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:	Kilkenny Care Centre
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Newpark Crescent, Newpark, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	27 August 2024
Centre ID:	OSV-0008695
Fieldwork ID:	MON-0042227

About the designated centre

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	62

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 27 August 2024	09:45hrs to 17:55hrs	Catherine Furey	Lead

What residents told us and what inspectors observed

The feedback from residents was that they were happy living in the centre. Residents described the premises as "beautiful", "stylish" and "exceptional" and said that the staff were "lovely people" who went "above and beyond". Overall it was clear from what residents and visitors told the inspector, that there was a high level of satisfaction with the service.

The inspector greeted and chatted to a number of residents in the centre to gain an insight into their experiences of living in Kilkenny Care Centre, and spoke privately, in more detail, with six residents. The inspector also spent time in the communal areas, observing the quality of resident and staff interactions. Staff were observed to be patient and kind when speaking to residents. It was clear that staff and management were aware of the differing needs of the residents, and their approach was tailored to these needs.

On arrival to the centre, the inspector was met by the person in charge, and later in the morning by the regional healthcare manager. The centre was registered and opened as a designated centre in December 2023. Over time, the occupancy of the centre had increased significantly, and each of the three floors of the centre was now occupied by residents. The ground and first floors were full, and there were 18 vacant beds on the second floor.

Residents had unrestricted access between floors by two lifts. Residents can use the stairs, however for safety reasons, this is accessed by entering a code. Use of the stairs was generally reserved for staff. Residents were observed using the lifts independently during the day. The communal areas on each floor were easily accessible from the bedroom corridors. There was supportive handrails along the corridors, and signage to orientate residents to their surroundings. Each of the three floors contained a dining room and a large sitting room.

In response to the findings of the previous inspection in April 2024, whereby there was insufficient equipment storage, the registered provider had repurposed a bathroom on the ground floor for this purpose. This meant that there was less equipment stored inappropriately on corridors and in bathrooms, which promoted good infection control procedures. The centre was exceptionally clean in all areas including ancillary rooms such as sluice rooms, and communal and bedroom areas. Residents and visitors told the inspector they were impressed with how well the centre looked.

Residents could enter the internal courtyard from the ground floor corridors and main sitting room. These doors were unlocked and residents could freely access the area. The courtyard was well-maintained, apart from a littering of cigarette ends in some parts. This was brought to the attention of management and addressed. Some residents were observed sitting in the main reception area where they watched people come and go. One resident liked to spend time behind the reception desk

with staff. Other residents were observed to go to and from the centre for appointments, visits and day care services. Residents who required dedicated one-to-one assistance were observed to have this in place at all times. The inspector spoke with staff providing one-to-one care and it was evident that the staff were very knowledgeable about the residents, and the residents were comfortable in their presence.

The inspector observed the lunchtime experience which was relaxed and sociable. Residents generally attended the dining room on the floor of their bedroom accommodation. Some residents chose to eat in their rooms. Meals were freshly prepared in the centre's kitchen on the ground floor and then transferred heated bainmaries in the dining rooms on each floor. Meals were then plated up to order and served to residents. The inspector chatted to residents while they were seated awaiting their meals in the first floor dining room, and a small number had forgotten what they had ordered. The inspector noted that there was a few menus on the sideboards which displayed the day's choices, however these were in small font and there was no larger or more accessible menu on display, to prompt or assist residents in making their choices. Residents spoken with were complimentary of the food, and said that there was good variety. The inspector noted that resident's who chose to dine in their bedrooms were served their soup, main course and dessert at the same time. This is not in keeping with a traditional dinner service, and was not in line with the type of service afforded to residents in the dining rooms. One resident was observed becoming confused with which course to eat first, and another resident's dinner went cold while they were eating their soup.

In the absence of scheduled activities on the day of inspection, staff worked hard to keep the residents entertained and occupied, however there were periods of time where residents were left sitting in their rooms or in the sitting rooms, particularly throughout the morning. Residents told the inspector that they very much enjoyed when activities were on and that they were happy with the schedule and the choices of things to do. One resident said they felt that there needed to be more on offer.

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 impacted the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection to monitor compliance with the regulations and standards. The inspector found that while established governance and management systems were in place, further oversight was required, to ensure a consistently safe level of care and service provision to residents.

Mowlam Healthcare Services Unlimited Company in the registered provider of Kilkenny Care centre, as part of the nationwide Mowlam Healthcare group. There is a person in charge who meets the criteria of the regulations, and who works full-

time in the centre. On a daily basis, support for the person in charge is provided by an assistant director of nursing who works in a wholly supernumerary capacity. Clinical support and supervision is provided by clinical nurse managers, registered nurses and healthcare assistants. A team of support services staff including catering, domestic and maintenance staff were in place to support the non-clinical services in the centre. There was a clearly-defined management structure within the centre and staff were clear on each member's individual roles and responsibilities. Within the wider Mowlam Healthcare group, there was direct lines of support via a dedicated healthcare manager, and shared group resources including facilities and human resources teams.

The registered provider had notified the office of the Chief Inspector of a number of incidents whereby residents had suffered injury requiring immediate medical or hospital treatment. Additionally, unsolicited information of concern relating to incidents in the centre had been received. As a result, prior to the inspection, the centre were requested to complete an internal review of these incidents including a quality improvement plan with the aim of reducing the number of these incidents reoccurring. Assurances were provided that systems including supervision, appropriate staffing and post-falls procedures had been reviewed, and dedicated quality improvement initiatives had been introduced. The registered provider carried out serious incident reports where required, and learning was documented and relayed to staff. Falls-reduction training had been undertaken by staff and there was an evident commitment to improve outcomes for residents. As result, the level of falls resulting in injury had reduced significantly.

The centre is registered to provide accommodation for 90 residents, and there was 62 residents living in the centre on the day of inspection. From speaking with staff and residents, and reviewing staff rosters, it was evident that the level of clinical staff was sufficient to meet resident's needs. Following the previous inspection, the registered provider had committed to reducing the level of agency healthcare staff, with the aim of promoting continuity of care. Recruitment had been ongoing as the centre's occupancy increased, and records showed that there was minimal agency use in recent months. The level of activity coordinator staff remained a concern, and the impact on the resident's experience in the centre, as a result of the vacant post in this department was evident, as discussed under regulation 15 below.

A schedule of clinical and environmental audits were in place including audits of infection control, mealtimes and care planning. Generally, the audits identified certain areas for improvement, and detailed the actions required to achieve compliance. Nonetheless, the inspector identified some areas, for example, gaps in assessments and care planning which were not identified by the centre's audit process.

Improvements were seen in the provision of staff training. A system was in place to ensure that as new staff were recruited, they were assigned to complete appropriate online training, which where required, was followed up with in-person training courses. Staff had access to a programme of training that was appropriate to the service.

The system of rostering and allocating staff to specific floors and areas provided assurance that staff were appropriately supervised by senior staff in their respective roles. The provider had good procedures in place for the recruitment and retention of suitable staff. Staff files reviewed contained all the requirements under Schedule 2 of the regulations. An Garda Síochána (police) vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available in the designated centre for each member of staff.

Regulation 15: Staffing

The registered provider did not ensure that the number of activity staff was appropriate, having regard for the assessed needs of the residents, and given the size and layout of the centre;

- the centre was not fully operating in line with the staffing levels outlined in their statement of purpose which outlines that there are two whole time equivalent (WTE) activity coordinators. There was currently one activity coordinator post in place, and one had remained vacant
- there was insufficient of staff on duty on the day of inspection, as evidenced by the lack of activities on offer, which led to residents spending long periods of time unoccupied at different times of the day.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge ensured that staff had access to training appropriate to their roles. A review of training records identified that mandatory training such as fire safety and safeguarding of vulnerable adults was up-to-date for staff. New cohorts of staff had training modules completed as soon as practicable.

Staff were appropriately supervised in their respective roles, and there was an improved system of induction in place for all staff. Staff were informed of the Health Act (2007) (as amended), and copies of the regulations and standards, and various other guidance were made available to staff.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was maintained in the centre. This directory contained all of the information specified in schedule 3 of the regulations, including the dates of admission and discharge from the centre and the name and contact details of each resident's next of kin.

Judgment: Compliant

Regulation 21: Records

Staff files were well-maintained and made available for inspectors to review. The sample of files reviewed contained all of the required documents set out in Schedule 2 of the regulations.

Other records, required to be maintained in the centre were in place, for example, records of medication administration and records of fire drills and fire alarm testing.

Judgment: Compliant

Regulation 23: Governance and management

While there were a range of oversight systems in place covering the operation of the service, At the time of inspection, assurances were not fully provided that all the systems in place to ensure oversight of key areas of the service were safe, appropriate, consistent and effectively managed. For example;

- the oversight arrangements in place for the review of incidents failed to identify some safeguarding concerns. As a result, the provider's systems had not identified the level of risk associated with these occurrences, and the incidents were not subject to thorough investigation, to determine if referral to an external safeguarding team was required
- the management systems in place to ensure oversight of residents' clinical and social assessments, fire safety, and the use of restraint, required strengthening, as discussed in the report under the relevant regulations.

As discussed under Regulation 15: Staffing, the level of activity coordinators in the centre was below that set out in the statement of purpose.

Judgment: Substantially compliant

Quality and safety

Overall, the quality and safety of care delivered to residents was of a good level and residents' individual rights were promoted in the centre. Some areas of improvement were identified in relation to residents' assessment and care planning, fire safety, managing behaviour that is challenging and protection of residents.

The inspector reviewed aspects of a number of residents' records throughout the inspection Some care plans were detailed and personalised, and accurately reflected the resident's assessed needs. However, there was a lack of oversight of aspects of nursing care which led to errors in some clinical risk assessments, as described further under regulation 5. This meant that associated care plans, when present, did not accurately reflect the needs of the residents. There was a low incidence of pressure ulceration occurring in the centre, and the inspector observed pressure-reliving devices such as cushions and mattresses in use. Nonetheless, the assessment of wound care required strengthening to ensure best practice was adhered to at all times.

The centre was actively promoting a restraint-free environment and the use of physically-restrictive practices such as bedrails in the centre was kept to a minimum. Restrictive practices were initiated following an appropriate risk assessment, and in consultation with the resident, or where required, their representative. These procedures were in line with national guidance. Notwithstanding this good practice, residents' safety while using bedrails could not be assured, as there was no system in place to monitor bedrails while in use. This is discussed under Regulation 7: Managing behaviour that is challenging.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of their safeguarding training and detailed their responsibility in recognising and responding to allegations of different types of abuse. Residents who spoke with inspectors, reported that they felt safe living in the centre. Improvement was required to ensure that all incidents involving residents were assessed to determine if they posed a safeguarding concern.

Resident's rights were respected in the centre. Residents meetings were held and records reviewed showed good attendance from the residents. There was evidence that at these meetings, residents were consulted about many aspects of life and care in the centre including the quality of the service provided, food choices and activities. Generally, the feedback from the residents was very complimentary and where concerns were brought forward by residents, there was documented evidence that these had been addressed to their satisfaction. There were large activities planners in the communal areas on each floor, which outlined the morning and afternoon activities for the week. Resident surveys identified that when activities did occur, they were well-enjoyed by residents.

Regulation 25: Temporary absence or discharge of residents

The inspector reviewed the discharge documentation for three residents and saw that each resident was transferred from the designated centre in a planned and safe manner, with all relevant information about the resident provided to the receiving hospital or service.

Judgment: Compliant

Regulation 28: Fire precautions

Not all aspects of this regulation were assessed on this inspection.

The registered provider did not ensure that adequate precautions were take against the risk of fire. Since the previous inspection, a new smoking shelter had been installed within the internal courtyard. This area was in use by residents, and despite being on the centre's risk register, the smoking shelter was not equipped with appropriate ashtrays, fire blanket or means to call for assistance. Cigarette butts were observed on the ground in various areas of the garden, meaning that smoking was occurring in areas other than the designated shelter.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While some care plans were seen to include detail on residents care and support needs, some were identified where the record did not clearly set out the residents needs, how it was to be met, and any changes to their needs. For example, a review of residents' records identified that there was inconsistent assessment of residents' wounds. For example;

- there was multiple examples whereby wound dressings were recorded as being changed, however no clinical assessment of the wound bed was documented in the wound chart or in the residents' daily notes. This is required to evidence if the wound is healing
- for a small number of wounds, the documentation identified that dressing were selected for use, which were not the dressings advised by the wound care specialist. There was no rationale provided for the change in dressing. This is important as the dressings were prescribed following expertise review
- From a review of a random sample of records, it was identified that the clinical assessment for malnutrition was not always completed correctly. This led to residents at high risk of malnutrition being incorrectly assessed as low

risk. This directly resulted in missed opportunities for residents to be referred to a dietitian.

Examples were seen where the system of clinical and social assessment did not consistently capture each resident's individual needs, and therefore were not documented in the residents' care pln;

- a resident, with a know risk of wandering prior to admission, had no risk assessment completed to determine the level of risk when living in the centre, despite daily records indicating that the resident was frequently wandering. As a result, there was no individualised plan of care to meet this need
- social assessments were not consistently completed. In the sample viewed, some were not completed at all, and some, while completed, did not contribute to the residents' care plan. For example, a social assessment identified a resident's love of gardening and being outdoors, however staff told the inspector that this resident did not currently access the garden in the centre, despite being able to do so.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Overall there were established systems to promote a restraint-free environment. Records reviewed by the inspector provided assurance that bedrails were routinely risk-assessed, however, there was no effective system of checking the safety and effectiveness of the bedrails when they were in use. This is required as per national guidelines.

Additionally, care planning for residents with known responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) required strengthening to ensure that care was assessed and delivered in a person-centred manner. For example, in one record reviewed, a resident who was known to wander and had been involved in incidents, did not have a specific care plan to meet these needs.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had not taken all reasonable measures to protect residents from abuse. For example, the records of accidents and incidents reviewed by the

inspector identified potential safeguarding risks that were not investigated and managed in line with the centre's own safeguarding policy.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were provided with a choice at all mealtimes. Residents were encouraged to maintain links with the community and keep up-to-date with national and international affairs through access to TV, radio, internet facilities and newspapers.

Independent advocacy services were available to residents and the contact details for these were on display. There was evidence that residents were regularly consulted with and participated in the organisation of the centre, through regular residents meetings, satisfaction surveys, and from speaking with residents on the day.

The availability of activities was impeded due to a lack of staff, as identified under Regulation 15: Staffing

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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Kilkenny Care Centre OSV-0008695

Inspection ID: MON-0042227

Date of inspection: 27/08/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Since the inspection another Activities Coordinator has been appointed so there are now two Activities Coordinators in post. • There is a full schedule of varied activities for residents to participate in, including small group activities, larger group gatherings and one-to-one activities. The range of activities provided is in accordance with residents' preferences and gives them a variety of opportunities for meaningful engagement and social interaction. • The PIC will ensure that there is regular feedback from residents via surveys, residents' meetings and through individual reviews, so that the centre continues to provide the activities that residents and enjoy and wish to participate in.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The PIC will monitor all adverse events, incidents and complaints and will ensure that any suspicions or allegations of abuse are reported, escalated, appropriately notified, investigated to the appropriate external authorities and addressed. • The PIC has reviewed the incidents and complaints and where there were any potential allegations of abuse, these have been retrospectively addressed, investigated and notified to the appropriate agencies, including HIQA and the HSE Safeguarding Team.	

• The PIC will ensure that there are safeguarding plans in place for vulnerable residents.
• The Healthcare Manager, Quality & Safety will conduct a Safeguarding Workshop for all staff, including management staff, to raise awareness of safeguarding concerns and to ensure that everyone will recognize a potential safeguarding concern and understand what their role is in protecting the residents.
• The PIC will review all wound care on a weekly basis to ensure that all wounds have been assessed, correctly classified and that an appropriate wound care plan is implemented. The Assistant Director of Nursing (ADON) will be responsible for the oversight of wound care and assessments, ensuring that clinical measurements and assessments are carried out to determine improvement or deterioration of the wound. Where advice is sought from a TVN, the prescribed advice will be adhered to.
• The PIC will review MUST assessments on a weekly basis and will support the CNM in ensuring that the MUST assessment tool is completed correctly. Nursing staff will be aware of the guidelines to follow and the appropriate actions to take and these assessments and action plans will be discussed at the monthly management meeting.
• The management team will continue to undertake reflective practice meetings with Nursing staff which will provide an opportunity to discuss areas requiring further improvement.
• The PIC and management team will continue to monitor all social assessments and care plans which have all been reviewed and updated since the inspection.
• The smoking shelter is now equipped with appropriate ashtrays and a fire blanket. A call bell system will be installed. Whilst awaiting installation of a call bell a staff member will supervise the area when in use. Residents have been consulted with in relation to ensuring that they smoke in the designated smoking shelter only.
• The PIC will ensure that documented hourly checks are in place for the safety and effectiveness of the bedrails in use.
• There are two Activities Coordinators in post, in accordance with the Statement of Purpose.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• The smoking shelter is now equipped with appropriate ashtrays and a fire blanket. A call bell system will be installed. Whilst awaiting installation of a call bell a staff member will supervise the area when in use. Residents have been consulted with in relation to ensuring that they smoke in the designated smoking shelter only.

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:

• The PIC will review all wound care on a weekly basis. The ADON will be responsible for the oversight of wound care and assessments, ensuring that clinical measurements and assessments are carried out to determine improvement or deterioration of the wound. Where advice is sought from a TVN, the prescribed advice will be adhered to.
• The PIC will review MUST assessments on a weekly basis and will support the CNM in ensuring that the MUST assessment tool is completed correctly, and that Nursing staff are aware of the guidelines to follow and the appropriate actions to take.
• The PIC will discuss these assessments at the monthly management meeting to ensure there is ongoing awareness and improvements in clinical practice.
• The PIC will continue to conduct reflective practice meetings with Nursing staff, which will provide an opportunity to discuss areas for further oversight and improvement.
• The PIC will ensure that all mobile Residents have a Dewing Wandering risk assessment completed. Residents care plans will be updated to reflect this.
• The PIC will ensure that social assessments are completed, reviewed as required and kept up to date.
• Care plans have been reviewed and updated and will be regularly audited to ensure they are person-centred and accurately reflect resident care needs.

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:

• We will ensure that the use of bedrails is in accordance with the centre's policy on the management of restraints and restrictive practice, including recording of hourly checks for the safety and effectiveness of the bedrails in use.
• We will ensure that the Restrictive Practice audit highlights areas that require closer attention and implement a quality improvement plan to ensure that restrictions are kept to a minimum.
• We will ensure that all staff have received training in managing responsive behaviours to enable them to assess resident's behaviour patterns, identify triggers and observe when behaviours are escalating, and to be able to provide appropriate interventions such as distraction and de-escalation techniques to help reduce agitation and anxiety. The aim of the training is to facilitate staff to take a consistent approach to managing behaviours that may be challenging in a calm and confident manner.
• We will ensure that the care plans for residents with responsive behaviours are individualised to their specific needs.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• The PIC will ensure that all safeguarding concerns are identified, and that the safeguarding policy is adhered to. All safeguarding incidents will be reported, escalated, notified to the appropriate external agencies, investigated and resolved to ensure the protection of all residents in the centre.
• The PIC will be vigilant in monitoring all adverse events, incidents and complaints to ensure that all potential safeguarding concerns are satisfactorily addressed.
• The Healthcare Manager, Quality & Safety will conduct a Safeguarding workshop in the centre for all staff, including the management team, to ensure that all staff are aware of how to recognise and respond to a potential safeguarding concern.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/10/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	27/11/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall	Substantially Compliant	Yellow	27/02/2025

	provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.			
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 designated centre concerned.	Not Compliant	Orange	30/11/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/11/2024
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	Substantially Compliant	Yellow	30/11/2024

	Health from time to time.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	31/10/2024