre:	Shaen, Portlaoise, Laois
Type of inspection:	Unannounced
Date of inspection:	16 July 2024
Centre ID:	OSV-0000531
Fieldwork ID:	MON-0044014

About the designated centre

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

St. Brigid's Hospital is a two-storey premises and provides residential care for 23 male and female residents over 18 years of age with continuing care, dementia, palliative care and respite needs. Residents' accommodation is over two floors and accessed by a mechanical lift and stairs. Both floors are of similar design. Each unit has two day rooms, one of which is a designated dining area. There is also a second dining room on the ground floor. An oratory, hairdressing salon, sensory room and activity room are also provided for residents' use. In total, there are seven single bedrooms and eight twin bedrooms. Shared toilets and washing facilities are conveniently located off the circulating corridors on both floors. Residents have access to an enclosed garden accessible from the ground floor. Adequate parking is available at the front and side of the premises. Nursing care is provided on a 24-hour basis, and the provider employs nursing staff, care staff, catering, household and administration staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 16 July 2024	09:00hrs to 17:00hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Residents living in St. Brigid's Hospital gave positive feedback with regard to their lived experience in the centre. Residents told the inspector that they received prompt assistance and care from a team of staff who were kind and respectful. Residents felt that staff were dedicated to keeping them safe and supporting them to enjoy a good quality of life. The only source of dissatisfaction expressed by residents was that the quality of activities did not always meet their interests and capacities.

The inspector was met by a clinical nurse manager on arrival at the centre. Following an opening meeting with the person in charge and clinical nurse manager, the inspector walked through the centre, reviewed the premises and met with residents and staff.

On a walk around the centre, staff were observed busily attending to the morning care needs of residents. There was a relaxed and calm atmosphere, and polite conversation was overheard between residents and staff. The inspector spoke with a number of residents in the communal sitting rooms and in their bedrooms. Residents reported that staff were kind, caring, and attentive to their needs. They described how staff respected their privacy, and their right to choose in many aspects of their daily life. Some residents preferred to remain in bed until late in the morning, and staff respected their choice. Staff were seen to ensure that privacy screens were drawn on bedroom door windows, and that bedroom and bathroom doors were closed before assisting residents with their care needs.

The centre was registered to provided accommodation to 23 residents over two floors. The first floor accommodated male residents and the ground floor accommodated female residents. There was ample communal and private space for residents to use.

The inspector spent time in the dayrooms, located on both the ground and first floor during the morning. Residents were observed watching television, reading the newspapers and a number of residents were asleep in their chairs. There was no social activities taking place in the morning. While staff were observed checking on residents in between their morning duties, those interactions were time-limited and residents were observed to spend long periods of time with no social engagement or activity.

The lunch-time experience was observed to be a pleasant occasion for residents. Food was freshly prepared and specific to resident’s individual nutritional requirements. Staff were observed providing discreet assistance and support to residents in the dining room and to those residents who remained in their bedroom. The dining room was a large spacious area with views of the surrounding landscape through large Georgian style windows. However, residents could not exercise choice with regard to where they could have their meals. The inspector observed some

residents enjoying the pleasant surroundings of the characterful dining room, while other residents were restricted to have their meals in a dayroom. Over the course of the inspection a number of residents were observed not to be facilitated to enjoy all areas of the centre.

Residents' bedrooms were bright and personalised with items of personal significance such as photographs and ornaments. Residents described that they were happy with their bedrooms. Some residents complimented the views of the gardens and surrounding landscape from their bedroom windows. There was access to television and call bells in all bedrooms.

The design and layout of the premises was generally suitable for its stated purpose and met the residents' individual and collective needs. The centre was found to be well-lit and warm and residents described the centre as homely and comfortable. The provider had made significant improvements to the premises since the previous inspection, including the repair of an assisted shower, additional signage along corridors, and redecoration of the entire centre. The centre was found to be visibly clean throughout.

Residents spoke about how they raised issued or concerns with the staff, and described how they would always tell staff if there was an aspect of the service they were not happy with.

There were some activities provided to residents in the afternoon. Some residents were observed sitting outside in the enclosed garden enjoying the warm weather with snacks and refreshments. Others enjoyed some games in a communal dayroom.

Visitors were seen coming and going throughout the day. Visitors expressed their satisfaction with the quality of the service provided to their relatives, and confirmed that there were no visiting restrictions in place.

The following sections of this report detail the findings in relation to the capacity and capability of the centre and describes how these arrangements support the quality and safety of the service provided to the residents.

Capacity and capability

This was an unannounced inspection carried out over one day by an inspector of social services to;

- monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).
- review the providers' progress to comply with a restrictive condition attached to the registration of the centre pertaining to the completion of fire safety works by dates specified by the Chief Inspector.

- review information received by the office of the Chief Inspector.

The findings of this inspection were that the provider had taken significant action to improve the quality of the premises for residents, fire safety, and facilities to support effective infection prevention and control. However, the provider had not ensured that the nurse management structure was maintained in line with the centre's statement of purpose. There was one vacant nurse management position. This was found to impact on accountability and responsibility for key aspects of the service and also nursing oversight and governance. Residents' rights were not fully promoted in the centre, as the provision of activities were not always in accordance with residents interests and capacities, and participation in the organisation of the service was not facilitated.

The Health Service Executive is the registered provider of St. Brigid's Hospital. The organisational structure, had changed since the previous inspection through the appointment of a new person in charge. This inspection found that the provider had not taken action following the previous inspection to ensure that the service had adequate management resources in place. On the day of the inspection, the clinical management support for the person in charge was not as described in the centre's statement of purpose, which detailed the management structure to include three clinical nurse managers (CNM). The inspector found that this structure was not in place as a result of extended planned leave. This organisational structure was found to impact on the supervision and monitoring of aspects of the service such as the oversight of residents clinical care records, the provision of social care to residents, and the systems in place to evaluate and improve the quality and safety of the service.

The centre had established management systems in place to monitor the quality and safety of the service provided to residents. Key aspects of the quality of resident care were collected and reviewed by the person in charge and included information in relation to falls, weight loss, nutrition, complaints, medication, and other significant events.

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

Record management systems comprised of electronic and paper-based systems. Records were securely stored and accessible. Records with regard to the care and treatment provided to residents were appropriately maintained. However, some records were not maintained in line with the requirements of the regulations. This included records pertaining to adverse incidents involving residents and complaints. Some documents, in relation to residents finances, fire safety, and records of meetings with the provider were not available for review on the day of inspection.

While there were systems in place to record and investigate incidents and accidents involving residents, the inspector found that the incident reporting system was not robust and did not detail the required information to understand the factors that may have contributed to the incident occurring, or to identify future learning so that similar incidents could be prevented. For example, some adverse incidents involving residents with complex behavioural needs had not been analysed to identify possible contributing factors to the high number of incidents such as staff training, or the effectiveness of care plans.

A review of the complaints management system found that the system in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely, supportive and effective manner. The inspector found information consistent with a complaint made by a resident regarding the quality and safety of care, contained within an adverse incident record. This complaint had not been identified and managed in line with the centre's own procedure, or regulatory requirements.

Notifiable incidents, as detailed under Schedule 4 of the regulations, were not always notified to the Chief Inspector of Social Services within the required time-frame.

While the planned roster was maintained on the day of inspection, a review of the rosters evidenced challenges in maintaining planned nursing and health care staffing levels with the centres own staffing resources. Consequently, the service was dependent on the use of agency support staff as the centre continued to have multiple staff vacancies.

There was a comprehensive training and development programme in place for all grades of staff. Records showed that all staff had completed mandatory training in fire safety, safeguarding of vulnerable people, and supporting residents living with dementia. Staff demonstrated an appropriate awareness of their training, with regard to fire safety procedures, and their role and responsibility in recognising and responding to allegations of abuse. However, staff were not appropriately supervised to deliver person-centred social care to a number in accordance with their interests and capacities.

Regulation 14: Persons in charge

The person in charge was a registered nurse with the required experience in the care of older persons, and worked full-time in the centre. The person in charge had the overall clinical responsibility for the delivery of health and social care to the residents.

Judgment: Compliant

Regulation 15: Staffing

On the day of inspection, the staffing numbers and skill mix were appropriate to meet the needs of residents, in line with the statement of purpose. There were satisfactory levels of health care staff on duty to support nursing staff. The staffing compliment included laundry, catering, activities staff and administration staff. There was adequate levels of staff allocated to cleaning of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised to ensure that the social care needs of residents were met, in line with their assessed needs and care plans. For example, some residents were assessed as requiring a health-care program that was based on music therapy, relaxation and communication skills, and sensory stimulation. However, staff were not supported and supervised to provide this program to residents.

Judgment: Substantially compliant

Regulation 21: Records

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

- A record of the duty roster of all persons working at the designated centre, and a record of whether the roster was actually worked by staff, was not maintained in line with the requirements of Schedule 4(9).
- A record of an incident in which residents may have suffered potential abuse was poorly documented and did not contain the detail required under Schedule 3(4)(j) of the regulations.
- A record of a complaint made by a resident, and the action taken by the registered provider in respect of any such complaint were not always maintained in line with the requirements of Schedule 4(6).
- Specific records of residents finances were not made available for inspection, as required by Schedule 3(5)(b) of the regulations.

Judgment: Substantially compliant

Regulation 23: Governance and management

The organisational structure, as described in the centre's statement of purpose, was not available and, therefore, not effective. A vacant position in a key management role impacted on accountability and responsibility for aspects of the service such as the quality of clinical care records and the oversight of the care provided to residents.

The organisational structure, as detailed above, impacted on implementing effective management systems to ensure the service provided was safe and appropriately monitored. This was evidenced by;

- inadequate oversight of record management systems.
- poor oversight of adverse incidents involving residents, and submission of statutory notifications to the Chief Inspector.
- poor oversight of the recognition and management of complaints.

Judgment: Substantially compliant

Quality and safety

Residents living in this centre received care and support which ensured that they were safe and that they could enjoy a good quality of life. The provider had taken significant action to ensure the physical environment met the care and safety needs of the residents, and to ensure residents' safety in relation to fire safety and infection prevention and control. However, this inspection found that residents individual assessments and care plan were not always reflective of their actual care needs, and that residents rights were not upheld in the centre through the provision of meaningful social activities and opportunities to provide feedback on the quality of the service.

The inspector reviewed the arrangements in place relating to fire safety. Inspectors found that regular fire safety checks in the centre were completed and recorded. There were daily, weekly and monthly checklists which included testing of fire equipment, fire alarm testing, emergency lighting, means of escape and fire exit doors, all of which were up-to-date. The centre was equipped with a fire detection and alarm system which covered all areas. The provider had taken action to ensure that fire containment measures, means of escape, and that the safe and timely evacuations of residents in the event of a fire emergency were in line with the requirements of the regulations.

Action had been taken with regard to the maintenance of the premises since the previous inspection. Significant renovations works had been completed in all areas of the premises. All corridors, communal facilities, and bedrooms were appropriately

decorated and maintained. All areas of the premises were made accessible to the residents. This included the installation of a button to operate a lift platform to access the hairdresser room and communal toilet.

The provider had improved the facilities to support effective infection prevention and control through the installation of additional clinical hand-washing sinks. Infection prevention and control practices were underpinned by up-to-date guidance documents and oversight by a nurse specialist. The provider had a number of effective assurance processes in place in relation to the standard of hygiene. This included cleaning specifications and checklists, colour coded cleaning equipment to reduce cross infection, policies and guidance documents for the prevention and control of infection and audits. Combined, these processes ensured a safe environment for residents in the centre.

Residents' health and social care needs were assessed on admission to the centre to inform the development of care plans that provided guidance to staff in the provision of individualised care. Validated assessment tools supported the assessment of residents to establish if residents were at risk of falls, malnutrition or impaired skin integrity. A review of resident's care plans found that they were developed in consultation with the residents and, where appropriate, their relatives. However, care plans were not always reviewed and updated when a residents condition changed. For example, a residents care plan had not been updated following an adverse incident in the centre. In addition, residents social care needs and plans were not always implemented.

A review of residents' records found that there was regular communication with residents' general practitioner (GP) regarding their health care needs and residents were provided with access to their GP, as requested or required. Arrangements were in place for residents to access the expertise of health and social care professionals for further expert assessment and treatment. This included access to the services of speech and language therapy, dietetics, occupational therapy, physiotherapy, and tissue viability nursing expertise.

Resident's nutritional care needs were appropriately assessed to inform nutritional care plans. These care plans detailed residents dietary requirements, the frequency of monitoring of residents weights, and the level of assistance each resident required during meal-times. There were appropriate referral pathways in place for the assessment of residents identified as being at risk of malnutrition.

Arrangements were in place for residents to receive visitors. There was no restrictions placed on visiting to the centre.

Residents had access to television, radio, newspapers and books. Internet and telephones for private usage were also readily available.

While there was an activity schedule in place, residents were not always provided with activities in accordance with their interests and capacities. A review of activity records showed that there was an over-reliance on activities that did not promote social engagement. This included activities such as television viewing.

Residents were not provided with opportunities to express their feedback about the quality of the service provided. There had been no satisfaction surveys or resident meetings since the last inspection in January 2024.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 17: Premises

The premises was designed, laid out and maintained in line with the requirements of the regulations.

Judgment: Compliant

Regulation 18: Food and nutrition

There were inadequate arrangements in place to monitor residents nutritional needs, and residents at risk of malnutrition or dehydration. This included weight monitoring, maintaining food intake monitoring chart, and timely referral to dietetic, and speech and language services.

Judgment: Compliant

Regulation 27: Infection control

The provider had taken action to ensure that infection prevention and control procedures were consistent with the National Standards for Infection Prevention and Control (IPC) in community settings published by HIQA. For example,

- There were systems in place to monitor infection prevention and control, antimicrobial usage, and the quality of environmental and equipment hygiene.

- Facilities to support effective prevention and control of infection were in place in areas such as sluice facilities and the laundry.
- Staff were provided with appropriate training and access to up-to-date policy guidance documents to underpin best practice in relation to protecting residents from the risk of infection.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had arrangements in place to monitor and review fire precautions in the centre. There were daily and weekly maintenance checks in place to ensure means of escape were unobstructed, fire-fighting equipment was functional, and fire and emergency lighting systems were operating.

The provider had adequate arrangements in place for detecting, containing and extinguishing fires. The fire alarm system was an L1 category alarm (smoke detection coverage to all areas). There was evidence that those systems were assessed and maintained on a quarterly basis by a competent person.

Staff were provided with opportunities to participate in fire evacuation drills. A review of the records showed that staff practiced simulated compartment evacuations and utilised information to support the safe and timely evacuation of residents, such as residents personal emergency evacuation plans.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A sample of resident's assessments and care plans found that they were not in line with the requirements of the regulations.

- Care was not always provided to residents in line with their assessed needs and care plans. Some residents required specific therapeutic techniques and interventions to meet their social care needs. Records reviewed showed that residents assessed social care needs were not being met in line with their individual care plan.
- Care plans were not guided by a comprehensive assessment of the residents care needs. Some resident's care plans did not accurately reflect the needs of the residents and did not identify interventions in place to support residents who had complex behavioural care and support needs. Consequently, staff did not have accurate information to guide the care to be provided to the residents.

- Care plans were not reviewed or updated when a resident's condition changed. For example, the care plan of a resident who had a significant incident and increase in their care needs had not been reviewed or updated. Consequently, the care plan did not reflect the nursing and medical interventions required to support their needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP), and the person in charge confirmed that GPs were visiting the centre as required.

Residents also had access to a range of allied health care professionals through a system of referral. There was evidence that the recommendations of health and social care professionals were implemented to ensure best outcomes for residents.

Judgment: Compliant

Regulation 9: Residents' rights

The provider failed to provide the residents with facilities for occupation and recreation and for opportunities to participate in activities in accordance with their interests and abilities.

Residents were not always supported to exercise choice. While male residents who resided on the first floor could attend the dining room on the ground floor for their meals, female residents who resided on the ground floor were required to have their meals in a separate dayroom. The inspector was informed that this was a residual practice arising from the pandemic.

Residents were not provided with opportunities to participate in the organisation of the service. There had been no resident meetings in over six months. This meant that residents were not facilitated to express feedback on the quality of the service they received. One resident told the inspector that there had been no meetings since they had come to live in the centre, and that they would welcome an opportunity to provide feedback on some aspects of the service.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Brigid's Hospital OSV-0000531

Inspection ID: MON-0044014

Date of inspection: 16/07/2024

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A review of the care practices to include roles and responsibilities throughout the day and in particular during the morning and at lunchtime will be undertaken to ensure the focus is on person centered care and routines. A number of staff will be trained in the social care programme to ensure suitable activities are provided for sensory stimulation in particular for those with cognitive impairment. A review of the planned schedule of activities will be completed in addition to the assessments completed for each resident.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A planned and actual worked roster will be maintained to distinguish whether the roster was actually worked as planned initially in line with Schedule 4(9). All incidents in relation to potential safeguarding concerns are documented on the preliminary screen form which is referred to the Designated Officer and incidents in which an accident or injury occurs are documented on the incident reporting form. The forms will be reviewed by the PIC to ensure all aspects are completed in full with sufficient detail. Training by the HSE risk advisor on completing incidents form will be undertaken.	

All incidents are reviewed by the PIC. Where an issue of concern arises it will be documented in the complaints reporting form and managed with in line with the complaint's policy of the centre. All accidents/incidents and compaints will be reviewed on a monthly basis to ensure they have been documeted on the correct forms and responded and managed in line with the relevant policy of the centre.

The procedure for the records in relation to residents finance are presently being updated to assign a new HSE employee as the designated pension agent. The forms for change of name of the designated pesion agent are awaited for return from the Dept of Social welfare for each of the residents for whom the HSE is the designated pension agent. The records when returned will be stored securely on site and available for inspection.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The current single vacant nurse management position will be filled to support the PIC maintain oversight and ensure robust operational governance of the service in line with the centre's statement of purpose

Additional training sessions in care planning will be provided by the Clinical Practice Development Facilitator. PIC will increase the frequency of care plan audit over the course of the next six months.
The CNM has been assigned the responsibility to monitor the implementation of the activities program and to ensure it is delivered by assigned staff on a daily basis.

Training by the HSE risk advisor on completing incidents form will be undertaken to support staff in detailing the required level of information accurately.
All accidents/incidents and compaints will be reviewed on a monthly basis to ensure they have been documeted on the correct forms and responded and managed in line with the relevant policy of the centre.
A residents survey will be completed with residents and their nominated next of kin to obtain feedback on the service. Any suggestions or recommendations will be reviewed and acted on accordingly.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Each staff nurse is assigned as a key worker for care planning. An audit of all care plans will be completed. The findings of actions and recommendations from the audit will be discussed at the next staff nurse/CNM team meeting.
The comprehensive assessment of need and the assessments for all residents will be reviewed and to ensure therapeutic and social care needs are being met in line with their current needs.

While training in care planning has been completed additional training sessions will be provided by the Clinical Practice Development Facilitator.
The PIC will increase the frequency of care plan audit over the course of the next six months to more closely monitor and maintain oversight to ensure care plans reflect the current assessed needs of residents.

Care Planning will be a standing agenda item on all nurse management and staff team meetings to ensure improved oversight of care planning.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The CNM has been assigned the responsibility to monitor the implementation of the activities program and to ensure it is delivered by assigned staff on a daily basis.

The mealtime experience has been revised and all residents now have the choice and are supported to use the main dining if this is their preferred option on a daily basis.

A residents' meeting has been organised and a schedule of meetings planned for the remainder of the year.
A residents survey will be completed with residents and their nominated next of kin to obtain feedback on the service.

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/07/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	15/09/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	31/07/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and	Substantially Compliant	Yellow	31/10/2024

	details responsibilities for all areas of care provision.			
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.	Substantially Compliant	Yellow	30/09/2024
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/08/2024
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	30/08/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not	Substantially Compliant	Yellow	30/08/2024

	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.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	15/08/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	30/07/2024
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	30/07/2024