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:	Esker Ri Nursing Home
Name of provider:	Blackden Limited
Address of centre:	Kilnabin, Clara, Offaly
Type of inspection:	Unannounced
Date of inspection:	01 October 2024
Centre ID:	OSV-0000733
Fieldwork ID:	MON-0038093

About the designated centre

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

Esker Ri Nursing Home is a purpose-built premises. The designated centre is situated on an elevated site off the Tullamore road on the way out of the village of Clara. The designated centre currently provides accommodation for a maximum of 143 male and female residents aged over 18 years of age. Residents' accommodation is provider on three floors. Residents are accommodated in single and twin bedrooms with full en suite facilities. The designated centre provides mainly residential care to older adults and also provides respite, convalescence and care for people with an intellectual disability, physical disability, acquired brain injury, dementia and palliative care needs. The provider employs a staff team consisting of registered nurses, care assistants, activity coordination staff, administration, maintenance, housekeeping and catering staff. The provider states in their statement of purpose for the designated centre that their aim is to provide a residential setting wherein residents are cared for, supported and valued within a care environment that promotes their health and well being.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	114

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 1 October 2024	10:00hrs to 17:30hrs	Sean Ryan	Lead
Tuesday 1 October 2024	10:00hrs to 17:30hrs	Una Fitzgerald	Support

What residents told us and what inspectors observed

Residents spoken with expressed a good level of satisfaction with the care provided in Esker Ri Nursing Home. The residents reported that the staff were very kind and that they treated them with patience, compassion and respect. A lot of good practice was observed during the inspection, with progress towards regulatory compliance across the majority of regulations reviewed. Based on the observations of the inspectors, and from speaking with residents, it was clear that the staff providing direct care were committed to providing person-centred care to residents. Residents voiced dissatisfaction with two aspects of the service with respect to the their call bell access and the food choices on offer.

Esker Ri Nursing Home is a three-storey premises. On the day of the inspection, there was 114 residents living in the centre. On arrival to the centre, the inspectors were met by the person in charge and a newly appointed general manager. Following an introductory meeting, the inspectors spent time meeting with residents and staff. There was a friendly and homely atmosphere in the centre. The main entrance foyer area was a large open space. This area was a hub of activity throughout the day. Many residents were observed to sit in this area chatting with other residents, sitting reading their newspaper and in many cases just watching the coming and goings of other residents and staff. In addition, this area had a reception desk. Inspectors observed multiple occasions where the residents utilised this staffed desk to clarify queries and have a chat with staff in the vicinity. Inspectors observed that staff greeted residents by name as they passed which added to the friendly, relaxed atmosphere.

Inspectors spoke with a number of residents in their bedrooms, and in the communal areas. Residents told inspectors that the staffing had become more consistent in recent months. Some residents and visitors attributed this to a change in management personnel. Residents described how they were familiar with the staff that supported them with their care needs and this made them feel safe in their care. Some residents told the inspector that they occasionally experienced delays receiving assistance from staff through using their call bell. Other residents reported that the call bell was not always placed in close proximity to them and they would have to call out for assistance.

Residents who spoke with inspectors said that they were satisfied with the layout and size of their bedrooms and that they had sufficient storage for their belongings. Residents were supported to personalise their bedrooms with ornaments and items of importance to them.

Inspectors observed the resident's dining experience and saw that there were adequate staff available to assist residents with their nutritional care needs. Some residents chose to have their meals in their bedrooms and staff were observed delivering their meals to their bedrooms. Staff were knowledgeable regarding residents individual food preferences and therapeutic and modified consistency diets

that some residents were prescribed. However, residents were consistent in their feedback about the quality of the food and expressed discontent with their food choices at mealtimes. Residents told the inspectors that there was limited choice of foods, and that chicken was on the menu every day. Residents told inspectors that they had raised their concerns on multiple occasions but could not see any improvement and therefore felt that they were not being listened to.

A programme of activities was available to residents, which was carried out by a team of activity staff with the support of health care staff. Throughout the day of the inspection, residents were observed engaging in a number of different activities. A live music session was held on the afternoon of the inspection. The activity was attended by a large gathering of residents and multiple visitors. Those in attendance were observed to be enjoying the event. Residents happily participated by singing along. Staff were observed to actively encourage residents to engage with the session. For example, residents that were able, were supported to enjoy a waltz to the music.

Residents' rights were promoted in the centre and residents were encouraged to maximise their independence with support from staff. Arrangements were in place for residents to meet with the management to provide feedback on the quality of the service they received. Residents spoken with were aware of the recent changes in the management of the centre and told the inspectors that they were satisfied with the communication received.

Visitors attending the centre throughout the day of the inspection were welcomed by staff. Residents and visitors were satisfied with the visiting arrangements in place. They confirmed that these arrangements were flexible. Residents said that they could spend time with visitors in communal areas or in the privacy of their bedroom. A number of visitors who spoke with the inspectors felt that their loved ones were well cared for in the nursing home and that they were kept up to date with any important changes to their care needs.

The next two sections of the report present the findings of this inspection in relation to capacity and capability of the provider, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection, carried out over one day, by inspectors 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). Inspectors followed up on the actions taken by the provider to address issues identified on previous inspections dating back to June 2023 which had resulted in a restrictive condition stopping admissions to the designated centre since July 2024.

The findings of this inspection were that the provider had established an

organisational structure to support their governance and oversight of the quality and safety of the service provided to residents. This was evidenced through progress towards regulatory compliance identified in key regulations that underpin the provision of safe and effective care to residents. However, while the provider had systems in place to monitor the quality and safety of the service provided, these systems were not fully established, particularly in relation to the management of risk, and the management of records. Inspectors found that accountability and responsibility for the aforementioned aspects of the service were not fully defined and this impacted on achieving full regulatory compliance.

On this inspection, inspectors reviewed unsolicited information received by the office of the Chief Inspector. The information received pertained to concerns regarding the management of complaints, the management of falls, and the supervision of staff to ensure residents care needs were met in a timely manner. This information was found to be partially substantiated on this inspection.

Blackden Limited is the registered provider of Esker Rí Nursing Home. It is a company consisting of two directors, one of whom represents the registered provider. The organisational structure, had changed since the previous inspection, through the appointment of a new person in charge and a general manager who was a person participating in the management of the centre. The general manager was responsible for monitoring clinical and operational aspects of the service, in addition to providing governance and support to the person in charge through their full-time presence in the centre. Within the centre, the person in charge was supported clinically and administratively by an assistant director of nursing, a team of clinical nurse managers and a health care assistant manager. This structure was found to have a positive impact on the oversight and supervision of the care provided to residents.

Staff were provided with information pertinent to providing safe, person-centred, and effective care to residents through revised systems of communication. There was evidence of effective communication with staff to ensure staff had the appropriate knowledge with regard to potential risks to resident's care and welfare, and the actions to be implemented to mitigate risk to residents. Staff attended a structured clinical handover, where detailed information to support the provision of person-centred and safe care to residents was discussed. For example, staff were informed of residents health status and changes to their individual care needs on a daily basis and this information was updated daily on a structured clinical handover document. This system was found to be effective to ensure the continuity of care provided to residents.

The provider had implemented management systems to monitor aspects of the quality of the service. Key clinical indicators with regard to the quality of care provided to residents were collated on a weekly basis. This included the incidence of wounds, adverse incidents, nutritional care, resident health care reviews, and resident transfers to hospital. This information was reviewed by the management personnel to identify deficits in the quality of the service, and improvement actions delegated to the nurse management team to ensure the appropriate policy, procedure, and care pathways were implemented. For example, where resident

weight loss was identified, the nurse management team were required to ensure nutritional monitoring was in place, an appropriate care plan was developed, and referrals for further expert assessment were made within a specified time frame. This process was also implemented in other areas such as the management of wounds, and adverse incidents involving residents.

There was a schedule of auditing being developed to monitor care delivery and to identify areas of quality improvement and learning. This included audits of the quality of clinical care records and call bell response times. Inspectors found that these management systems facilitated the oversight of some aspects of the service, resulting in improved outcomes for residents. For example, information collected from each unit in the centre in relation to residents falls was analysed, resulting in trends being identified and appropriate action being taken to address falls risks, and improve care delivery following a fall.

There was a risk management policy in place that detailed the process to identify and manage clinical and environmental risks within the centre. While there was a system in place to record and monitor risks in a register, inspectors found that the risk management system was not robust and resulted in inconsistent recording and review of risks that may impact on the safety and welfare of residents. There were two risk registers in operation, and the management personnel were unclear on which system to use. The lack of clear direction to management personnel on the appropriate risk management system to record risks impacted on timely assessment of risks, and thus delayed identification of actions to appropriately manage risks. For example, the risk associated with the malfunction of a passenger lift, and the impact on residents accessing the first and second floor of the premises, had not been reviewed or updated following an incident in the centre. In addition, risks that had been assessed by the provider were not always managed in line with the centre's own risk management policy. For example, risks had not reviewed or updated since February 2024, to assess the effectiveness of the controls in place.

Records required to be maintained in respect of Schedule 2, 3 and 4 of the regulations were made available for review. Staff personnel files contained all the information required under Schedule 2 of the regulations. However, inspectors found that some records were not maintained in line with the requirements of the regulations, as they were incomplete. This included records pertaining to the directory of residents, and some adverse incidents involving residents.

A centre-specific complaints policy detailed the procedure in relation to making a complaint and set out the time-line for complaints to be responded to, and the key personnel involved in the management of complaints. The complaints procedure was displayed in the centre and residents and staff were aware of the procedure. A review of the record of complaints found that while complaints were documented, the process of the management of some complaints was not always completed. For example, a number of complaints did not have the outcome of an investigation documented, or details of the action taken on receipt of a complaint. Additionally, the system in place to recognise and respond to complaints did not ensure that complaints and concerns were acted upon in a timely manner. Complaints regarding the quality of aspects of the service contained in survey forms and from resident

meetings were not identified or managed in line with the centre's own complaints policy and procedure.

Inspectors found that policies and procedures, as required by Schedule 5 of the regulations, were in place. Care practices observed were underpinned by policies and procedures that were informed by best practice guidelines and regulations. Staff were familiar with the Schedule 5 policies and referenced these documents as additional supports and guidance in the provision of safe and effective care to residents. This is a completed action from previous inspections.

The centre had adequate staffing resources available to ensure resident's care and support needs were met. On the day of the inspection, there were sufficient numbers of qualified staff available to support residents' assessed needs.

A review of staff training records evidenced that all staff had up-to-date training, pertinent to providing residents with safe quality care. Staff demonstrated an awareness of their training with regard to the safeguarding of vulnerable people, supporting residents living with dementia, and fire precautions. Staff demonstrated an awareness of the procedures to commence in the event of a missing person and fire safety. Additional training had been provided to staff in the areas of clinical assessment of residents, early warning signs of the deteriorating resident, and incident management. Staff were appropriately supervised and supported by the management team.

Regulation 15: Staffing

On the day of inspection, the staffing numbers and skill mix were appropriate to meet the needs of residents in line with the statement of purpose. There was sufficient nursing staff on duty at all times, and they were supported by a team of health care staff. The staffing compliment also included catering, housekeeping, administrative and management staff.

Judgment: Compliant

Regulation 16: Training and staff development

Training records reviewed evidenced that all staff had up-to-date training in safeguarding of vulnerable people, fire safety, and manual handling. Staff had also completed additional training to support the provision of safe and person-centred care to residents.

There were arrangements in place for the ongoing supervision of staff through senior management presence, and through formal 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 fully in line with the regulatory requirements. For example;

- The directory of residents was not maintained in line with the requirements of Schedule 3. Information regarding the sex of each resident, and some resident transfers and discharges from the centre were consistently recorded.
- Some records of adverse incidents involving residents were not documented in line with the requirements of Schedule 3 of the regulations. For example, incident records in which a resident may have suffered harm did not consistently detail if medical treatment was required, the care provided, or the results of any action taken in response to the incident.
- Records of all complaints were not always documented in line with the requirements of Schedule 4 of the regulations. For example, complaints regarding the operation of the centre were not appropriately documented, or the action taken by the registered provider in respect of any such complaint.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had not ensured there was a fully defined management structure in place, with clear lines of accountability and responsibility. For example, it was unclear who held overall accountability and responsibility for key aspects of the service that included the management of risk and the oversight of records. This resulted in ineffective action been taken to fully address risks and deficits in those areas.

The overall governance and management of the centre, while much improved, was not yet fully effective. Management systems were not sufficiently robust to ensure the service was safe, appropriate, consistent and effectively monitored. For example,

- There was poor oversight of the complaints management system to ensure the quality of care of residents were monitored, reviewed and improved on an ongoing basis. For example, issues of concern in relation to the quality and quantity of food and residents care needs not being met in a timely manner, had been brought to the attention of the management team but

were not documented and managed within the centre's complaints register. Consequently, no action had been taken to resolve the issues. This also meant that there was no record of how these issues were acknowledged, investigated or resolved to the satisfaction of the complainant.
- Risk management systems were not effectively implemented to manage risks in the centre. Risks that had been assessed by the provider were not managed in line with the centre's own risk management policy. This was indicative of a lack of clear procedures and processes to underpin a safe and effective management system.
- There was ineffective record management systems were in place to ensure regulatory compliance.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The required policies and procedures were in place in line with the requirements of Schedule 5 of the regulation. Policies were up-to-date and were in the process of being updated by the management personnel on a phased basis and updated communicated to staff.

Policies and procedures were accessible to all staff and provided appropriate guidance and support on the provision of safe and effective care to the residents.

Judgment: Compliant

Quality and safety

The inspectors found that residents living in the designated centre received a high standard of direct care. Inspectors found improvements in the quality and safety of the service as a consequence of the provider's actions with regard to the management and oversight systems described in the capacity and capability section of this report. The impact of such actions were evidence in the positive feedback from residents with regard to the quality of the direct care they received and their access to medical and health care. However, the provider had not ensured that resident's rights were fully upheld through ensuring residents could exercise choice, and effectively participate in the organisation of the service.

Residents clinical care records were maintained on an electronic record systems and staff were observed to be proficient in navigating the system. Information requested was presented without delay. A sample of residents' records were reviewed by the inspectors. Residents' care plans and daily nursing notes were recorded. Overall,

care plans were underpinned by validated assessment tools to identify potential risks to residents such as impaired skin integrity and malnutrition. Care plans were person-centered and guided care. Inspectors reviewed resident records in relation the management of resident care needs specific to falls management, skin integrity and nutritional care needs. Care plans were detailed and guided the care to be provided. For example, resident's skin integrity and the management of wounds were appropriately assessed to inform skin integrity care plans. Records evidenced that the implementation of care plans had resulted in the healing of wounds.

Inspectors reviewed residents files in relation to the transfer of residents to and from the centre. A full review of the systems in place had been completed. Education sessions had been delivered and all staff were knowledgeable of the new documentation in place to ensure that all appropriate information was communicated to the receiving place of care. In addition, inspectors found that when residents returned to the centre, a reassessment of their needs was completed, advice received in relation to the changing care needs of the resident were implemented, and care plans were updated with relevant information.

Residents were reviewed by a medical practitioner, as required or requested. Referral systems were in place to ensure residents had timely access to health and social care professionals for additional professional expertise. There was clear evidence that recommendations made by allied health care professionals was implemented which had a positive impact on a resident's overall health.

Residents had access to advocacy services and information regarding their rights. Residents were supported to engage in activities that aligned with their interests and capabilities. There was a number of information notice boards strategically placed along corridors.

Residents were complimentary of the care provided by staff and reported that they felt safe and comfortable in their care. This was supported by the observations of the inspectors who observed a number of positive interactions between staff and residents.

While residents were consulted about their care needs and the overall quality of the service, through schedule resident forum meetings, residents told the inspector that they did not always receive an outcome or response to issues raised at resident meetings.

Regulation 25: Temporary absence or discharge of residents

Transfer letters to and from the centre were available. This information was reviewed which meant that the most relevant information was provided in accordance with the residents care needs.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plan documentation was available for each resident in the centre. All care plans reviewed were updated regularly and contained detailed information specific to the individual needs of the residents. Comprehensive assessments were completed and informed the care plans.

The care plans reviewed were person-centred, and reflected residents' needs and the interventions in place to manage identified risks such as those associated with impaired skin integrity, risk of falls and risk of malnutrition. There was sufficient information to guide the staff in the provision of health and social care to residents based on residents individual needs and preferences.

Judgment: Compliant

Regulation 6: Health care

Residents were provided with timely access to medical care as necessary. Arrangements were in place for residents to access general practitioner service.

Residents were provided with timely access to a range of health and social care professionals. This included physiotherapy, dietitian services, speech and language therapy, tissue viability nurse, psychiatry of old age, and palliative care.

Judgment: Compliant

Regulation 9: Residents' rights

While residents meetings were scheduled and documented, and residents were offered an opportunity to complete surveys on the quality of the service they received, the feedback from meetings and surveys were not acknowledged or responded to. For example, residents had voiced dissatisfaction regarding the quality of the food and food choices since March 2024. Residents had not received a response to their feedback and the issues were raised again in September 2024.

Judgment: Substantially 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	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Esker Ri Nursing Home OSV-0000733

Inspection ID: MON-0038093

Date of inspection: 01/10/2024

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The PIC conducted a full review of the resident directory to update missing information, such as the sex of each resident and details of transfers and discharges. This brought the directory into full compliance with regulatory standards, ensuring all the necessary information is now complete and accurate. Timeframe: Complete To maintain accountability, specific staff members have been assigned the responsibility to update the Centres Resident's register consistently and in line with regulatory requirements. This clear accountability structure aims to sustain compliance in record management. Timeframe: Complete The Person in Charge has been assigned sole responsibility for overseeing and closing off all incidents. The PIC will ensure that each incident report will include a detailed account of the incident, the medical response provided, and any follow-up care provided. Additionally, the PIC will document the lessons learned, disseminate this information to staff to support collective learning and outline the measures taken to prevent similar incidents in the future. After closing each incident, the PIC will review and update the risk register to effectively manage risks and detect potential issues promptly. Timeframe: Complete A robust complaints management process has been implemented. This procedure ensures that all complaints are accurately documented, outlining an accurate & concise summary of the concern raised. Each complaint is investigated by the complains officer and the investigation actions will be clearly outlined. The outcome of the investigation is shared with the complainant and their level of satisfaction determined. The complainant in each instance is advised of the appeal process. This systematic approach to handling complaints will be regularly monitored to maintain ongoing compliance. This systematic approach will be audited monthly to maintain ongoing compliance. Timeframe: 30/10/'24	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A detailed review of the risk register was conducted to identify gaps in its implementation. The Risk Management Officer, the Person in charge, will analyse Clinical Risks, develop action plans for improvement activities within the centre, update the register and put the necessary mitigation measures in place.
Timeframe: Complete
The risk register clearly outlines the risk identified, the person responsible for the risk, the likelihood, impact and rating of the risk and a summary of the controls and planned actions in place to further reduce the risk.
Timeframe: Complete
The Person in Charge will maintain a comprehensive complaint's register. A robust complaints management process has been implemented. This procedure ensures that all complaints are accurately documented, outlining an accurate & concise summary of the concern raised. Each complaint is investigated by the complaints officer and the investigation actions will be clearly outlined. Monthly audits of the complaints register will be conducted to identify trends, with findings reviewed by senior management to ensure compliance with the centres Policy.
Timeframe: Complete
Clear accountability has been established, with designated staff members assigned to maintain important records like the resident directory, complaints register, and risk assessment in the risk register. Monthly audits of these records will be conducted to ensure compliance, and these findings will be shared with management to promptly address any issues.
Timeframe: Complete
To maintain ongoing improvements, the GM and PIC only, will analyse future satisfaction surveys and review feedback to identify recurring themes or new concerns. An action plan will be compiled following this review to address any matters that require attention. Short-term residents will be provided with feedback Surveys during their stay to gather their insights on the services received.
Timeframe: 30.11.2024

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A food quality survey will be conducted with residents from all areas. The feedback will be analysed by the Health care assistant Manager and the Person in Charge (PIC) to identify areas for improvement.

Timeframe: Complete
A collaborative meeting will be scheduled with the residents and the head chef, to facilitate the residents to directly share their suggestions on how the mealtime service and experience could be further enhanced. This meeting will give the chef a clear understanding of the resident's food preferences and their specified requests.
Timeframe: Complete
As a result of this feedback, the management team plan to amend the menu within the centre so it aligns with the resident's expressed preferences. The head Chef, PIC, General manager, and a dietitian will work together to finalize this menu. The goal is to systematically address the residents' requests and ensure the menu will meet the resident's expectations and their nutritional requirements.
Timeframe: 08/11/'24

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.	Substantially Compliant	Yellow	30/10/2024
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	02/10/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service	Substantially Compliant	Yellow	30/11/2024

	provided is safe, appropriate, consistent and effectively monitored.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	08/11/2024
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	03/10/2024