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:	Loughshinny Residential Home
Name of provider:	Bartra Opco No. 1 Limited
Address of centre:	Blackland, Ballykea, Loughshinny, Skerries, Co. Dublin
Type of inspection:	Announced
Date of inspection:	17 July 2024
Centre ID:	OSV-0006616
Fieldwork ID:	MON-0037342

About the designated centre

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

Loughshinny Residential Home is a designated centre registered to provide 24-hour health and social care for up to 126 male and female residents, usually over the age of 65. It provides long-term residential care, convalescence and respite care to people with all dependency levels and varied needs associated with ageing, physical frailty as well as palliative and dementia care. The philosophy of care as described in the statement of purpose is to provide a person-centred, caring and safe alternative for older people and to enable each resident to maintain their independence and thrive while enjoying a more fulfilled and engaged life. The designated centre is a modern two-storey purpose-built nursing home on the edge of the village of Loughshinny in North County Dublin. Accommodation is provided in 124 single and one twin bedroom, each with its own en-suite facilities and decorated to a high specification standard. There is a wide range of communal areas, including dining rooms, sun rooms and lounges available to residents, as well as a hairdresser facility. There are several enclosed, safe, wheelchair accessible gardens available for residents to use during the day. There is ample parking available for visitors.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	110

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
Wednesday 17 July 2024	09:00hrs to 18:20hrs	Aislinn Kenny	Lead
Wednesday 17 July 2024	09:00hrs to 18:20hrs	Niamh Moore	Support

What residents told us and what inspectors observed

From what residents said and from what inspectors observed, residents were happy with the care and services that they received from the dedicated staff team within Loughshinny Residential Home. Comments from residents included "I am happy about everything here", "I don't think you would get anywhere nicer than what we have here" and that the staff were "patient and kind". These comments echoed inspectors observations where many positive interactions were seen throughout the day between staff and residents, leading to a calm, relaxed and homely atmosphere in the centre.

The centre was newly built and opened in 2019, it was bright, warm and nicely decorated. It is laid out over two floors with residents' bedrooms and communal areas on both the ground and first floors. The centre is divided into four units, referred to as St Patricks 1, St Patricks 2, Shennick and Colt. Each unit had separate day and dining facilities and additionally there were other communal spaces available. These areas were seen to be utilised throughout the inspection including a coffee dock where many residents and their visitors spent time together.

The design and layout of the centre supported the free movement of residents with wide corridors and access to secure garden areas. Some areas had pin codes, however there was details of the codes available and on display to ensure visitors and residents could access as required. Inspectors saw one dining room which had swipe access and were told this room was locked due to the proximity to the kitchen. Some staff and residents spoken with also said this dining room is only open at mealtimes. Management on the day provided assurances that this room is only closed during cleaning. While windows had window restrictions in place on the ground and first floor, many of these restrictions could be easily unlatched, which meant the window could be opened fully. This was an important safety consideration as there had been two incidents where residents had attempted to climb out the window. Inspectors saw records that the provider had identified this risk, had ordered replacements and were told that the provider was awaiting delivery of same

Inspectors noted inappropriate practices during the premises walk-around and at lunch-time where doors such internal doors to dining rooms, communal rooms and an external store in a staff area were propped open with items such as chairs. Management explained to inspectors that this practice was something they were aware of and it was due to these doors not having self-closure devices fitted. This posed a safety risk in the event of fire and assurance was requested that this would be addressed and inspectors acknowledged that by the end of the inspection no doors were seen to be held open with furniture. Residents' bedroom accommodation comprised of 124 single and one twin room, all with en-suite facilities. Inspectors viewed some bedrooms and saw that they were bright, spacious and well laid out with sufficient storage space for belongings. Residents were supported to personalise their bedrooms, with family photographs and personal items, to help

them feel more at home. Some bedrooms also had decorations such as balloons and banners from recent birthday celebrations.

Inspectors reviewed the questionnaires completed by residents or their family members as part of this announced inspection. A total of five questionnaires were completed. Overall the feedback was positive with comments such as "I am very pleased with the staff", "I feel very safe", "staff are so good", "staff listen to me" and "we as a family are very happy with the care Mam has been receiving". However, there were some areas that residents would like improvements on, with one resident stating that while initially their complaint about the laundry service was addressed, the issue had reoccurred with items going missing and one resident reported to be unhappy with the food taste and portion size.

Inspectors observed many occasions where residents' rights were upheld within the centre. Advocacy services were available to residents. There were two activity coordinators working on the day of the inspection. There was an activity schedule available to outline what activities were available each day. Inspectors observed hand massage, chair exercises and bingo to be held on the day of inspection, facilitated by the activity staff and external service providers. Many residents reported to enjoy the activities on offer including Mass, art, music and walks on the grounds. One resident reported they would like to have more outings.

Residents could choose to dine in any of the dining rooms or in their bedrooms. Menus on display detailed there was a choice of food available for each meal, including hot options at breakfast, lunch-time and tea-time. Inspectors observed that residents were offered snacks and drinks throughout the day. The lunch time service was reviewed on the day of the inspection and residents were complimentary of the food provided to them. However, inspectors observed one resident who returned their served meal as it was not their preferred choice of meal. Staff quickly responded to the resident, however there was no availability of the residents' preference and an alternative option was offered, which again following delivery was not in line with the resident's preferences.

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

Capacity and capability

Overall, there was a well established governance and management team in place in the centre who were focused on ongoing quality improvement to enhance the daily lives of residents. The inspectors found that residents were receiving good service from a responsive team of staff delivering a good standard of care and support. Notwithstanding, further oversight was required to review staff practices regarding

fire safety precautions as fire doors were observed propped open throughout the day of the inspection.

This was an announced inspection conducted over one day to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. This inspection also followed up on the compliance plan from the last inspection in November 2023.

Bartra Opco No 1. Limited is the registered provider for Loughshinny Residential Home. The company has two directors, one of whom is the named provider representative. There were clearly defined roles and responsibilities and a robust management structure in place. There was a governance structure in place which identified clear lines of accountability and responsibility. The person in charge worked full-time in the centre and was supported in their management role by an assistant director of nursing and four clinical nurse managers. Other staff members included nurses, healthcare assistants, activity coordinators, catering, household, maintenance and administration staff. On the day of inspection the assistant director of nursing was deputising for the director of nursing and was supported by a member of the senior management team, who was a nominated person participating in the management of the centre.

There were sufficient resources in place in the centre to ensure the effective delivery of high-quality care and support to residents. Staff were supported to attend mandatory training such as fire safety, manual handling and safeguarding vulnerable adults from abuse. Some staff were awaiting refresher fire safety training however, a training plan was developed for the coming months to ensure that staff were up-to-date with their training and inspectors could see there was upcoming training scheduled in this area.

The inspectors saw that systems were in place to manage risks associated with the quality of care and the safety of the residents. The senior management team was kept informed about the performance of the service with a comprehensive auditing programme which was reviewed at regular intervals and had identified areas where improvements in practice were required, with improvement action plans in place. Notwithstanding the management systems in place, some further action was required to ensure all management systems were effective as discussed further in the report.

Regular meetings were held such as clinical and non-clinical operations including governance meetings, clinical management meetings, staff meetings and housekeeping meetings. An annual review of the quality and safety of care delivered to residents in 2023 was completed.

The inspectors reviewed a sample of staff files and found that all of the information required under Schedule 2 of the regulations was available. There was evidence that each staff member had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021.

A record of accidents and incidents was maintained in the centre. Notifiable incidents, as detailed under Schedule 4 of the regulations, were notified to the Chief

Inspector of Social Services within the required time-frame. However, a sample of incidents on record were found to be vague and the information provided was not specific enough to ascertain if further intervention was required. It is acknowledged that at the end of the inspection the management team committed to a more comprehensive analysis of incidents.

Regulation 15: Staffing

There was an appropriate number and skill mix of staff relating to the assessed needs of the residents and the size and layout of the designated centre. There was at least one registered nurses on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Mandatory training provided to staff was up-to-date and there was a training plan in place for further refresher training to ensure that staff maintained sufficient knowledge for their roles.

Judgment: Compliant

Regulation 21: Records

Inspectors reviewed a sample of five staff files and found that they contained the required information outlined in Schedule 2.

Judgment: Compliant

Regulation 23: Governance and management

While there were management systems in place action was required to strengthen the oversight of quality and safety to ensure that the service was safe, appropriate, consistent and effectively monitored. For example;

Fire safety practices required review to ensure the daily safety checks were

effectively monitored as they did not pick up on the findings relating to the fire doors under Regulation 28: Fire Precautions.

A review and analysis of the incident log was required to ensure incidents were being detailed sufficiently to effectively inform investigations and learning for example;

Inspectors reviewed the incident log where there was an incident between two residents. While it is acknowledged that the safety of both residents was immediately ensured, the registered provider's policy was not followed at the investigation stage to ensure all relevant information was taken into account. The inspectors were not assured that the review into this incident was sufficiently robust to ensure all information had been obtained and residents were protected from abuse.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifications to the Chief Inspector were submitted in accordance with regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

Residents spoken with were aware how to raise a complaint. The complaints log was reviewed and further evidence provided following the inspection was that complaints were recorded in line with the regulations.

Judgment: Compliant

Quality and safety

Inspectors found that the residents living in this designated centre received good clinical care. Residents' rights were upheld with opportunities for social engagement available. Staff were seen to know residents' needs and preferences well, and interactions were kind and respectful. Some improvements were required to ensure a safe and high quality service for all residents, particularly in the areas of restrictive

practice and fire safety.

Inspectors reviewed a sample of care records, validated assessment tools and care plans. Each resident had a pre-assessment carried out prior to admission. Residents had access to a general practitioner (GP) who visited the centre twice a week. Referrals were made to health and social care practitioners, such as dietitians, speech and language therapists and tissue viability nurses, for when such services were required. Inspectors were told that eligible residents were facilitated to access the services of the national screening programme as required.

The registered provider had a policy available to guide staff on restraint use. A restraints register recorded the restraints in place during the inspection. This register was reviewed on a monthly basis by the management team. From a sample of records reviewed there were risk assessments, care plans and consent in place on the use of the relevant restraints. There was also evidence of safety checks being completed when bed rails were in use. Care plans seen on bedrails clearly documented alternatives trialled. However, this information was not seen for all restraint use. This is further discussed under Regulation 7: Managing behaviour that is challenging.

The registered provider had a safeguarding policy in place and staff received online and in-person training on safeguarding vulnerable adults. Examples were seen where the provider's safeguarding policy was implemented, through internal investigations and referrals to the National Safeguarding team.

Residents living in the centre had appropriate access to, and maintained control over their personal possessions.

The centre had a fire safety policy in place and there was evidence of fire drills taking place. The inspectors were informed by the management team that a fire safety risk assessment was due to take place in the centre. Nevertheless, improvement in fire safety practices was required as discussed under the relevant regulation.

Residents were assessed for the risk of malnutrition and care plans were developed to guide staff regarding each resident's needs. Support was available through speech and language therapists and dietitian for residents who required specialist assessment with regard to their dietary needs. Residents were seen to have a supply of fresh drinking water in communal areas and individual bedrooms. There was access to adequate quantities of food with set meal times and additional refreshments available throughout the day. Choice was offered at mealtimes including for any special dietary requirements. Feedback from residents was that the food was good, with positive feedback received from many residents, however, as detailed earlier in the report one residents' choice and preferences were not fully met on the day of the inspection.

Regulation 12: Personal possessions

The person in charge had ensured that residents had access to and retained control over their personal property. Residents told inspectors that they were afforded the opportunity to lock their bedroom door to protect their property. Inspectors observed residents had adequate space within their rooms to store and maintain their clothes and there was lockable storage available. Laundry was completed by an external service provider and overall residents reported to be happy with this service.

Judgment: Compliant

Regulation 18: Food and nutrition

There were adequate numbers of staff on the day of inspection available to assist residents with their nutritional intake. Residents who required assistance were seen to be assisted with their meals in a respectful and dignified manner. Menus were on display in dining rooms including in written and pictorial formats. Inspectors observed that residents were provided with adequate quantities of food and drink which were seen to be wholesome and nutritious.

Judgment: Compliant

Regulation 28: Fire precautions

Action was required by the provider to ensure they made adequate arrangements for containment of fire and to bring the centre into compliance with Regulation 28: Fire Precautions, for example;

The inspectors observed poor staff practices with chairs being used to hold three fire doors opened. In the event of a fire these doors would be ineffective at containing smoke and fire. Inspectors observed there were no automatic door closure devices on these doors or on a number of doors in the centre. This required review and mitigating measures in place.

Fire doors on either sides of the kitchen were not fully closing and would not provide adequate protection against the spread of smoke or fire. This was addressed by the

provider before the end of the inspection, however enhanced oversight is required in this area to ensure any such risks are proactively identified and addressed

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of residents' assessments and care plans and found that they were detailed to sufficiently guide care. Validated risk assessment tools were used to identify specific clinical risks, such as risk of falls, pressure ulceration and malnutrition. Records reviewed were also updated as a resident's condition changed and at intervals not exceeding four months. Overall, care plans reviewed were person-centred and were able to guide care such as to the preferences and for the medical, nursing and social needs of residents.

Judgment: Compliant

Regulation 6: Health care

The registered provider had ensured that residents had access to appropriate medical and healthcare. From a review of records, these demonstrated that advice given by health and social care professionals were acted upon to provide good outcomes for residents.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

While it was noted that there was good oversight of restraint use within the designated centre, information reviewed did not provide evidence that the least restrictive measure was always trialled in accordance with National Policy and the provider's own restraint policy. For example, in three residents' care plans on the use of restraints such as sensor alarms and wander tags, it was evident these restraints were put in place due to the risk of falls or unexplained absence. However, there was no evidence that the assessment for the use of the restraint or restrictive practice included the alternatives that had been tried, including the length

of time and the trial outcome.

Judgment: Substantially compliant

Regulation 8: Protection

A safeguarding policy was maintained which guided staff on the measures to take to ensure residents were protected from harm. Staff working in the centre had a Garda Vetting disclosure in place prior to taking up employment.

The registered provider was acting as pension agent for three residents and held some personal monies for a small number of residents. Inspectors reviewed these records and found that there were clear processes in place for the safe storage and management of residents' personal monies.

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	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Loughshinny Residential Home OSV-0006616

Inspection ID: MON-0037342

Date of inspection: 17/07/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC in Loughshinny Residential Home performs her functions in accordance with relevant Legislation, Regulations, National Policies and Standards, to protect each resident and promote their health and wellbeing. There is a clear and effective Management and Governance structure with clear lines of accountability for all roles and responsibilities. There are management systems in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. There is a well-developed auditing system in place for managing all risk and which the DON/ADON are experienced and competent in carrying out throughout the year. Audits are conducted on a weekly, bimonthly, monthly, quarterly, biannual and annual. Analysis of all falls, restraints, pressure areas and wounds are conducted monthly and learning shared. As of 31/07/24 an analysis and review of all incidents will also be completed to ensure that incidents are being detailed sufficiently to effectively inform investigations and learnings. Loughshinny have very good systems in place when it comes to fire safety, daily, weekly and monthly inspections are conducted of all emergency doors as follows: Daily Inspections: Checking that all doors forming part of the means of escape are functioning correctly. That all means of escape routes are always free from obstruction. Visual inspection of the fire alarm panel for any defects etc. After all the checks have been completed the maintenance manager must sign and date section 1.06 in the fire alarm register book at reception. Weekly Inspections: A visual inspection of all the emergency lights, any defects are recorded in section 1.07 in the fire register book. Weekly Inspection: Any event affecting the fire alarm system should be recorded, An '' event" shall include fire alarms, false alarms, failure, inspections, tests, disconnections, dates of Service. The fire alarm is set off once a week every Tuesday at 11:00am and section 1.08 in the fire register book should be filled in and signed off and any defects recorded. Monthly Inspection: All fire extinguishers, fire blankets, ski sheets, throughout the building must be visually inspected monthly and section 1.09 in the fire register book	

must be signed off and any defects recorded.
Six Monthly Inspections: All fire doors throughout the building must be visually inspected and any defects are to be recorded in section 1.15 in the fire register brook.
The Group Maintenance Manager inspects the fire register books monthly to ensure that all inspections have been completed and signed off and any defects have been attended. Going forward the maintenance manager will conduct spot checks throughout the day to ensure that all fire doors are kept shut and that staff are abiding by best practice. The PIC will also ensure that Fire Safety and the importance of not holding doors open is discussed during the next CNMs and staff nurses meeting on 2nd and 5th September 2024 and monthly floor meetings with the staff. Furthermore, the staff will be remained at the start of their shift.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Loughshinny have very good systems in place when it comes to fire safety, daily, weekly and monthly inspections are conducted of all emergency doors.
Daily Inspections: Checking that all doors forming part of the means of escape are functioning correctly. That all means of escape routes are always free from obstruction. Visual inspection of the fire alarm panel for any defects etc. After all the checks have been completed the maintenance manager must sign and date section 1.06 in the fire alarm register book at reception.
Weekly Inspections: A visual inspection of all the emergency lights, any defects are recorded in section 1.07 in the fire register book.
Weekly Inspection: Any event affecting the fire alarm system should be recorded, an '' event" shall include fire alarms, false alarms, failure, inspections, tests, disconnections, dates of Service. The fire alarm is set off once a week every Tuesday at 11:00am and section 1.08 in the fire register book should be filled in and signed off and any defects recorded.
Monthly Inspection: All fire extinguishers, fire blankets, ski sheets, throughout the building must be visually inspected monthly and section 1.09 in the fire register book must be signed off and any defects recorded.
Six Monthly Inspections: All fire doors throughout the building must be visually inspected and any defects are to be recorded in section 1.15 in the fire register brook.
To ensure enhanced oversight of our inspection systems the Groups Maintenance Manager will complete a weekly review and conduct spot checks to ensure that all risks are proactively identified and addressed. In addition, the homes maintenance manager will conduct spot checks throughout the day to ensure that all fire doors are kept shut and that staff are abiding by best practice and not using devises to keep doors open. The PIC will also ensure that Fire Safety and the importance of not holding doors open is discussed during the next staff meeting on the 2nd and 5th September 2024 and that staff will be remained at the start of their shift. The Chief Risk Compliance and Services Officer made contact with the Homes External Fire Consultant and informed them to ensure that going forward, the importance of not holding doors open was included in all

fire training. While there is no requirement to have automatic door closure devices on these doors observed by the inspector on the day of the inspection a review will take place by the Groups Head of Maintenance and The Chief Risk Compliance and Service Officer before the 30/09/24 and report back to the Senior Management Team with findings and recommendations.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Loughshinny Residential Home always ensures that there is good oversightin relation to managing behaviours that challenge and the use of restraint use within the home. There are good sysyems in place for residents with health conditions that predisposed them to episodes of responsive behaviours, how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment. We in Loughshinny always ensure that these residents are well supported to ensure any behaviour that caused them distress is minimised. Arrangements are in place to ensure residents with episodes of responsive behaviours that pose a risk to themselves or others are closely supervised and monitored. Residents' behaviour support care plans are detailed with information that inform staff on prevention procedures such as triggers to the behaviours and effective person-centred de-escalation strategies. Loughshinny promotes a culture of a restraint free environment and ensures that all restraints are reviewed on a monthly basis or as required. All residents that have a restraint care plan in place will be reviewed by the 30/09/24 to ensure that least restrictive measure is documented as trialled in accordance with National Policy and Loughshinys restraint policy.

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 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/09/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/09/2024
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.	Substantially Compliant	Yellow	30/09/2024