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:	The Residence Portlaoise
Name of provider:	The Residence PL Limited
Address of centre:	Block B The Maltings, Harpur's Lane, Portlaoise, Laois
Type of inspection:	Unannounced
Date of inspection:	24 October 2024
Centre ID:	OSV-0008667
Fieldwork ID:	MON-0044979

About the designated centre

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

The Residence Portlaoise is a purpose-built nursing home which consists of 101 single registered bedrooms with en suite bathrooms. The Residence Portlaoise is situated a short distance from the town of Portlaoise, therefore the Nursing Home is serviced by restaurants, public houses, local library, community hall, places of worship and also has easy transport links. The Residence Portlaoise accommodates male and female residents over the age of 18 years for short term and long term care. It provides 24 hour nursing care and caters for older people who require nursing care, dementia care, palliative care, respite and post-operative care. There are a variety of communal day spaces provided including dining rooms, day rooms and visitor rooms available. Residents also have access to a large secure enclosed garden.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	55

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 24 October 2024	09:35hrs to 18:05hrs	Sean Ryan	Lead
Thursday 24 October 2024	09:35hrs to 18:05hrs	Sharon Boyle	Support

What residents told us and what inspectors observed

Residents living in The Residence Portlaoise told inspectors that this was a nice place to live. Residents were complimentary of the staff and the care they received. Residents stated that they were happy, felt safe, the food was good, and that the staff were kind to them. Inspectors observed warm, kind, dignified and respectful interactions between staff and residents throughout the day of the inspection.

Inspectors arrived in the morning to carry out an unannounced inspection. Throughout the day, inspectors spoke with several residents and their families to gain insight into their experience of the centre. Inspectors also spent time observing interactions between staff and residents, reviewing the premises, and observing the care delivery.

There was a comfortable and homely atmosphere in the centre. Residents were observed chatting with one another and staff in the communal dayroom, and staff were seen to be attentive to their requests for assistance. While staff were busy attending to residents' requests for assistance, residents were observed to receive patient and unhurried care from the staff. Call bells were answered promptly.

Inspector spoke with a number of residents in their bedrooms and in communal areas. Residents told the inspectors that staff supported them to get up from bed at a time of their choosing, and that they could have a shower when they wished. Residents described how they generally would not have to wait long for a member of staff to respond to their requests for assistance, with the occasionally delay experienced at night-time. Residents added that this was due to there being less staff on duty and added that this rarely impacted on them.

Residents were observed to mobilise independently around the centre, spending time in their bedrooms alone or with visitors, and participating in activities in the communal day room. Throughout the day, the inspectors observed staff supporting residents with refreshments, in a respectful and dignified manner.

Inspectors observed that the centre was bright, visibly clean, spacious and laid out to meet the needs of the residents. The centre provided accommodation over three floors and comprised of single bedroom accommodation. On the day of the inspection, the second floor was unoccupied by residents. The centre was warm and comfortable for residents. Residents could independently access secure enclosed gardens which were observed to be appropriately maintained and furnished.

Residents' described their bedroom accommodation as 'homely and comfortable'. Bedrooms were personalised with photographs, pictures, art and other items of significance belonging to the residents. Each room was laid out to provide a pleasant environment for residents and included a call bell, bedside locker, storage facilities,

a wardrobe, seating and television facilities. All bedrooms had accessible en-suite bathrooms.

Residents were served their lunch in the dining room and in their bedrooms. Residents stated that they were offered choice at mealtimes and were very complimentary regarding the quality of food provided. Residents described how seating was assigned in the dining room for meal times and that this was based on their preferences. The dining room was appropriately laid out with cutlery and condiments, and was comfortable and relaxed for residents. 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.

Residents told the inspectors that staff supported them to maintain their individual style and appearance. They detailed how staff supported them to choose their clothing and help them with their hair styles.

The social activities timetable was displayed throughout the centre. The activities available to residents included yoga, music and dance, baking, gardening and exercising. Residents also had access to day trips scheduled for the last Thursday of every month. Residents told the inspectors that they looked forward to activities as they were the most enjoyable part of their day. During the afternoon, residents participated in a parachute exercise game facilitated by dedicated activities staff. The person facilitating the session actively encouraged all residents to participate. Residents were observed to be enjoying the activity.

The following sections of this report detail the findings with regard to the capacity and capability of the provider and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This unannounced risk inspection was 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 centre for older people) Regulation 2013 (as amended).
- follow up on the actions taken by the provider to address significant issues of non-compliance found on the last inspection in July 2024 with regard to the governance and oversight of the service.
- review the actions taken by the provider following monitoring notifications submitted to the Chief Inspector, pertaining to the unexplained absence of a resident from the designated centre.
- review unsolicited information received by the Chief Inspector. The information pertained to concerns regarding the quality and safety of the care provided to vulnerable residents who were at risk of leaving the centre

unnoticed and unaccompanied, and the quality of nutritional care provided to residents. This information was substantiated on this inspection.

The findings of this inspection were that the provider had not fully implemented or sustained their compliance plan following the previous inspection of the centre in July 2024, and urgent action was required with regard to the governance and management of The Residence Portlaoise. Inspectors found that a weak organisational structure, and ineffective management systems of monitoring and oversight impacted on the quality and safety of the care provided to residents. Inspectors found that the provider had not effectively managed risks to residents' safety and welfare. Actions to protect residents assessed as requiring close supervision were not fully implemented, and there continued to be inadequate and ineffective risk management systems in place to ensure the safe, and monitored delivery of care to residents. Furthermore, inspectors found that the systems in place to ensure effective monitoring of residents' nutritional care needs and nutritional risks were not effective. As a consequence of these concerns, an urgent compliance plan request was issued to the provider following this inspection.

The Residence PL Limited is the registered provider of The Residence Portlaoise. The registered provider is a company with four directors. One of the directors represented the registered provider in engagement with the Chief Inspector. Within the centre, the clinical and administrative support for the person in charge had increased since the previous inspection through the appointment of an additional assistant director of nursing and clinical nurse manager. A regional director and associate regional director, both of whom were persons participating in the management of the centre, attended the centre on a weekly basis to provide governance and support to the person in charge, and to support the provider's oversight of the service.

The lines of accountability and responsibility for the oversight of care and safety of the residents were not clear. It was unclear who held responsibility for the implementation and oversight of key management systems, pertinent to supporting effective governance, such as risk management, record management, and monitoring the provision of appropriate health care to residents. Inspectors found that the absence of an effective system of governance and management, negatively impacted on the registered provider’s ability to recognise, respond to, and manage risks and regulatory non-compliances in the centre, and maintain a safe and quality care for residents.

The provider had not ensured that risk management systems were effective to manage risks in the centre. Inspectors found that risks that had been identified by the provider had not been managed in line with the risk management policy. For example, the risk associated with residents assessed as requiring increased supervision due to the risk of leaving the centre unaccompanied had not been reviewed or updated following two significant incidents in the centre. Consequently, there was no documented risk management plan in place to effectively manage the risk.

The provider had committed to implementing management systems to ensure the service was safe and consistently monitored. Key clinical indicators, with regard to the quality of care provided to residents, were collated on a monthly basis by the person in charge and submitted to the senior management team for review. This included the incidence of wounds, restrictive practices, falls, and other significant events. There was an audit schedule in place which identified risk and areas of quality improvement. Audits had been completed in line with this schedule. However, inspectors found that the monitoring of some aspects of clinical care was poor. For example, a review of residents care records found that residents who were assessed as being at risk of malnutrition did not have always have an appropriate care plans developed or implemented to address this risk. The system of clinical oversight, including the clinical audits, failed to identify this risk to residents. In addition, while the number of resident's transfers to the acute services was audited on a monthly basis, audits did not include an analysis of the high incidence of resident transfers to hospital to identify contributing factors. Therefore, an effective or appropriate quality improvement plan had not be developed.

A review of the record management systems in the centre found repeated issues of non-compliance with the requirements of the regulations. While records pertaining to staff personnel files were appropriately maintained, records pertaining to specialist treatment and nursing care provided to residents were not appropriately maintained. In addition documents requested for review at the start of this inspection were not received in a timely manner. Requests for records relating to risk management, complaints management, audits and assessments were presented in a disjointed and disorganised manner.

On the day of inspection, the staffing levels were appropriate for the size and layout of the building, and to meet the assessed needs of the current residents

Staff were facilitated to attend training such as fire safety and manual handling. While staff were facilitated to attend training relevant to safeguarding of vulnerable people, some staff did not demonstrate an appropriate awareness of the procedure in place to respond to suspected allegations of abuse. Additionally, a significant number of staff had not completed training relevant to supporting residents to manage their responsive behaviour (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Consequently, the needs of some residents with complex care needs and behaviours were not met.

There were ineffective systems in place to supervise staff to provide safe and effective care to the residents. A number of staff allocated to provide care to residents did not demonstrate appropriate knowledge of the care needs of the residents such as their nutritional care, supervision and mobility care needs. Additionally, staff were not appropriately supervised to implement the centre's policies and procedures in relation to nutritional care and complaints, and to maintain accurate records of the care provided to residents.

Regulation 15: Staffing

On the day of the inspection, the staffing level and skill mix were appropriate to meet the needs of residents in line with the centre's 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

Staff supervision arrangements were not appropriate to protect and promote the care and welfare of residents. This was evidenced by poor supervision of;

- the systems in place to ensure appropriate transfer to hospital.
- provide oversight of the resident's clinical documentation to ensure that resident's assessments and care plans were an accurate reflection of the residents care needs.
- the delivery of care and the recommendations of allied health care professionals.
- communication of key clinical information to staff to ensure care was delivered in line with the residents assessed needs and care plans.
- nursing care records, including records of referrals to medical professionals, were appropriately maintained.

Judgment: Not 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;

- Records of on-going medical assessment, treatment and care were not consistently maintained, as required by Schedule 3(4)(e) of the regulations. For example, a record of a resident's medical reviews was not maintained in the centre, or available to staff for review.
- Records of all medical referrals were not maintained in line with Schedule 3(4)(f). For example, inspectors were informed that three residents had been referred to medical professionals for further assessment. However, there was no record of the referral available for review.

- Records of specialist treatment, nutritional care and nursing care provided to residents were not accurately or appropriately maintained in line with the requirements of Schedule 3(4)(b). For example, records of repositioning charts for residents of high risk of impaired skin integrity were not maintained in line with the resident's care plan. Records of nutritional care and residents dietary intake did not reflect the actual nutritional care and dietary intake of residents. Records of residents locations, maintained for residents assessed as being at risk of absconsion, were not accurately maintained.
- Records were not kept in a manner as to be accessible. Repeated requests for records were made throughout the inspection, and some required records were presented in a disjointed and disorganised manner.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not ensured there was an effective management structure in place. Unclear roles and responsibilities impacted on accountability and responsibility for the oversight and management of key aspects of the service such as the management of risk, the management of records, and the provision of health care to residents. Consequently, ineffective action had been taken to address risks and regulatory non-compliance identified in those areas.

Some of the management systems in the centre were ineffective and posed a significant risk to residents. Following this inspection, the provider was required to submit an urgent compliance plan to address the following risks;

- There were inadequate systems of governance and oversight in place to ensure that residents received nutritional care in line with the directive of health care professionals, and that accurate and consistent assessment of nutritional risks were carried out, including the recording of residents weights. This was compounded by ineffective systems of monitoring and escalation to ensure an appropriate pathway of care was implemented in response to a resident's risk of malnutrition. The providers response to the urgent compliance plan provided assurance that the risk was urgently addressed.

In addition to the above, the following management systems were not effective.

- Poor oversight of record management systems to ensure compliance with the regulations.
- Ineffective systems in place to monitor and promote the well-being of residents through providing timely and appropriate referral to medical and health care services.

- 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. For example, the risk associated with resident who had complex supervision and care needs were not subject to review to assess the effectiveness of controls in place to manage the risk. Risks that were known to the provider were not assessed or managed in line with the centre's own policy. This included the risk associated with inadequate access for residents to medical professionals. Consequently, there was no effective plan in place to manage the risk and poor systems in place to escalate risks to the provider.
- Ineffective communication systems to ensure key clinical information regarding residents care needs and complaints were effectively communicated to staff and escalated to the management team.
- Ineffective implementation of the complaints management system. There was poor oversight of the centre's complaints management system, and identification and escalation of complaints, to ensure complaints were managed in line with the requirements of the regulations.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints were not consistently managed in line with the centre's own policy or with the requirements of Regulation 34. For example;

Complaints and concerns in relation to resident access to medical and health care and the quality of nutritional care had been brought to the attention of staff and management. However, these issues were not managed through the complaints management process. Consequently, there was no documentation of how these issues were acknowledged, investigated or if the complaints had been resolved to the satisfaction of the complainant, as required under Regulation 34.

This is a repeated finding from the previous inspection.

Judgment: Substantially compliant

Quality and safety

Inspectors found that there were aspects of the quality and safety of care provided to residents that was impacted by inadequate governance and management as described under the Capacity and Capability section of this report. Inspectors found

that while some action had been taken to improve the quality of residents care plans specific to falls prevention and management, the absence of effective quality assurance and clinical oversight posed a risk to resident's nutritional care needs, the quality of individual assessments and care plans, and timely access to appropriate health care.

In a compliance plan submitted following the last inspection of the centre in July 2024, the provider had committed to taking action to improve the quality of the nursing documentation with regard to the resident's individual assessment and care plans. While there was evidence that residents needs had been assessed using validated assessment tools, the care plans reviewed were not always informed by these assessments, and did not reflect person-centred guidance on the current care needs of the residents. In addition, not all care plans were reviewed as the residents' condition changed.

A review of residents' records showed that residents were not always provided with timely referral or access to general practitioner (GP) services regarding their health care needs, or following early detection of signs and symptoms of physical deterioration. This impacted on the care of the residents, necessitating transfer to the acute health care services for further assessment in some instances. This was compounded by a lack of clear policy, procedure and process to underpin the criteria for appropriate hospital transfers and the provision of safe and effective health care to residents.

While there were arrangements in place for residents to access the expertise of other health care professionals, the recommendations made by health care professionals were not always implemented by staff, to ensure the best outcome for residents.

There were systems in place to safeguard residents and protect them from the risk of abuse. There were processes in place to appropriately investigate incidents or allegations of abuse. Safeguarding training was up-to-date for all staff and a safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. However, staff spoken inconsistent responses with regard to their role and responsibility in recognising and responding to an allegation of abuse.

A restraint-free environment was promoted in the centre and the use of restrictive practices were monitored to ensure alternative, less restrictive, measures were utilised. Residents had a restrictive practice care plan in place which contained person-centred details that clearly outlined the rationale for use of these practices, and included details of any alternatives trialled. Care plans were in place for residents that experienced responsive behaviour. The care plans were person-centred and detailed the intervention that should be in place to support the residents to manage their responsive behaviours and maintain their safety. However, staff did not have knowledge to support residents to manage their behaviours.

There was a range of stimulating and engaging activities that provided opportunities for socialisation and recreation. The centre employed activities staff who designed and planned activities in consultation with residents. Staff demonstrated an understanding of their role and responsibilities in facilitating social engagement and appropriate activities for residents.

Inspector found that residents were free to exercise choice in how to spend their day. Residents were consulted about their care needs and about the overall quality of the service. Residents were provided with access to independent advocacy services.

Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Care plans were not guided by a comprehensive assessment of the residents' care needs. For example, an appropriate care plan had not been developed for a resident who had lost a significant amount of weight and was assessed as being at high risk of malnutrition. Consequently, staff did not have accurate information to guide the care to be provided to the resident.
- Care plans were not updated when a resident's condition changed. For example, a resident assessed as being at high risk of falling did not have their care plan updated to include a fall prevention strategy despite the resident having had a recent fall, and a history of multiple fall incidents.
- Residents care plans were not reviewed and updated. For example, the care plan for a resident with sustained weight-loss had not been reviewed or updated following further significant weight-loss.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 6: Health care

The registered provider did not ensure that all resident had appropriate access to medical and health care. This was evidenced by failure to;

- provide timely referral and access to medical services when clinically indicated.
- provide a resident with timely and appropriate access to health care professionals for further assessment and expertise when clinically indicated, in line with the centre's policies and associated procedures.

- ensure arrangements were in place to implement the recommendations and interventions prescribed health care professionals following expert assessment.

This is a repeated finding from the previous inspection.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

A significant number of staff had not been facilitated to attend training appropriate to their role, to respond to and manage behaviour that is challenging.

Some staff did not have appropriate knowledge of residents individual behavioural care and support needs, and the interventions in place to support the residents to manage their needs.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found that the effectiveness of the safeguarding training provided to staff had not been evaluated to assess the effectiveness of the training. While all staff had attended training relevant to the safeguarding of vulnerable people, staff were unclear with regard to their role and responsibilities in recognising and responding to an allegation of abuse.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Inspectors found that residents' privacy and dignity was respected.

Residents told the inspectors that they were well looked after and had the opportunity to exercise choice in how they spent their day, what activities they participated in and what they ate.

Residents were supported to exercise their religious beliefs and were facilitated to attend religious services in the centre.

Through the residents monthly meetings with the management team, residents were facilitated to participate in the organisation of the service and provide feedback on the quality and safety of the service provided.
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	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Residence Portlaoise OSV-0008667

Inspection ID: MON-0044979

Date of inspection: 24/10/2024

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: From 1st December 2024, a clinical nurse manager (CNM) will be on duty on all shifts to enhance clinical supervision and support nursing staff in clinical decision making and management of the deteriorating resident. The role of the CNM will include supporting the nurse to escalate to the GP, as required and ensuring that escalation and transfers to hospital, are timely and appropriate and that records of all care delivered are maintained comprehensively and clearly. From 1st December 2024, the Director of Nursing or Assistant Director of Nursing (ADON) will review all transfers to and from hospital and all reviews by GP and other members of the MDT, within one working day, to ensure that transfers were appropriate and that all clinical documentation is completed and appropriately maintained. The review will also include ensuring that all recommmmendations from the MDT are recorded, communicated across the team and implemented. Learning from these reviews will be shared with the nursing team weekly by the DON. From 1st December 2024, additional review and oversight of all hospital transfers, clinical decision making and resident access to GP and MDT services will continue to be provided by the regional director and this will be increased to weekly via an agreed KPI dashboard. Resident care and documentation, including care plans and assessments will be audited on a weekly basis by the CNMs and ADONs from 1st December 2024 to ensure that they accurately reflect residents' care needs including identified clinical risks and that this care was delivered, including changes recommended by the MDT. The Director of Nursing is responsible for overseeing that these audits are completed and that learning is shared with all nursing staff. By 31st December 2024, two separate audits of care plans will be carried out by the Quality team and as part of the Regional Director's audit, to ensure that the actions outlined have been effective and are addressing the risks identified. Reports of these audits will be shared for learning and improvement, with the nursing staff, by the Director of Nursing.	

The staff handover sheet/meeting has been updated to enhance communication of changes in resident needs, identified clinical risks and agreed interventions- complete
From 1st November 2024, the CNM/ADON will attend the daily safety pause which provides an opportunity for all staff to be updated on individual resident needs and for the CNM/ADON to provide additional supervision and oversight to nursing and HCA staff and support strong clinical decision making, enhanced clinical supervision and daily management of clinical risk for residents - complete and on-going
From 1st November 2024, enhanced daily checks will be in place for nurse sign off on documentation to ensure that care delivered is in line with the residents' assessed needs, identified clinical risks and care plans. Daily checks will be validated and spot checks completed on a daily basis by CNM and/or ADON to ensure compliance in this area and to ensure robust supervision of staff- complete and ongoing
A review of the MDT referral process in the home has been completed to provide assurance that access for residents is timely and appropriate and that evidence of referrals sent and recommendations provided by the MDT are maintained in the residents' file- complete
A review of GP access has been completed and a process agreed to ensure all residents have equal access to GP services. An agreed process has been established to ensure that required medical records are requested, retrieved and available in the home with clear responsibilities for this tasks outlined and agreed- complete
From 1st December 2024, the CNM allocated to support GP rounds will be responsible for ensuring that referrals/recommendations/prescriptions are reflective of clinical decisions taken, evidence based and timely care and are maintained securely in the resident's file- complete.
From 1st December 2024, an audit will be completed weekly by the DON to ensure all documentation is captured accurately; this will include reviewing the GP referral documentation and following the pathway to treatment and review if indicated. Oversight by the regional director to ensure that this is effective will be increased to weekly and will be reviewed via an agreed KPI dashboard.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A review of the MDT referral process in the home has been completed to provide assurance that access for residents is timely and appropriate and that evidence of referrals sent and recommendations provided by the MDT are maintained in the residents' file- complete
An agreed process has been established to ensure that required medical records are requested, retrieved and available in the home with clear responsibilities for this tasks outlined and agreed- complete
From 1st December 2024, the CNM allocated to support GP rounds will be responsible for ensuring that referrals/recommendations/prescriptions are reflective of clinical decisions taken, evidence based and timely care and are maintained securely in the resident's file- complete.

From 1st December 2024, an audit will be completed weekly by the DON to ensure all documentation is captured correctly; this will include reviewing the GP referral documentation and following the pathway to treatment and review if indicated. Oversight by the regional director to ensure that this is effective will be increased to weekly and will be reviewed via an agreed KPI dashboard.
A further 3 tablet devices have been ordered to facilitate improved access for staff to the system to ensure timely and accurate information is documented to reflect care delivered to residents. Resident daily documentation on clinical risk enhanced checks will only be held electronically going forward to ensure compliance with records and facilitate robust supervision and oversight. Nurses will conduct a spot check of documents during every shift to confirm that documentation is correct and completed in a timely manner, and will note this in progress notes at the end of each shift. The PIC/ADON will oversee this action and it will be completed by the 15/12/2024
From 1st November 2024 the Regional Director will oversee and provide oversight on the quality of audits and documentation completed and will create action plans to address any improvements identified.
In addition, a regional audit will be completed every 3 months to ensure compliance in all areas, including availability and organisation of records required to be maintained in the home and an audit is scheduled for the 5th of December.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Roles and responsibilities have been clearly redefined and communicated in the home, specifically across the nursing management team and focusing on strengthening clinical supervision and oversight in the home- complete
Onsite support and training is ongoing and will be completed by 31st January 2025 to ensure that all nurse managers are equipped with the skills and knowledge to ensure supervision practice is strengthened. This includes robust and timely clinical risk management, comprehensive record management and overseeing access to safe and appropriate health care for all residents
Risk management and healthcare in the home has been further strengthened through enhanced daily handovers and safety pause meetings which will be attended by ADON/CNM to support clinical decision making and timely escalation of emerging resident care needs and complaints-complete
From 1st December 2024, the effectiveness of this structure and enhanced processes outlined above will be monitored three times weekly by the regional team with onsite visits and review of an agreed KPI dashboard weekly and a full review of governance monthly.
A comprehensive review of MUST assessments and care plans has been conducted for all residents to provide assurance that resident information is accurate and that appropriate referrals and their recommendations have been actioned and communicated to all staff-

complete
An updated nutrition tracker has been fully implemented and is being shared with the kitchen on a weekly basis with updated information- complete

Any changes in resident nutritional needs which occur more frequently will be immediately notified to the kitchen as they occur by the ADON- complete
The Regional Director will oversee the MUST audit and actions arising from it (including referrals to MDT) during weekly visits to the home from 28th October 2024 and through weekly KPI reports from the DON from 1st December 2024.
From 1st November 2024, residents requiring weekly weights will have their MUST assessment completed on the same day as their weight is recorded. The CNM/ADON in charge will oversee that this process is completed accurately on a weekly basis. The Regional Director will review this process through weekly reports from the DON from 1st December 2024.
From 1st November 2024, all residents identified with a MUST of 2 or above will have all intake recorded with oversight by nurses on a daily basis. This has been added to the nurse's daily checklist and will be signed and submitted by nurses and overseen by the CNM/ADON daily. The DON will review this process daily and the regional team will oversee weekly through a KPI report to be submitted by the DON.
Comprehensive training will be provided to all nurses in respect of supporting the nutritional needs of residents. This will include, review of the nutrition policy, training on MUST assessments and a "Nutrition for the Elderly" session. This training will include the process of escalation when a resident is losing weight. This will be completed by all nurses by 31/10/2024.
An independent health and safety audit has been completed in the home, providing a foundation for the development of a comprehensive new risk register, which will include clinical risks. This updated risk register will be fully implemented by 31/12/2024. This will ensure all risks, including new and live risks, are effectively identified, captured, and monitored by the DON/ADON.
The register will be reviewed weekly by the Regional Director or Associate Regional Director for the first three months following its implementation to ensure the register is up to date with risks and that risks are controlled and reviewed as per policy. This process will facilitate the timely escalation and management of risks, ensuring a proactive approach to maintaining safety and compliance- complete by 31st March 2025
Training on clinical risk management will be provided to all nurse managers by 31/01/2025. This will be extended to all staff nurses and health care assistants to include repositioning charts, food and fluid balance and safety checks to ensure accurate recording, this will be monitored on a daily basis by the staff nurses and management team to ensure compliance.
From 1st December 2024, a clinical nurse manager (CNM) will be on duty on all shifts to enhance clinical supervision and support nursing staff in clinical decision making and management of the deteriorating resident. The role of the CNM will include supporting the nurse to escalate to the GP, as required and ensuring that escalation and transfers to hospital, are timely and appropriate and that records of all care delivered are maintained comprehensively and clearly.
From 1st December 2024, the Director of Nursing or Assistant Director of Nursing (ADON) will review all transfers to and from hospital and all reviews by GP and other members of the MDT, within one working day, to ensure that transfers were appropriate and that all clinical documentation is completed and appropriately maintained. The

review will also include ensuring that all recommmmendations from the MDT are recorded, communicated across the team and implemented. Learning from these reviews will be shared with the nursing team weekly by the DON.
From 1st December 2024, additional review and oversight of all hospital transfers, clinical decision making and resident access to GP and MDT services will continue to be provided by the regional director and this will be increased to weekly via an agreed KPI dashboard.
From 1st December 2024, resident and family communication will be addressed by the ADON/CNM as part of the handover and safety pause daily with all staff. The DON will review progress notes daily to ensure that any concerns raised are recorded as complaints and managed in line with the agreed policy.

From 1st December 2024, a comprehensive review of complaints will be completed monthly at the governance meeting by the regional director, including spot checks with residents that issues have been addressed to their satisfaction.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
From 1st December 2024, resident and family communication will be addressed by the ADON/CNM as part of the handover and safety pause daily with all staff. The DON will review progress notes daily to ensure that any concerns raised are recorded as complaints and managed in line with the agreed policy.

Further complaints training will be provided to all nursing and care staff by 31/1/2025 to ensure that complaints are communicated and escalated in a timely manner, by all staff.

From 1st December 2024, a comprehensive review of complaints will be completed monthly at the governance meeting by the regional director, including spot checks with residents that issues have been addressed to their satisfaction.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A full review of each resident's individual care plan and assessments has been completed to ensure that they fully reflect the current assessed needs of the residents- complete.

An updated education tool is being used to provide staff with training to ensure that they have the skills and knowledge to complete resident assessments and develop care plans which are reflective of resident current needs. All staff will receive training by 31st December 2024.
From 1st December 2024, care plans will be reviewed on a daily basis by the DON/ADON/CNMs to ensure that emerging resident care needs are reflected in a timely manner in care plans to guide all staff in the delivery of appropriate care.
Resident care and documentation, including care plans and assessments will be audited on a weekly basis by the CNMs and ADONs from 1st December 2024 to ensure that they accurately reflect residents' care needs including identified clinical risks and that this care was delivered, including changes recommended by the MDT. The Director of Nursing is responsible for overseeing that these audits are completed and that learning is shared with all nursing staff.
By 31st December 2024, two separate audits of care plans will be carried out by the Quality team and as part of the Regional Director's audit, to ensure that the actions outlined have been effective and are addressing the risks identified. Reports of these audits will be shared for learning and improvement, with the nursing staff, by the Director of Nursing.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
From 1st December 2024, a clinical nurse manager (CNM) will be on duty on all shifts to enhance clinical supervision and support nursing staff in clinical decision making and management of the deteriorating resident. The role of the CNM will include supporting the nurse to escalate to the GP, as required and ensuring that escalation and transfers to hospital, are timely and appropriate and that records of all care delivered are maintained comprehensively and clearly.
From 1st December 2024, the Director of Nursing or Assistant Director of Nursing (ADON) will review all transfers to and from hospital and all reviews by GP and other members of the MDT, within one working day, to ensure that transfers were appropriate and that all clinical documentation is completed and appropriately maintained. The review will also include ensuring that all recommmmendations from the MDT are recorded, communicated across the team and implemented. Learning from these reviews will be shared with the nursing team weekly by the DON.
From 1st December 2024, additional review and oversight of all hospital transfers, clinical decision making and resident access to GP and MDT services will continue to be provided by the regional director and this will be increased to weekly via an agreed KPI dashboard.
From 1st December 2024, the CNM allocated to support GP rounds will be responsible for ensuring that referrals/recommendations/prescriptions are reflective of clinical decisions taken, evidence based and timely care and are maintained securely in the resident's file-complete.

From 1st December 2024, an audit will be completed weekly by the DON to ensure all documentation is captured accurately; this will include reviewing the GP referral documentation and following the pathway to treatment and review if indicated. Oversight by the regional director to ensure that this is effective will be increased to weekly and will be reviewed via an agreed KPI dashboard.
A review of the MDT referral process in the home has been completed to provide assurance that access for residents is timely and appropriate and that evidence of referrals sent and recommendations provided by the MDT are maintained in the residents' file- complete
A review of GP access has been completed and a process agreed to ensure all residents have equal access to GP services. An agreed process has been established to ensure that required medical records are requested, retrieved and available in the home with clear responsibilities for this tasks outlined and agreed- complete

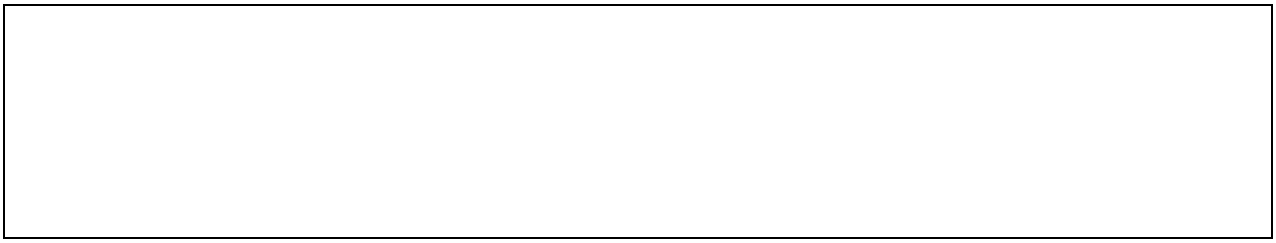
Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Training to ensure that all staff have the skills and knowledge to support residents with responsive behavior and to ensure they have skills to access care plans to ensure enhanced and effective communication of resident needs will be completed by 15/12/2024.

From 1st December 2024- the CNM/ADON on duty will attend handovers and provide daily supervision and checks to provide assurance that all staff are fully aware of the care needs of residents who display responsive behavior and that care plans are providing appropriate and up to date guidance for staff.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Additional toolbox talks on safeguarding will be provided for all staff. This will include an assessment of staff knowledge on responding to allegations, suspicions or actual abuse to follow the training. This will be completed by the 15/12/2024.
From 1st December 2024, the ADON/CNM will assess staff knowledge and understanding of training delivered by checking this with staff on daily walkabouts and during handovers and safety pause and through weekly review and analysis of reported incidents, complaints and resident feeedback.



Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/12/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	15/12/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	15/12/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and	Substantially Compliant	Yellow	06/12/2024

	details responsibilities for all areas of care provision.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	31/01/2025
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.	Substantially Compliant	Yellow	31/01/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the	Not Compliant	Orange	31/12/2024

	designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/12/2024
Regulation 6(2)(a)	The person in charge shall, in so far as is reasonably practical, make available to a resident a medical practitioner chosen by or acceptable to that resident.	Not Compliant	Orange	01/12/2024
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Not Compliant	Orange	01/12/2024
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in	Substantially Compliant	Yellow	01/12/2024

	paragraph (1) or other health care service requires additional professional expertise, access to such treatment.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	15/12/2024
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	15/12/2024