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:	TLC Carton
Name of provider:	TLC Spectrum Limited
Address of centre:	Tonlegee Road, Raheny, Dublin 5
Type of inspection:	Unannounced
Date of inspection:	15 February 2024
Centre ID:	OSV-0005800
Fieldwork ID:	MON-0042862

About the designated centre

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

TLC Carton is a purpose-built nursing home designed to meet the individual needs of the older person, while facilitating freedom and independence for the more active. TLC Carton is located off the Malahide Road and close to Beaumont Hospital, and can accommodate up to 163 male and female residents over 18 years of age. The building has three storeys consisting of 135 single bedrooms and 14 double/twin bedrooms. Each bedroom has full en-suite facilities, and furniture which includes a television, call bells and a phone. Each floor is serviced by stairwells and passenger lifts and access to outdoors spaces are available on the ground and first floor.
TLC Carton provides long term, respite care and stepdown care to meet the health and social needs of people with low, medium, high and maximum dependencies. The centre provides 24-hour nursing care. The provider's aim is to ensure freedom of choice, promote dignity and respect within a safe, friendly and homely environment that respects the individuality of each resident who chooses to reside in TLC Carton.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	135

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
Thursday 15 February 2024	08:50hrs to 15:20hrs	Niamh Moore	Lead
Friday 16 February 2024	08:55hrs to 16:30hrs	Niamh Moore	Lead
Thursday 15 February 2024	08:50hrs to 15:20hrs	Bairbre Moynihan	Support
Friday 16 February 2024	08:55hrs to 16:30hrs	Bairbre Moynihan	Support
Friday 16 February 2024	08:55hrs to 16:30hrs	Siobhan Nunn	Support
Thursday 15 February 2024	08:50hrs to 15:20hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

The general feedback inspectors received from residents was that they were content with their bedrooms and the premises within TLC Carton. Some residents reported that staff were very good and kind to them, but they were very busy and at times residents were left waiting for their call bells to be answered and to receive care. Inspectors were told that this was particularly an issue if they required assistance of two staff at a time which meant they could be waiting some time before they had their needs met. One resident also reported this was a particular issue at night time. Visitors also reported that staff were kind but stated they felt there could be more staff available so that their loved one's needs could be met better.

When inspectors arrived to the centre each day, they were met by the receptionist to sign in, completed hand hygiene and wear appropriate personal protective equipment such as a face mask. There was a visitors book for visitors to sign in at the reception desk. The reception area was decorated with Valentine's day decorations.

The designated centre is located in North Dublin. The centre is registered for 163 residents with 135 residents living in the centre on the day of the inspection. The residents accommodation was provided in 135 single rooms and 14 twin bedrooms, all with en-suite facilities laid out across three floors. Bedrooms were observed to be personalised with ornaments, family photos and art work. They were clean and residents reported to be happy with their accommodation.

The centre was in the middle of an outbreak of respiratory illness which was contained to the ground floor of the centre. As a result there was limited group activities taking place throughout the inspection which was on the advice of public health. On the first day of inspection, inspectors noted that residents remained mainly within their bedrooms and in bed. On the second day, some restrictions had eased and there was communal activities occurring, with music on the ground floor.

On both days of inspection, residents primarily had their meals within their bedrooms. Some residents reported the food was nice and they were satisfied with the choice available, others reported that their meal was cold by the time it reached their bedrooms. Inspectors saw that health care assistants attended the dining rooms to receive the meals and then the trays were placed on trolleys to deliver to bedrooms. Inspectors observed there were not enough staff available to deliver meals, provide hot drinks and to assist residents with their meals in a timely manner. Feedback received from a resident was that they did not like to use their call bell during meal times as they knew it was a busy time for staff. In addition, inspectors observed that a resident who required full assistance and supervision with their meal did not get this assistance.

A customer satisfaction report was completed for 2023 with 40 respondents providing feedback. Overall satisfaction had decreased with 86 percent of respondents satisfied in 2022 and this was 77 percent in 2023. Inspectors saw that high levels of satisfaction were recorded with the friendliness of the service, maintenance and cleanliness of common areas and the ability to personalise the environment. Lower levels of satisfaction were identified with the presence and availability of nursing staff, time and attention declared to daily hygiene and attention to the resident's appearance and their expectations.

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

Capacity and capability

While there was established management structures within the designated centre, inspectors found that the provider's governance systems were not effective and did not ensure that there were sufficient resources to address the findings of the previous two inspection. As a result this had a negative impact on the quality and safety of the service provided to residents.

The purpose of this two day unannounced risk inspection was to:

- to monitor compliance with the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2013 amended March 2023.
- review the assurances provided in the compliance plan response submitted by the registered provider following inspections carried out in December 2023 and January 2024.
- review an application submitted by the registered provider to vary Condition 1 of the current registration to remove an office space from the footprint of the designated centre.
- follow up on unsolicited information of concern that has been submitted to the Office of the Chief Inspector relating to the management of the current outbreak and safeguarding processes in place in the designated centre. Inspectors found these concerns were substantiated on inspection.

TLC Spectrum Limited is the registered provider for TLC Carton. The board of directors includes three people, within this board, there is a Chief Executive Officer and a Chief Operating Officer who were present during the inspection. The centre is part of Orpea Residences Ireland and therefore additional group services were available to support the centre through a quality team, Human Resources (HR) and a maintenance team. A regional director was in place to support the person in charge with oversight and governance in the centre.

At the time of the inspection, the registered provider was not in compliance with the Health Act 2007 as they were in breach of Condition 1 of their registration as the function of an office room had been changed for use by a homecare team. While an application to vary the registration had been received to change the function of the room, the application had not been approved by the Chief Inspector.

The registered provider had prepared a statement of purpose which had been reviewed and revised within the last year. However this document did not contain all the information as set out in Schedule 1 of the regulations.

While overall Schedule 5 policies were available and reviewed at intervals not exceeding three years, some policies were not seen to be adopted and implemented by staff. This is further discussed under Regulation 4: Written policies and procedures.

The person in charge worked full time within the centre and was supported in their management role by a deputy director of nursing, two assistant directors of nursing and 4.5 clinical nurse managers. Other staff included nurses, senior health care assistants, health care assistants, housekeeping, catering, and maintenance and administration staff. There was no worked roster available to inspectors during the inspection, however from a review of the allocation sheets, inspectors were not assured that there was a sufficient number and skill mix of staff to meet the assessed needs of residents.

Inspectors reviewed the training matrix for the designated centre and saw a high level of staff were supported to attend mandatory training on safeguarding and manual handling. However there were significant gaps for training on fire safety, infection control, responsive behaviours and medicines management. While management were supernumery and there were managers on site daily with an on call roster in place for management support at night, inspectors found that staff were not appropriately supervised. These findings will be further discussed under Regulation 16: Training and Staff Development.

There was poor oversight and management of records within the designated centre. Inspectors had to request documentation on numerous occasions with some of these documents still not made available at the end of the inspection. In addition, a review of resident daily progress notes found that they did not provide sufficient information to inform staff about each resident's daily progress and did not support person centred care. This is further outlined under Regulation 21: Records.

The designated centre had experienced three separate outbreaks since January 2024 which affected each floor in the centre. These outbreaks related to norovirus, COVID-19 and respiratory illness such as influenza. At the time of the inspection, the norovirus outbreak had recovered with two confirmed cases and thirteen suspected cases. The COVID-19 and respiratory illness outbreaks were current at the time of the inspection. There was 11 confirmed cases of COVID-19 and 27 confirmed cases of influenza. In addition there was 30 cases of suspected influenza like illness. There had been five deaths during the current outbreaks. The staff working in the centre had access to the Health Service Executive’s (HSE’s) public health department for outbreak support. An Outbreak Control Team meeting with public health was held on the 2 February 2024 and on the second day of the inspection, 16 February 2024. Inspectors reviewed the minutes of the meeting of 02 February 2024 and received assurances that the actions required by the public health team had been completed. Overall responsibility for infection prevention and control (IPC) and antimicrobial stewardship within the centre rested with the person in charge who has completed the national link practitioner course. The person in charge had identified other staff members to attend training in Infection Prevention and Control in order to build expertise within the staff team.

Management oversight systems were in place which included auditing and gathering key quality indicators such as on falls, care plans, restrictive practices, medicine incidents, safeguarding and infection control. However the inspectors found that the systems did not always identify areas of the service that required improvement. For example, these systems did not identify gaps, in staff training and were ineffective in identifying other areas for improvement, such as findings relating to restrictive practices. Audit results and quality indicators were discussed at monthly management meetings, including corporate and clinical governance meetings. However records showed that while some areas requiring improvement were being discussed, actions to drive improvement were not being implemented in the centre which was impacting on the quality and safety of the care and services provided for the residents. As a result the inspectors found a disimprovement in compliance across a number of regulations on this inspection.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

An application to vary condition 1 of the centre's registration had been received to amend the footprint of the designated centre to remove an office space. Complete and correct information had been submitted with this application. This application was under review.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had not ensured that there was a sufficient number and skill mix of staff available within the designated centre to meet the assessed needs of the 135 residents in accordance with Regulation 5, and the size and layout of the designated centre. For example:

- During the first day of this inspection, short notice leave was not covered for two staff. In addition, records showed that on one day the previous week, five health care assistant day shifts and two health care assistant night shifts had not been covered. A request had been submitted for agency cover however out of these seven absences only one night shift cover was approved by senior management.

- The registered provider had recently reduced staffing levels within the designated centre. Inspectors were told by senior management, the person in charge and staff that one whole time equivalent staff member was reduced. There was no documented evidence for why this reduction had occurred and that information such as the assessed needs of residents and a review of the number of incidents had not been taken into account.
- 50 percent of residents were assessed as being high dependency. Some residents spoken with told inspectors that at times staff were slow to respond to their needs. This was validated by inspectors' observations on the day of the inspection. Furthermore no call bell audits had been completed to review response times to ensure that residents' needs were being addressed in a timely manner.
- A resident with an assessed need for one-to-one staffing was observed to not have this in place on one occasion on both days of the inspection.
- Some staff spoken with told inspectors that there was not enough time to complete all assigned duties, such as the completion and sign off of additional care checks for residents at risk of falls or safeguarding incidents, especially during busy times such as during morning care delivery.

Judgment: Not compliant

Regulation 16: Training and staff development

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

- One in six staff required refresher training in infection control.
- One in eighteen staff required first time training in infection control.
- One in seven staff required refresher training in fire safety.
- One in six staff required first time training for fire safety.
- One in eight staff required fresher training and seven out of ten staff required first time training for medicines management.

The person in charge had not ensured that staff were appropriately supervised in line with their own policy. For example:

- There was ineffective oversight of clinical care which led to a number of poor findings and outcomes for residents, further detailed within the quality and safety section of this report.
- A staff member who commenced post in April 2023 did not have an induction form completed or evidence of any probation review completed.
- A staff member identified as requiring additional supervision did not have any documented evidence that this supervision had taken place. In addition, this arrangement was due for review three months post supervision. There was no evidence to show this review had taken place.

- A staff member on a performance improvement plan (PIP) was due to receive additional support from a clinical nurse manager. There were four meetings due to take place over a 60 day period. There was evidence of one meeting taking place and the 60 days lapsed in September 2023. There was no close off or review of this staff member's performance.
- The performance review tracker viewed by inspectors detailed that a number of staff were overdue their annual appraisal. For example, from nine members of management within the designated centre, one performance review had been completed in 2023.

Judgment: Not compliant

Regulation 21: Records

There was poor oversight and management of records within the designated centre. For example:

- The rosters provided to inspectors on the first day of the inspection were not accurate as they did not include the names of the staff who had worked each day in the designated centre.
- On many occasions, staff were not clear about where records could be found. For example, inspectors were provided with staff files to evidence supervision records. When records of supervision were not within these files, inspectors were then told to go speak with the Human Resources team (HR), these records were also not available from HR and by the end of the inspection only one record out of the six requested was made available to inspectors.
- Inspectors requested the following documentation which was not provided during the inspection:
    - The retention and turnover of staff
    - The whole time equivalent of staff employed and the whole time equivalent of all vacancies in the centre
    - A care update for one resident who had a fall.
- Progress notes in resident files were not comprehensive and in some instances omitted critical information pertaining to residents. As a result staff did not always have the information they needed to provide safe and appropriate care.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider was in breach of condition 1 of their registration. An application applying to vary condition 1 of the centre's registration had been received and was under review. The application requested an office space to be removed from the centre’s registration with plans that it was to be used by a separate service. On the day of the inspection, inspectors found that this office space was occupied by staff who were not employed by the registered provider.

The management systems in place failed to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- The registered provider had failed to provide the resources required to address all of the areas from the compliance plans of previous inspections and improvements identified within their own management systems,. As a result repeated non compliances with the regulations were found on this inspection which were negatively impacting on the quality and safety of care for the residents. For example:
    - increased supervision was due to take place during mealtimes following a recent inspection. In addition, mealtime supervision was raised as being a priority within the clinical governance meeting of January 2024. However, inspectors observed a resident who was due to get full supervision and assistance at meal time was provided with their meal in their bedroom without any supervision or assistance. Furthermore, residents prescribed a level six (soft and bite size) meals were not provided with the correct modified diet.
    - Medication stock reviews were due to occur monthly. However this had not taken place and as a result the registered provider had not identified that discontinued medicines had not been appropriately disposed of.
- Analysis of information through audits and incidents occurring within the designated centre was not always leading to quality improvements and outcomes for residents. For example:

    - A system of analysis of safeguarding incidents had commenced in May 2023 to ensure that all safeguarding incidents were reviewed by the senior management team. Recommendations from this review were recorded however there was no agreed time bound action plan developed and allocated to a responsible person. As a result these improvements had not been implemented at the time of the inspection thus missing an opportunity to reduce safeguarding incidents.
    - A finding from a falls committee meeting in November 2023 identified that 30 minute safety checks were not being completed. This remained a finding in inspections of December 2023 and February 2024. In addition, there was no time bound action plan put in place following a review of falls which occurred in January 2024.
    - Data collection was not accurate. For example, inspectors were provided with incident analysis data from December 2023. This analysis detailed that 30 incidents had occurred within the month however inspectors found that not all of these incidents were accurately reported as a number of incidents which met the threshold of safeguarding as per the provider's own safeguarding policy were recorded under challenging behaviour or other.

- A medication incident identified that a medication was not administered in accordance with the directions of the prescriber. No review of the incident had taken place at the time of inspection to identify learning and to prevent it occurring again.
- A medication audit was completed in January 2024 which identified some of the issues identified on this inspection. However, the required improvements from the January 2024 audit findings were not actioned at the time and had not been followed up to ensure the changes were implemented effectively.

Judgment: Not compliant

Regulation 3: Statement of purpose

While the statement of purpose had been updated in February 2024, it did not accurately reflect all staff working within the designated centre and the measurements of the nurse's stations on the first floor.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

As mentioned throughout this report, the registered provider had not ensured that all Schedule 5 policies were adopted and implemented in the designated centre. For example:

- Transcribing of medications was not taking place in line with the centres' policy on Prescribing, Ordering, Storage and Disposal of medication.
- Staff were not returning medications to the pharmacy which were no longer required in line with the policy above.
- Supervision of staff was not occurring in line with the provider's policy on Staff Induction, Orientation and Supervision.
- The management of restraints was not in line with the provider's policy on restraint use.

Judgment: Substantially compliant

Quality and safety

While some residents provided positive feedback on the life and care they received in the centre this inspection found that the provider had repeatedly failed to provide the resources that were required to bring about sustained improvements in the quality and safety of care and services provided for the residents. This was impacting on key areas such as meal times and nutrition, infection prevention and control, medicines and pharmaceutical services, individual assessment and care planning, healthcare, managing behaviours that challenge, protection and residents' rights.

Residents' had access to medical care. A general practitioner attended the designated centre twice weekly. Outside of this an out of hours service was contacted. There was evidence from a review of resident records that residents were reviewed by health and social care professionals. However, through a review of progress notes and observation charts, inspectors identified that residents were not always referred to a medical practitioner in a timely manner. This is discussed further under Regulation 6: Healthcare.

A sample of care plans and validated assessment tools were reviewed. Care plans were updated at four monthly intervals in line with the regulations. The standard of care planning was not consistent and did not ensure up to date and complete information was available to guide staff providing care. Some care plans were person-centred and detailed care required, however significant gaps were identified in others. Similarly, validated assessment tools were completed at regular intervals, however, they were not always updated. For example; following a fall.

At the time of the inspection, residents were restricted to staying in their rooms and units due to the outbreaks. However inspectors were assured for talking with residents and staff that when there was no outbreak residents could freely move around the centre with no key pads or fob access required to access the lift, other units or the front door. On the day of the inspection some residents who smoked were observed using the lift and accessing the internal garden, the door to which was unlocked. Restrictive practices in use in the centre included bedrails, posey alarms and chair alarms. Almost one in four residents had bedrails in place. While risk assessments were completed there was no evidence that this was in consultation with a multi-disciplinary approach and that less restrictive options were trialled before equipment such as bed rails was implemented.

The registered provider had not taken all reasonable measures to protect residents from abuse. Access to the designated centre and residents' accommodation was not appropriately controlled and therefore posed a potential risk to residents' safety. For example, inspectors observed that individuals who were not resident or working in TLC Carton had access to enter the building and had not been signed in at reception.

Residents' care preferences for their end of life were discussed with them and recorded in their care plan. There was evidence that residents' were placed on an end of life pathway in a timely manner with input from the general practitioner and in some cases the hospice. Ongoing discussions were documented between the staff and family members providing an update on the residents' condition, however, while care plans generally indicated the residents spiritual and religious wishes, in a review of three records, there was no evidence that these were provided as the resident approached end of life.

Overall inspectors found that the layout of the premises met residents' needs and residents gave positive feedback relating to the environment and their bedrooms. Some repair works requiring review is noted under Regulation 17: Premises.

Residents had access to drinking water in their rooms. Inspectors observed residents were provided with snacks and drinks outside of mealtimes and when requested by residents. Residents on a normal diet and on a level 4 (pureed) and 5 (mince moist) diet were provided with a choice at mealtimes, however, residents on a level 6 (soft and bite sized diet) were not provided with the same choice. Furthermore, residents on a level 6 diet were not always provided with the correct modification. These areas for action along with additional improvements required are discussed under Regulation 18: Food and nutrition.

Some improvements were noted in the management of the outbreak from the last inspection. For example, all staff had personal hand sanitiser toggles and there were appropriate health care risk waste bins for doffing personal protective equipment. However, on the day of inspection the inspectors observed four staff members wearing their mask below their nose. This practice increases the risk of infection spread to staff and residents. A number of practices were identified which had the potential to impact on the effectiveness of infection prevention and control within the centre. These included inconsistencies in the implementation of standard infection control precautions including equipment hygiene and sharps safety. Findings in this regard are presented under Regulation 27: Infection Control.

Medications requiring strict control measures (MDAs) were stored securely and correctly. A sample of these were checked and were correct. Inspectors were informed that staff had access to advice from a pharmacist. However, the systems in place for the management of medicines required strengthening.

Regulation 13: End of life

Action was required to ensure that residents were afforded access to religious and spiritual services, in accordance with their wishes and preferences. For example; an inspector reviewed a sample of residents care plans and end of life care and there was no evidence that residents' spiritual and religious needs were met.

Judgment: Substantially compliant

Regulation 17: Premises

Inspectors found that some action was required to ensure the premises conformed to all of the matters set out in Schedule 6. For example:

- Carpet in some residents room on the second floor had staining and cannot be cleaned properly.
- Wear and tear to paintwork was observed on hand rails.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The following areas for action were identified on inspection:

- An inspector observed that the old descriptors were still in use in some areas of the centre which could potentially cause errors in the modifications to food and drinks and posed a risk that residents might not receive fluids and died in line with their nutritional needs. For example; inspectors observed three incidents where residents on a Level 6 diet (soft and bite sized) were provided with a level 7 diet (regular).
- Not all residents were afforded appropriate choices at meal times. For example, residents on a Level 6 diet (soft and bite sized) were not provided with the same choice as the residents on other modified diets or on a regular diet.
- Some meals were not properly and safely served. For example, a small number of residents on the second floor stated that the food was cold and they were unable to eat it.

Judgment: Substantially compliant

Regulation 27: Infection control

Infection prevention and control and antimicrobial stewardship governance arrangements did not ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. For example;

- The overall antimicrobial stewardship programme needed to be further developed and strengthened in order to support good antimicrobial stewardship practices within the centre. For example, there was no evidence of recent antimicrobial stewardship audits, training or quality improvement initiatives.
- Staff showed limited awareness of the "Skip the Dip" campaign, which focuses on avoiding the improper use of urine dipstick tests. These

unnecessary tests can lead to over prescribing antibiotics, which doesn't help the resident and could lead to harmful outcomes like antibiotic resistance.

Standard infection control precautions were not effectively and consistently implemented by staff. This was evidenced by;

- Some staff at the time of inspection were wearing masks below their nose. Wearing a mask below the nose reduces its' effectiveness in preventing the spread of respiratory droplets.
- In an open store room, three sharps bins were unlabelled, overfilled, stored on the floor and the lids were open. This practice increased the risk of sharp injuries to residents and staff.
- Four phlebotomy trays were visibly dirty, one tray had evidence of blood splashes. These trays were on a cleaning checklist that had not been completed the week of the inspection. Medical equipment that is not cleaned after use is an infection risk to residents and staff.
- The hydrotherapy bath was visibly unclean and not on a cleaning check list. Staff were unable to describe how the hydrotherapy jets were cleaned. These baths are potentially a high-risk source of fungi and bacteria, including Legionella if not effectively decontaminated after use.
- The provider had not yet substituted all traditional unprotected sharps/ needles with a safer sharps devices that have features or a mechanism to prevent or minimise the risk of accidental injury.
- The treatment room on the ground floor had no clinical hand hygiene sink. Hand hygiene facilities are necessary prior to the preparation of medication and preparing for an aseptic technique if hands are visibly soiled.
- The bedpan rack for storage of clean items in the sluice room stored bed pans that were visibly dirty. Equipment that is not cleaned properly after use may increase the spread of infection.
- The medication fridge on the second floor was signed as being clean on the morning of inspection, however the lower shelf was sticky with brown residue. In addition, a large stained area was noted at the fridge door.
- The individual medication boxes contained on the drug trolley were not clean and contained dust and debris.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Improvement was required in the medication management systems in the centre to ensure that they are safe and effectively monitored. For example;

- There was inappropriate storage of a high risk medication in a fridge. The inappropriate storage of medications in fridges was identified in the medication audit in January 2024 but had not been adequately addressed.

- The lock on the medication fridge which was located at the nurses station on the second floor was broken. The inspector was informed that it was broken for a number of weeks and it was escalated to management.
- A resident was recently prescribed a liquid form of a drug, however, the tablet remained in the residents "roll" of drugs. While staff stated they were aware to dispose of the tablet version of the drug, it posed a risk of inadvertent administration of a double dose of the medication or the incorrect form.

An inspector observed multiple incidents where medications which were out of date or had been dispensed to a resident but were no longer required were not appropriately segregated from other medicinal product. For example;

- There was a number of out of date high risk medications contained in a plastic bag in a medication fridge alongside other medications.
- Medications where the course of the drug was completed, remained in the residents "medication box". Multiple examples of these were identified on inspection.
- High risk medications belonging to resident who were no longer residing in the centre were in one fridge. The inspector was informed that the resident had not resided in the centre for a number of months. However their medications had not been disposed of in line with the provider's own medication policy.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans and validated assessment tools to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example;

- An inspector observed that a number of care plans were not updated when residents' needs changed. For example; multiple examples were identified where the infection control care plan stated the resident was isolating, however, this was not in line with the residents isolation status on the day of inspection.
- Residents on the second floor were all in bed on the afternoon of the day of inspection. An inspector was informed that this was the residents' preferred routine. However, on review of residents' care plans this preferred routine was not reflected.
- No care plan was in place for residents with urinary catheters to guide staff practice to prevent a catheter associated urinary tract infection.
- Falls risk re-assessments were not always completed following a fall to ensure that any change in the resident's mobility needs was identified.

- A small number of care plans were not consistent with the malnutrition universal screening tools (MUST) assessment scores. As a result inspectors were not assured that the nutritional care plans reflected the most up to date assessment of the resident's nutritional needs.
- A care plan on a resident's skin integrity was not sufficiently comprehensive enough to guide care.
- Care plans on restrictive practices did not provide sufficient detail to ensure that any restrictive practices were used in line with the resident's assessed needs and were used for the least time required.
- One resident's safeguarding care plan had a different resident's name in the narrative. Furthermore the care plan did not clearly identify the safeguarding risk and what steps staff needed to take to protect the resident.
- A care plan reviewed indicated that three monthly meetings were to be held to discuss the resident's end of life wishes. There was no evidence in documentation reviewed that these had taken place and a member of the management team confirmed that they had not.

Judgment: Not compliant

Regulation 6: Health care

Significant improvements were required under Regulation 6. For example;

- The inspector observed a small number of incidents where residents whose condition had deteriorated were not adequately monitored and therefore did not receive the treatment they required from a medical practitioner in a timely manner. This finding was validated by a review completed by the registered provider. For example; no monitoring observations were completed on one resident for 22 days in January, despite three ongoing outbreaks. On the 23rd day observations were completed and the resident was found to be unwell and required transfer to hospital.
- A resident who was identified as requiring supervision and assistance due to the risk of choking during mealtimes was left alone in their room to eat their lunch unsupervised.
- Information provided to staff by a health and social care provider regarding the positioning of a resident who was at risk of aspiration when receiving food and fluids was not detailed in the residents' care plan and there was no evidence from progress notes reviewed that these instructions were being followed by staff.
- Records showed that one resident was six days isolating with influenza like symptoms before a viral swab was taken.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The registered provider had failed to ensure that restraints were used in accordance with national policy: For example:

- The person in charge had not ensured that staff had up to date knowledge and skills, to respond to and manage behaviour that is challenging (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Records showed that one in five staff had not received training in challenging behaviour.
- The restraint register was not up-to-date and did not contain all restraints identified on inspection. As a result the clinical team did not have all of the information they required to ensure that restraints were being used in line with national guidance.
- The centre had a high use of bed rails with 31 of the 135 residents having a bedrail in place. On review of two resident care plans where bedrails were in place, there was no multidisciplinary assessment, or GP involvement. Resident consent or family involvement was not documented. There was no evidence of less restrictive alternatives being trialled.
- Inspectors noted that a posey alarm and a low low bed were documented in the care plan as being in place for one resident, but these were not on the restraint register, and there was no assessment available for these restraints. Bedrails were documented in the restraint register for the same resident but were not in the care plan. The bedrails which were in place were trialled in November 2023 and had not been reviewed, or alternative less restrictive practices trialled.
- Inspectors observed a chair alarm in one resident's room. There was no record of any assessment related to this restriction in the residents records.
- As per the registered provider's policy on the use of restraint, staff nurses were required to review the use of bedrails every 24 hours and sign an assessment form. Staff nurses who spoke with inspectors were unaware of this procedure or the form they were required to complete.

Judgment: Not compliant

Regulation 8: Protection

All reasonable measures to protect residents from abuse had not been taken. For example:

- Individuals who were not working in the designated centre had codes to access the centre and were not recorded as having been in the centre.
- Inspectors reviewed a sample of records of 30 minute checks that were put in place to protect six residents. They found that staff had not signed to indicate

that checks had been completed, or that one signature was in place for checks for a number of hours. Records for one resident showed that over a 20 day period 30 minute checks were recorded on six days.

Inspectors were not assured that staff received appropriate training in relation to the detection, prevention of and responses to abuse. For example, gaps in appropriate risk assessments and care plans in place to guide staff on how to respond to and prevent abuse were discussed under Regulation 5: Individual assessment and care plan. Dedicated training on how to develop safeguarding care plans had not taken place which was identified as a requirement from the compliance plan in December 2023.

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	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	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 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for TLC Carton OSV-0005800

Inspection ID: MON-0042862

Date of inspection: 16/02/2024

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: Staffing levels are reviewed weekly by the Person in Charge to ensure that there are sufficient resources to meet the assessed needs of the residents, including any additional staffing needs (for one to one supervision) as identified by the Person in Charge. This will be overseen weekly by Chief Operations officer from 1st April. The Person in Charge and/or ADONs has daily huddles with staff to improve communication, review emerging resident needs and to ensure that there are sufficient resources to meet these needs. This commenced on 19/2/24 Administrative tasks have been re-assigned to ensure CNMs are available to supervise care and support staff- complete A weekly call bell audit was commenced on 27th February. The response times as well as a check on the presence of the call bell, whether it is within the resident's reach and also if the resident's needs were met following the call, are all recorded in this audit. The Person in Charge will review the audit weekly and the Regional Director will oversee that actions are addressed at the monthly governance meeting from 1st April 2024.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A review of the management structure, roles and responsibilities has been completed. A restructure of CNM duties has been completed to ensure that CNMs are fully visible and supervising duties on floor to support staff- complete An assigned support has been provided to project manage the improvement plan, allowing the current Person in Charge to supervise staff, oversee care and provide appropriate clinical leadership. This will continue until the full improvement plan is	

implemented by 30th April 2024

Refresher sessions to ensure staff are aware of the content and location of all policies will be completed by 30th June 2024.

A robust audit programme to identify issues with staff compliance with policies is in place. From 1st April 2024, the Person in Charge and Regional Director will review and oversee the findings of audits and improvements identified at the monthly governance meeting.

Training and support is currently being delivered to all nurses to ensure that they are aware of the importance of ongoing assessment and care planning specifically in the areas of falls and catheter care but also for all emerging/changing care needs, including spiritual needs. Training will be completed by 30th April 2024.

The requirement for staff supervision at mealtimes has been re-iterated and all staff and nurse managers are now present for all mealtimes to support residents and to ensure a good dining experience- complete
Training has been scheduled for staff to ensure that they are aware of the updated IDDSI framework. This will be completed by 30th April 2024
A daily walkabout by the senior nursing team commenced on 19th February 2024 and specifically reviews staff practices in relation to IPC, housekeeping and sharps management. Immediate identification of any improvements in practice is noted and addressed and staff are monitored for their ongoing compliance- complete and ongoing

From 1st April, the Regional Director will do a weekly review to ensure that these daily walkabouts are consistently performed and will spot check staff practice to ensure full compliance and to identify any new training needs.

Staff have been provided with additional information to ensure they are aware of appropriate sharps management- complete

Staff have been provided with refresher training for Infection Prevention and Control and outbreak management- this will be fully complete by 31st May 2024 and will be refreshed again prior to 30th September 2024 as part of the winter readiness plan.

Medication management training (both online and an in person competency assessment) has been provided to 100% of nurses- complete
Increased auditing of storage and disposal of medications has been put in place to ensure that any improvements in practice are identified and addressed in a timely manner. From 1st April, these audits will be reviewed weekly by the Person in Charge and overseen monthly by the Regional Director at the Governance meeting.
Training on recognising the deteriorating resident has been scheduled for nurses and will be completed by 30th June 2024
Training for staff on supporting residents with responsive behaviour and restrictive practice has been provided and will be complete for all staff by 31st May 2024.
Staff training on recognising and responding to allegations or suspicion of abuse has been provided and all staff will have completed this by 31st May 2024.
A system has been established to review progress on timely and comprehensive

completion of induction and appraisals for all staff. This will be reviewed monthly at the governance meeting by the Person in Charge and overseen by the Regional Director of Nursing from 1st April 2024 with support from the HR department.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A system has been put in place to ensure that all records required to evidence regulatory compliance are readily available and up to date. This will be reviewed monthly by the Regional Director from 1st April 2024

A monthly review of the KPIs in respect of staff retention and turnover and current vacancies and FTEs in the centre is conducted by the Chief HR Officer and reviewed by the Senior Management Team. This is sent to the Person in Charge monthly and from 1st April 2024 will be reviewed at the monthly governance meeting to ensure that actions arising from the review are actioned and/or escalated.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review of the management structure, roles and responsibilities has been completed.
A restructure of CNM duties has been completed to ensure that CNMs are fully visible and supervising duties on floor to support staff- complete
The improvements identified in the safeguarding review have been implemented to support the reduction in safeguarding incidents- complete
A live action plan is in place to identify all required improvements across all areas with clear timeframes and responsible persons- complete
An assigned support has been provided to project manage the improvement plan, allowing the current Person in Charge to supervise staff, oversee care and provide appropriate clinical leadership. This will continue until the full improvement plan is implemented by 30th April 2024
From 30th March 2024, enhanced and comprehensive incident analysis is conducted monthly (to include falls, safeguarding concerns, medication variance, complaints, responsive behaviour) and reviewed by the Person in Charge and overseen by Regional Director at the governance meeting to ensure the integrity of the data and to ensure that identified actions are addressed or escalated.
Bi-weekly meetings are held in the centre by the Person in Charge to track progress on

this action plan and this is overseen by the Chief Operations Officer and CEO- ongoing.

Additional information requested on the submitted Application to Vary was submitted to the authority on 12th March 2024- complete
The process for any changes to Statement of Purpose, floorplans or proposed changes of use in the designated centre has been reviewed and strengthened to ensure that all conditions of registration are adhered to at all times- complete

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
A revised Statement of Purpose with updated information was submitted to the authority on 12th March 2024- complete

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
All policies are available on SharePoint and printed copies are available in the home- complete

Refresher sessions to ensure staff are aware of the content and location of all policies will be completed by 30th June 2024.

A robust audit programme to identify issues with staff compliance with policies is in place. From 1st April 2024, the Person in Charge and Regional Director will review and oversee the findings of audits and improvements identified at the monthly governance meeting.

Regulation 13: End of life	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:

All resident care plans have been reviewed and updated to ensure that their assessed needs (including spiritual needs) are reflected- complete
Training and support is currently being delivered to all nurses to ensure that they are aware of the importance of ongoing assessment and care planning specifically in the areas of falls and catheter care but also for all emerging/changing care needs, including spiritual needs. Training will be completed by 30th April 2024.
The importance of documenting resident activities, including access to spiritual services and ensuring residents' end of life preferences have been met has been re-iterated to staff nurses, healthcare assistants and activities staff in the daily huddles. The Person in Charge and nurse managers are overseeing these daily- complete and ongoing

Care plan audits are conducted monthly in the home. From 1st April 2024, the Person in Charge and Regional Director will review the audit findings at the monthly governance meeting and ensure that the findings are addressed and/or escalated.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A new IT solution has been implemented to quickly identify any maintenance issues in the home, track progress to remedy the issue identified and to assign a responsible person to address the issues- complete
Issues raised in the above system are tracked weekly in the centre by the Person in Charge and will be overseen monthly by the Regional Director at the governance meeting from 1st April 2024.
The progress on tasks outstanding is also visible by the Facilities manager and Senior Management team who will review outstanding tasks and resource requirements monthly from 1st May 2024.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
A revised process has been implemented to ensure communication regarding resident dietary needs is effective and timely. This will be reviewed weekly by the Person in Charge and monthly by the Regional Director at the Governance meeting from 1st April 2024.
The requirement for staff supervision at mealtimes has been re-iterated and all staff and nurse managers are now present for all mealtimes to support residents and to ensure a good dining experience- complete

Training has been scheduled for staff to ensure that they are aware of the updated IDDSI framework. This will be completed by 31st May 2024	
Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

A daily walkabout by the senior nursing team commenced on 19th February 2024 and specifically reviews staff practices in relation to IPC, housekeeping and sharps management. Immediate identification of any improvements in practice is noted and addressed and staff are monitored for their ongoing compliance- complete and ongoing

From 1st April, the Regional Director will do a weekly review to ensure that these daily walkabouts are consistently performed and will spot check staff practice to ensure full compliance and to identify any new training needs.

Staff have been provided with additional information to ensure they are aware of appropriate sharps management- complete

Staff have been provided with refresher training for Infection Prevention and Control and outbreak management- this will be fully complete by 31st May 2024 and will be refreshed again prior to 30th September 2024 as part of the winter readiness plan.

A 3 monthly audit on sharps management will be conducted and reviewed to ensure that no further staff training/support is required. From 1st April, this will be reviewed at the governance meeting and the regional director will oversee that all actions identified have been addressed or escalated.

A system has been put in place to ensure that when documentation is updated e.g. cleaning schedules, that this is readily available for staff and previous versions are removed- complete

Handwashing facilities will be made available in the clinical room on the ground floor by 30th June 2024.

In the interim period, staff will have access to a handwashing sink adjacent to the room and alcohol hand sanitiser in the room, to ensure that they can adhere to IPC best practices.

Alternative safer sharps products are available to order through procurement and all staff have been made aware of the need to order these- complete.

The antimicrobial stewardship programme will be reviewed and strengthened to ensure appropriate use of antibiotics, including roll out of training for nursing staff on their role in stewardship and specifically on the “skip the dip” campaign. This will be complete by 30th June 2024.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Medication management training (both online and an in person competency assessment) has been provided to 100% of nurses- complete
Increased auditing of storage and disposal of medications has been put in place to ensure that any improvements in practice are identified and addressed in a timely manner. From 1st April, these audits will be reviewed weekly by the Person in Charge and overseen monthly by the Regional Director at the Governance meeting.
Responsibility has been assigned to specific clinical managers to ensure that the system to review the medication trolley and ensure that unused medication is removed and returned to pharmacy, is in place and adhered to. This is audited monthly in the centre and three monthly by pharmacy. From 1st April, the Regional will oversee compliance with this monthly.

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 resident care plans have been reviewed and updated to ensure that their assessed needs are reflected- complete
Training and support is currently being delivered to all nurses to ensure that they are aware of the importance of ongoing assessment and care planning specifically in the areas of falls and catheter care but also for all emerging/changing care needs. Training will be completed by 30th April 2024.

Care plan audits are conducted monthly in the home. From 1st April 2024, the Person in Charge and Regional Director will review the audit findings at the monthly governance meeting and ensure that the finding are addressed or escalated.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The Person in Charge and/or ADONs has daily huddles with staff to improve communication, review emerging resident needs and to ensure that there are sufficient resources and skills to meet these needs. This commenced on 19th February 2024

A restructure of CNM duties has been completed to ensure that CNMs are fully visible and supervising duties on floor to support staff- complete
All resident care plans have been reviewed and updated to ensure that their assessed needs are reflected- complete
Training and support is currently being delivered to all nurses to ensure that they are aware of the importance of ongoing assessment and care planning specifically in the areas of falls and catheter care but also for all emerging/changing care needs. Training will be completed by 30th April 2024.

Training on recognising the deteriorating resident has been scheduled for nurses and will be completed by 30th June 2024

A revised process has been implemented to ensure communication regarding resident dietary needs is effective and timely. This will be reviewed weekly by the Person in Charge and monthly by the Regional Director at the Governance meeting from 1st April 2024.
The requirement for staff supervision at mealtimes has been re-iterated and all staff and nurse managers are now present for all mealtimes to support residents and to ensure a good dining experience- complete
Training has been scheduled for staff to ensure that they are aware of the updated IDDSI framework. This will be completed by 30th May 2024
Staff have been provided with refresher training for Infection Prevention and Control and outbreak management- this will be fully complete by 31st May 2024 and will be refreshed again prior to 30th September 2024 as part of the winter readiness plan.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The improvements identified in the safeguarding review have been implemented to support the reduction in safeguarding incidents- complete
The restraint register has been reviewed to reflect all restrictive practices currently in place- complete
As part of the care plan review- all restrictive practices are reviewed and re-assessed to

ensure they are appropriate- complete and ongoing Training for staff on supporting residents with responsive behaviour and restrictive practice has been provided and will be complete for all staff by 31st May 2024. Life Story work and increased involvement by the activities team in supporting residents with responsive behaviour has been commenced in the centre- ongoing

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Additional information in relation to the submitted Application to vary was submitted on 12th March 2024- completed. A system to ensure that required regular checks are in place to safeguard residents and completed in a timely and comprehensive manner has been put in place- complete The Person in Charge and/or ADONs has daily huddles with staff to improve communication, review emerging resident needs and to ensure that there are sufficient resources to meet these needs. This commenced on 19th February 2024 Staff training on recognising and responding to allegations or suspicion of abuse has been provided and all staff will have completed this by 31st May 2024. Further training to ensure all staff can develop and deliver an appropriate safeguarding care plan will be completed by 31stMay 2024. Life Story work and increased involvement by the activities team in supporting residents with responsive behaviour has been commenced in the centre- ongoing

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 13(1)(b)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that the religious and cultural needs of the resident concerned are, in so far as is reasonably practicable, met.	Substantially Compliant	Yellow	30/04/2024
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	01/04/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Not Compliant	Orange	30/06/2024

	appropriate training.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2024
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	01/05/2024
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	01/04/2024
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	01/04/2024
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff,	Substantially Compliant	Yellow	01/04/2024

	based on nutritional assessment in accordance with the individual care plan of the resident concerned.			
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Yellow	01/04/2024
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.	Not Compliant	Orange	30/04/2024
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	01/04/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Not Compliant	Orange	30/04/2024

	consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/06/2024
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.	Substantially Compliant	Yellow	30/04/2024
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.	Substantially Compliant	Yellow	30/04/2024
Regulation 29(6)	The person in charge shall ensure that a medicinal product	Not Compliant	Orange	30/04/2024

	which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
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	12/03/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/06/2024
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs	Not Compliant	Orange	30/04/2024

	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.	Not Compliant	Orange	30/04/2024
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	30/04/2024
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the	Not Compliant	Orange	30/04/2024

	resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	31/05/2024
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 to time.	Not Compliant	Orange	01/04/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/03/2024
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	31/05/2024