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:	Droimnin Nursing Home
Name of provider:	Droimnin Nursing Home Limited
Address of centre:	Brockley Park, Stradbally, Laois
Type of inspection:	Unannounced
Date of inspection:	05 November 2024
Centre ID:	OSV-0000702
Fieldwork ID:	MON-0038815

About the designated centre

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

Droimnin Nursing Home is a designated centre for older people. The centre has two buildings that are purpose built. The centre provides accommodation for a maximum of 70 male and female residents, over 18 years of age. Residents are admitted on a long-term residential, respite and convalescence basis. The centre is located at the end of a short avenue in from the road and within walking distance to Stradbally, Co Laois. A variety of communal rooms are provided for residents' use including sitting, dining and recreational facilities. Each resident's dependency needs is assessed to ensure their care needs are met.The provider employs a staff team in the centre to meet residents' needs consisting of registered nurses, care assistants, activity, administration, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	60

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 5 November 2024	19:45hrs to 21:45hrs	Sean Ryan	Lead
Wednesday 6 November 2024	09:00hrs to 17:00hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Resident's living in Droimnin Nursing Home told the inspector that the care and support they received was of a very good standard. Residents told the inspector that they 'felt at home' and 'relaxed' living in the centre. Residents described the staff as kind, respectful and 'genuinely interested in caring', and this made residents feel safe in their care.

The inspector arrived unannounced at the centre during the evening time and was met by the nurse in charge. Following a brief introductory meeting, the inspector walked through the centre and spent time talking to residents, visitors and staff, and observing the care provided to residents, and the care environment. A clinical nurse manager and the person in charge arrived at the centre to support the inspection process.

Residents were observed to be comfortable in a variety of communal areas. Some residents were meeting their visitors in the reception area, while other residents were enjoying refreshments in the communal dayrooms. Some residents were seen walking through the corridors. Soft music was playing along the corridors and some residents told the inspector that they liked to listen to the music as they walked around. The inspector spent time talking with residents in their bedrooms and in the communal dayrooms. Visitors were observed spending time with residents in the communal areas observing card games being played.

The inspector spoke with a number of residents who had lived in the centre for many years, and also residents who had recently been admitted to the centre. The feedback from residents was positive with regard to their experience of living in the centre. Two resident told the inspector that they had come to the centre for a short period of time to support their recovery. They described how the attentiveness and kindness of the staff, the quality of the food, and the respect they were afforded to make their own choices had made their overall experience of the centre a positive one. Throughout the evening, it was observed that staff offered choices to the resident throughout the evening, which included preferences for going to bed, food and drink options, and where and how they wished to spend their time.

Overall, residents were complimentary in their feedback about the staff, who they described as 'all very nice and helpful'. Some staff were observed to spend time with residents in communal areas and provide assistance with their evening tea and snacks. Other staff members were observed bringing refreshments to residents in their bedrooms. The inspector overheard polite conversation between staff and residents who spoke about the day's activities they had taken part in.

The inspector observed that the centre was bright, visibly clean, spacious and laid-out to meet the needs of the residents. The centre provided accommodation over two floors and comprised of single bedroom accommodation. Residents told the inspector that they were happy with their bedrooms and comfortable furnishings.

Some residents were provided with additional equipment and aids in their bedroom, such as toileting aids, to support their independence. Residents said that their room was cleaned daily.

On the second day of the inspection, the meal service was observed. Residents were served their lunch in the dining room and in their bedrooms. Residents stated that they were offered a choice at mealtimes and were very complimentary regarding the quality of food provided. Meals were observed to be appetising and well-presented. Residents who required assistance were attended to by staff in a dignified, relaxed and respectful manner.

Throughout the inspection, visitors were observed coming and going. Residents were observed receiving visitors in their bedrooms and in the communal areas. The inspector spoke with visitors throughout the days of inspection and they expressed their satisfaction with the quality of care their relatives received.

Residents stated that they were consulted about the quality of the service frequently and told the inspector that they felt that their feedback was listened to by the staff and management. Residents were also provided with information on the services available to support them. This included independent advocacy, and safeguarding services.

Residents told the inspector that the activities schedule had a variety of activities to suit their individual needs, capabilities and capacities. An activities staff member was observed to facilitate group and one-to-one activities for residents.

The inspector spent time with residents who enjoyed doing their own activities such as art. They expressed how they enjoyed the company of others that shared similar interests but equally enjoyed doing some activities on their own and that this was facilitated by staff. Some residents were unable to verbalise their views on the quality of the service but the inspector observed that they appeared included, content and comfortable in their environment. Residents were complimentary of the activities staff and the efforts they made to ensure that there was a variety of activities to look forward to and keep them occupied on a daily basis.

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

Capacity and capability

This was an unannounced inspection, carried out over two days, 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 address significant issues of non-compliance identified during the last inspection of the centre in May 2024 regarding fire safety.

The findings of this inspection were that the centre had an effective management structure that was responsible and accountable for the provision of safe and quality care to the residents. The inspection found that the provider had progressed their compliance plan to address fire safety risks in the centre and this was due for completion by 31 December 2024. However, this inspection found that some aspects of the management systems in place to oversee complaints, risk and records management were not fully effective. Additionally, the arrangements in place to ensure implementation of care plans designed to safeguard and protect residents from the risk of abuse was not effective.

Drominin Nursing Home Limited, a company consisting of three directors, is the registered provider of Drominin Nursing Home. The organisational structure had remained unchanged since the previous inspection of the centre in May 2024. The centre was supported by a senior management team consisting of management personnel with delegated responsibility for key aspects of the service including clinical and non-clinical operations, human resources, and facilities remained in place. A clinical services director, who was a person participating in the management of the centre, attended the centre on a weekly basis to provide governance and support to the person in charge. Within the centre, the person in charge was supported clinically and administratively by an assistance director of nursing and a clinical nurse manager.

The centre had established management systems in place to monitor the quality and safety of the service provided to residents. Key aspects of the service that included resident falls, restrictive practices, resident assessments and care plan, nutrition and infection prevention and control, were monitored and subject to frequent auditing to identify areas for continuous quality improvement.

The provider had not sustained compliance with regard to the management of records in the centre. While the provider had previously committed to ensuring effective oversight and management of staff roster records, an accurate record of the duty roster worked by staff was not maintained, in line with regulatory requirements. In addition, staff personnel files were incomplete and did not contain the information required by Schedule 2 of the regulations. This included a full and satisfactory history of employment and references. Additionally, records were not maintained in a manner that was accessible. Requests for information and records were required to be repeated throughout the inspection. This included records of meetings, complaints, and staff rosters.

A risk register was maintained to identify, record and manage risks that may impact on the safety and welfare of residents. Risks were generally categorised according to their level of priority and detailed the actions in place to mitigate risks to residents. However, risks that had been assessed by the provider were not always managed in line with the centre's own risk management policy. While potential fire risks were identified, assessed, and controls were developed to mitigate the risk to

residents, the provider had not reviewed the effectiveness of existing risk mitigating controls in the context of revised time lines for completion of all fire safety works. While remedial works had been carried out with regard to the emergency lighting and fire doors, risk assessments had not been reviewed or updated to reflect works completed, and works outstanding.

The management systems in place to respond to complaints did not ensure that complaints and concerns were acted upon in a supportive and effective manner. The record of a complaint regarding the quality of care provided to a resident had not been fully investigated, appropriately reviewed by the personnel responsible for the management of complaints, or escalated to senior management, in line with the centre's own complaints management policy. This impacted on the providers ability to identify contributing factors to deficits in the quality of the service, and resulted in further complaints of a similar nature being made.

A review of the records of adverse incidents involving residents showed that incidents were appropriate documented, investigated, and learning identified to improve the quality and safety of the service provided to residents.

A review of the centre's staffing roster on the day of inspection found that the staffing levels and skill mix were appropriate to meet the assessed health and social care needs of the residents, given the size and layout of the building. There were sufficient numbers of housekeeping, catering and maintenance staff in place.

Staff had access to education and training appropriate to their role and a training schedule was in place. Staff had completed training such as fire safety, safeguarding of vulnerable people and manual handling techniques. Arrangements were in place to supervise staff.

Regulation 15: Staffing

There was sufficient staff with an appropriate skill mix on duty to meet the needs of the current residents, having regard to current occupancy of the centre, and for the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Training records reviewed by the inspector evidenced that all staff had up-to-date training in safeguarding of vulnerable people, fire safety, and manual handling. Staff had also completed training in infection prevention and control.

There were arrangements in place for the ongoing supervision of staff through induction and performance review processes.

Judgment: Compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements. For example;

- Staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations. For example, one staff file did not contain two written references, or evidence of the person's identity including their full name, address, date of birth and a recent photograph. Three staff files did not contain a full employment history, together with a satisfactory history of any gaps in employment.
- Staff rosters were not maintained in line with the requirements of Schedule 4(9), and were not reflective of the actual roster worked by staff.
- Records were not kept in a manner as to be accessible. Repeated requests for records were made throughout the inspection

Judgment: Not compliant

Regulation 23: Governance and management

The roles and responsibilities of the management team were poorly defined. For example, accountability, responsibility and oversight of key aspects of the service such as the management of records were not clear and impacted on regulatory compliance.

Additionally, there were poorly defined systems in place to escalate complaints to the senior management. This impacted on the effectiveness of the complaint management system. For example, concerns regarding the assessment and care provided to a resident had not been fully investigated to establish all contributing factors and to identify opportunities to learning and improving the service.

The management systems in place to monitor the quality of the service were not fully effective to ensure the service provided to residents to residents was safe and effectively monitored. For example;

- There was poor oversight of record management systems to ensure full compliance with the regulations. For example, there was no established system within the centre to ensure staff personnel files were maintained in line with the requirements of the regulations.

- Risk management systems were not effectively implemented to manage risks in the centre. For example, while fire safety risks were identified by the provider, risks were not subject to review to assess the effectiveness of controls in place to manage fire risks in line with the centre's risk management policy.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifiable events, as set out in Schedule 4 of the regulations, were notified to the Chief Inspector of Social Services within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

A review of the complaints register found that complaints were not always managed in line with the requirements of the regulations. For example;

- A record of a complaint did not evidence that an investigation had been carried out into concerns raised regarding the quality of care. For example, the complaint record did not contain an investigation of all aspects of a complainants concerns regarding the quality of care provided to a resident, and the quality of assessments to underpin the provision of person-centred care.
- Records of complaints received by the centre did not consistently detail the outcomes of any investigations into complaints.

Judgment: Not compliant

Quality and safety

Residents were satisfied with the quality of care they received and staff were observed to respond to residents requests for assistance without delay. Residents told the inspector that they felt safe and comfortable living in the centre and that they were satisfied with their access to health care. However, this inspection found that the provider had not taken reasonable measures to ensure that residents were

safeguarded and protected from the risk of abuse, in line with the requirements of the regulations.

The inspector reviewed the arrangements in place in relation to fire safety. A fire safety action plan was in progress at the time of the inspection and was due for completion by 31 December 2024. The provider had progressed to address deficits in relation to emergency lighting, fire doors and installed automatic ventilation to vent smoke in the event of a fire emergency. Staff demonstrated an awareness to the procedure to commence in the event of a fire emergency. Staff participated in fire drill to ensure residents could be safely evacuated from the centre in the event of an emergency.

Residents' needs were assessed on admission to the centre through validated assessment tools in conjunction with information gathered from the resident and, where appropriate, their relative. This information informed the development of person-centred care plans that provided guidance to staff with regard to residents specific care needs and how to meet those needs. Care plans detailed interventions in place to manage identified risks such as those associated with impaired skin integrity, risk of malnutrition, and falls.

Residents were provided with unrestricted access to a general practitioner (GP) as required or requested. Where residents were identified as requiring additional health and social care professional expertise, there was a systems of referral in place. A review of the residents' care records found that recommendations made were implemented and updated into the resident's plan of care.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff spoken with demonstrated an appropriate awareness of their safeguarding training and detailed their responsibility in recognising and responding to allegations of abuse. Procedures were in place for the management of residents' monies, and locked storage was provided for residents' valuables. The provider supported four residents in the centre to manage their pension and welfare payments, in line with best practice guidance. However, the inspector found that where safeguarding plans were developed, the plan was not always fully implemented to ensure residents were adequately protected from the risk.

The person in charge promoted a restraint-free environment. The use of restrictive practices was monitored to ensure that restrictive practices were only initiated after an appropriate risk assessment was completed, and in consultation with the multidisciplinary team and the residents concerned.

Residents stated that they felt at home in the centre, that their privacy and dignity was protected, and that they were free to exercise choice about how to spend their day.

Residents had opportunities to participate in scheduled activities throughout the week. Activities staff were seen to engage with residents and encourage participation in group and individual activities. Residents told the inspector that they enjoyed the activities in the centre.

Resident meetings took place frequently and records indicated a high level of attendance by residents. These meetings provided residents' with opportunities to be consulted about and participate in the organisation of the centre. Residents had access to independent advocacy services.

Regulation 11: Visits

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

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Records demonstrated that individualised care plans were developed following a comprehensive assessment of residents need. Care plans were person-centred and reflected residents' needs, and reflected the supports they required to maximise their quality of life.

Judgment: Compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP), as required or requested.

Residents also had access to a range of allied health care professionals such as physiotherapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of old age, and palliative care.

The recommendations from health and social care professionals were incorporated into the residents care plan.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

A restraint free environment was supported in the centre. Each resident had a full risk assessment completed prior to any use of restrictive practices. Assessments were completed in consultation with the residents and the multidisciplinary team.

Residents who experienced responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were observed to receive care and support from staff that was person-centred, respectful and non-restrictive. Staff were appropriately trained to support residents to manage their responsive behaviours and implement person-centred interventions as detailed in the residents care plan.

Judgment: Compliant

Regulation 8: Protection

The provider had not taken all reasonable measures to ensure residents were protected from the risk of abuse. For example, safeguarding plans designed to protect residents from the risk of abuse were not appropriately implemented. This included actions such as the supervision of staff and the provision of refresher training to staff with regard to recognising and responding to allegations of abuse.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' rights and choice were respected in the centre. Residents detailed the past activity events that had occurred in the centre and contributed to the development of the activity schedule to ensure activities met their interests. Residents who did not participate in group activities were provided with one-to-one time.

Residents said that they were kept informed about changes in the centre through resident forum meetings and daily discussions with staff and felt that their feedback was valued and used to improve the quality of the service. This included discussions about the quality of the food, activities, and services such as laundry.

Residents could enjoy access to communal and private space in the centre where they could receive visitors in private, watch television or listen to the radio without impacting on others around them. Residents were provided with access to religious services in the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Droimnin Nursing Home OSV-0000702

Inspection ID: MON-0038815

Date of inspection: 06/11/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. Following the inspection, a comprehensive review of all staff personnel files was conducted to ensure compliance with Schedule 2 of the regulations. All missing documentation has been obtained, including:
o Two written references that were missing for one staff member, and to include evidence of identity, including full name, address, date of birth, and a recent photograph.
• A complete employment history that was missing for three staff members, including explanations for any gaps.

To prevent recurrence, enhanced recruitment and file-auditing procedures have been implemented. Moving forward, a regular audit schedule will ensure all personnel records remain complete and compliant. A monthly internal audit will be conducted by local management to ensure personnel files are complete and up-to-date and a quarterly audit will be performed by a member of the HR Team to provide additional oversight and ensure adherence to regulatory standards.

In addition, Recruitment processes have been updated to include stricter checks at the point of hiring to ensure all required documentation is collected and verified before employment begins.

2. A detailed review of the rostering process was undertaken to align practices with Schedule 4(9) requirements. Rosters are now maintained to accurately reflect the actual hours worked by all staff members. This includes immediate implementation of daily monitoring mechanisms to verify roster accuracy and ensure that changes to staffing schedules are documented in real time. Additional training has been provided to those responsible for roster management to reinforce compliance expectations.

In addition, and to further strengthen compliance and oversight, we are transitioning to a modernized HR system that will centralize and standardize key processes, including personnel file management, rostering, and record accessibility. This system will enhance

visibility and accountability at both local and senior management levels, providing automated checks and alerts for regulatory compliance. Additionally, the system will support secure and efficient record-keeping, ensuring records are maintained in line with best practices and regulatory requirements.

3. Following the inspection, a full review of the processes for managing and retrieving records was completed. Records are now organized and maintained in a manner that ensures timely and efficient accessibility. Staff have been briefed on the importance of record management and retrieval procedures to meet both operational and regulatory expectations. This will prevent unnecessary delays and repeated requests for documentation during future inspections or internal audits.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The responsibility for the management of records is a shared responsibility among all staff, with ultimate accountability resting with the Person In Charge. The PIC will oversee the implementation and maintenance of effective record management systems to ensure compliance with Schedule 2 and other regulatory requirements.
The PIC will be supported by:
o Frequent audits conducted by local management to ensure compliance and identify any deficiencies.
o The SMT will provide guidance and additional oversight as required to support the PIC in fulfilling this responsibility.

2. Following the inspection, a full review of the complaints process was completed to address identified gaps. This is detailed in full under Regulation 34, Complaints and in summary the following actions have been taken:
o All complaints will be dealt with promptly and in line with the centre's Complaints Policy.
o Weekly oversight by the Senior Management Team member will ensure thorough investigation and resolution.
o Complaints will not be closed until all issues have been addressed and reviewed.

3. Record management systems have been strengthened, with measures to ensure that staff personnel files comply fully with regulatory requirements. This is detailed in further under Regulation 21, Records.

4. The centre's risk management policy has been reviewed and updated to include clearer procedures for reviewing identified risks. A dedicated fire safety risk review schedule has been established to ensure all fire safety controls are effective and

reviewed regularly. Findings from risk reviews will be documented and addressed during monthly management meetings.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Following the Inspection, a gap analysis was conducted, and corrective measures have been implemented to ensure all complaints are managed in accordance with the centre's Complaints Management Policy. Key actions to include:
1. All complaints will be managed in line with the centre's policy and monitored through the home's Complaints Management System.
2. Each complaint will be fully documented to include the investigation process, outcome, identified learnings, and resolution. This ensures all concerns are addressed comprehensively and transparently.
3. All complaints will be investigated and resolved within the scheduled timeframes, with outcomes clearly communicated to complainants.
4. To enhance transparency, the Senior Management Team will review and approve all complaints before they are closed.
5. All staff will complete Effective Complaint Handling training by 15/12/2024.
6. The local Management Team will complete Effective Complaint Investigation training by 11/12/2024.
7. The Group Clinical and Services Director will provide additional Group Training on effective complaint management for all Person In charge and Assistant Person In charge by 13/12/2024.

These measures ensure all complaints are handled efficiently, with outcomes clearly documented and learnings integrated to improve practices and maintain compliance with regulatory requirements.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All safeguarding plans have been reviewed to ensure they are robust, actionable, and tailored to individual residents' needs. Measures going forward will include specific actions for staff supervision (where required) and clear protocols for monitoring adherence to these plans.

All staff have completed online safeguarding refresher training since the Inspection,

focusing on recognising and responding to allegations of abuse. This will be supported and enhanced with onsite specific Safeguarding Training and will be completed by January 31st 2025. Training records will be monitored through the centre's training management system to ensure compliance and timely completion.

Any allegations of abuse will trigger immediate investigation in accordance with the centre's safeguarding policy. A designated safeguarding officer will oversee the implementation of immediate protective measures, such as adjusting staff duties or resident care plans, as necessary.

A safeguarding compliance audit will be conducted monthly to assess the effectiveness of implemented safeguarding plans and staff adherence. Audit outcomes will be reviewed by the Senior Management Team and actions will be taken to address any gaps that may be identified.

The Person In charge and Assistant Person In charge will receive training on safeguarding investigations by December 13th to enhance their oversight capabilities. In addition to the above, The SMT will conduct quarterly reviews of safeguarding measures/practices to ensure continuous improvement and alignment with best practices and regulations.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	29/11/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	22/11/2024
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 details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	29/11/2024

Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	29/11/2024
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	15/12/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	06/12/2024
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.	Substantially Compliant	Yellow	31/01/2025