Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	The Royal Hospital Donnybrook
Name of provider:	The Royal Hospital Donnybrook
Address of centre:	Morehampton Road, Donnybrook, Dublin 4
Type of inspection:	Unannounced
Date of inspection:	14 August 2019
Centre ID:	OSV-0000478
Fieldwork ID:	MON-0027510

About the designated centre

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

The designated centre is located in the Royal Hospital Donnybrook The provider is the Royal Hospital Donnybrook and the primary governing body of the hospital is the Board of Management. The Chief Executive Officer(CEO) of the Royal Hospital Donnybrook is the nominated provider representative for the designated centre. The Director of Nursing for the Royal Hospital Donnybrook is the person in charge of the designated centre. The designated centre provides long-term residential services for 66 residents over the age of 18 years old with high and maximum dependency care needs. The premises is divided into three distinct units; Rowans, Oaks and Cedars. Accommodation is provided in a mix of single, twin and multi-occupancy rooms (of four to five beds). Oaks and cedars units are identical and each can accommodate up to 27 residents in either single or multi-occupancy rooms. All rooms are en-suite. There is a large dining room and a visitor's lounge on each unit. Rowans unit can accommodate 12 residents under the age of 65 years in eight single and two twin rooms. The unit has two communal lounges and a dining room. There are communal disabled access bathrooms and toilets on each corridor. All residents can access the facilities available throughout the centre including the prayer room, the concert hall, and a range of activities and therapy rooms located across the hospital site. The designated centre is located in South Dublin and is close to local shops and amenities and is accessible by Dublin Bus transport routes. There is a large car park at the front of the building with designated disabled parking areas.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	64

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
14 August 2019	09:25hrs to 17:55hrs	Sarah Carter	Lead
14 August 2019	09:25hrs to 17:55hrs	Paul McDermott	Support
14 August 2019	09:25hrs to 17:55hrs	Susan Cliffe	Support

What residents told us and what inspectors observed

During the course of this inspection inspectors spoke with a number of residents and observed routines in two of the units in the designated centre. A small number of residents shared their views with inspectors.

Residents who could mobilise around the centre independently or with minimal assistance reported that they were satisfied with the variety of activities available to them. In particular the mobile library service, the activity programme in the main hospital, the café in the main hospital and the polytunnel were praised by residents.

However, residents who did not enjoy the same level of independence were observed to spend the majority of their time in bed or by their bedside throughout the day with little interaction or stimulation. Some residents who required assistance to move their wheelchairs reported hesitation to ask for help as they were concerned their request would inconvenience staff. One resident also described having to ask for this assistance on a daily basis just to be able to leave their multi-occupancy room to clear their head for 10 minutes. One resident also described how they "waited for Friday" when their boredom could be relieved by heading out and about with visitors.

Some residents told inspectors they disliked, for various reasons, their multi-occupancy bedrooms. The reasons given included feeling claustrophobic, not getting along with other occupants, lack of space for their belongings, and noise and disruption from the activities of other residents such as their snoring. Some residents said they felt their space was "ok" and that they did not think they could ask for more.

It was observed that multi-occupancy bedrooms were cluttered with belongings, and this limited residents' ability to store their possessions and staff ability to clean spaces properly. As the majority of residents (up to 48 in total) in Oaks and Cedars Units shared bedrooms with four or five beds in each, there was limited opportunity for privacy within these bedrooms.

Inspectors observed that the multi-occupancy rooms contributed to a culture of institutional care. Bedroom doors were left mostly open, including when residents were in bed or the room was vacant, and staff did not consistently knock or request entry at bedroom doors. En-suite facilities were used as storage space which impacted on residents' ability to use them independently. Other institutional practices observed included:

- staff placing clothing protectors on residents at mealtimes without asking them if they wanted one
- residents repeating their greetings until staff, who were near-by, answered them
- residents told inspectors they disliked the food, saying it was tasteless and

never changed, while others were observed eating and drinking without comment.

Capacity and capability

This inspection was carried out to assess progress on improving the service following the high level of regulatory non-compliance found during the previous inspection of this designated centre in December 2018.

Following the last inspection inspectors of social services had corresponded with and met the registered provider responsible for this designated centre for the purpose of discussing:

- the requirement for urgent action to address identified regulatory non-compliances
- the requirement for urgent action to ensure that residents were protected from the risk of fire
- the future plans to renovate this centre before 31 December 2019

During this meeting the provider was reminded that regulatory compliance was a requirement of registration. The provider was also advised that the Chief Inspector was not satisfied with the most recent plans for the renovation of this designated centre, due to plans for the majority of future residents to continue to be accommodated in multi-occupancy rooms designed to accommodate four residents. The provider was advised that this was not were conducive to achieving and sustaining regulatory compliance.

In addition, on foot of the findings of the last inspection pertinent to fire safety, the Chief Inspector referred the centre to the local fire authority for their review.

Following the December 2018 inspection, the provider had engaged the services of specialist fire contractors and had corresponded with the Chief Inspector to report on their findings and progress. However, findings on this inspection indicated that there had been limited progress in the works needed to improve fire safety arrangements. There was poor oversight by the provider of the works completed to date, their effectiveness, and of the works that remained outstanding. It was also identified that the provider had not put adequate interim measures in place to ensure the service was safe, consistent and effectively monitored.

This inspection found that there was a lack of urgency and a fragmented approach at senior governance levels to address non-compliance and improve residents'

quality of life in the centre. There were insufficient measures in place to deal with issues of non compliance the management team were aware of, this was evidenced by:

- a failure to train staff correctly to reflect the reality of units of the designated centre
- not having sufficient compartmentation to prevent the spread of fire
- up to 48 residents who shared multi-occupancy rooms (of four or five beds in each) were continuing to live in a premises that negatively impacted their well-being, and limited their rights to privacy and dignity
- residents continued to have a lack of suitable storage and control over their own possessions.
- residents in multi-occupancy rooms were not fully safeguarded from incidents of abuse and aggression from other residents.
  lack of response to residents' and relatives' feedback
- a lack of involvement of senior managers in the day-to-day management of the three units of the designated centre.
- inadequate governance structure within the centre.
- the annual review of quality and safety in the centre had not been completed.
- the statement of purpose did not outline a clear governance structure or correctly describe bedroom occupancy.
- reduced staffing levels from 5.30pm impacted on residents preferred routines.
- complaints records were not consistent.

As a result of findings on the day of this inspection, an urgent compliance plan was issued to the registered provider to provide assurance that fire precautions were adequate in the centre. This was returned within five working days and contained satisfactory immediate assurance that work had commenced to complete key remedial works to create compartments in the units of the designated centre.

This urgent compliance plan also reported that drills had commenced, however these were grounded on a model of unit compartments which were not actually in place. Additional checks and documentation had also been implemented to address some of the non compliances in the regulation on fire precautions.

It is acknowledged that some works had been undertaken to address the risk of fire (these are detailed in the quality and safety section of the report) by the provider. However the provider was required to take further actions to strengthen the governance and management of the centre for the purposes of improving the the quality of life and well-being of the residents who live there and to protect the residents from the risk of fire. Areas identified as non-compliant in the previous report persisted and are detailed in the next section of this report.

Regulation 14: Persons in charge

The registered provider appointed a person in charge who has sufficient experience and qualifications as required by this regulation.

Judgment: Compliant

Regulation 15: Staffing

There was sufficient staff on duty to manage the needs of the residents on each of the three units in the designated centre throughout the day.

However this allocation of staff over the 24-hour period required review to ensure that residents are not adversely affected by staffing numbers decreasing to night time staffing levels at 17.30hrs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

This inspection found that staff were fully trained in safeguarding vulnerable adults and the prevention of abuse. While staff had been trained in responding to fire, improved oversight was required by the person in charge to ensure that the content of the training reflected appropriate fire and evacuation procedures based on the correct information regarding the building structures. This will be discussed further in Regulation 28 Fire precautions.

Additional person-centred communication training had commenced across the hospital which was an action from the last inspection; however, to date just nine staff in the centre had completed this.

Judgment: Substantially compliant

Regulation 21: Records

Staff records were reviewed and were found to contain all documents required in schedule 2 of the regulation. While files reviewed contained references, it was noted the system of verification of references required increased oversight.

Garda vetting disclosures were in place as required.

Judgment: Compliant

Regulation 23: Governance and management

The system of governance and management in place for this centre did not provide adequate oversight to ensure the effective delivery of a safe, appropriate and consistent service. A number of actions remained outstanding from the last inspection and had not been addressed in a timely manner.

There was a governance structure in place, however this was deemed insufficient to meet the needs of the designated centre. There was inadequate oversight of the day to day operation by the management team as evidenced by:

- poor levels of cleanliness, hygiene, general maintenance, and storage
- lack of awareness of fire risks and appropriate fire precautions
- failure to ensure that actions implemented following the last inspection were consistently adhered to.

The governance team had insufficient oversight of works that had taken place, and works that were planned to address fire safety risks as evidenced by:

- absence of oversight to monitor the quality and consistency of the fire safety checks allocated to staff following the last inspection
- minutes of recent governance meetings did not evidence ongoing oversight and management of these risks
- contradictory information pertinent to compartmentation provided before, during and after this inspection
- a lack of understanding of the structural issues pertaining to fire safety in the centre.

The clinical governance meetings and steering groups were hospital wide, and the designated centre was not a standing item on the agendas of these meetings. As a result:

- audits were completed and incidents were logged, but it was not clear how this information was actioned and whether learning was brought to staff in the centre on foot of any findings, for example complaints management
- metrics which were compiled were not specific to the management of the designated centre and so did not focus on areas of good or poor performance for the centre to support ongoing improvements
- management team walk-abouts which were commenced following the last inspection did not identify or address the issues identified on this inspection.
- an annual review of the quality and safety of care delivered to residents in

the designated centre had not been completed for the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required updating to ensure the services, facilities and structures within the designated centre were correctly described.

Judgment: Substantially compliant

Regulation 30: Volunteers

There was a large number of volunteers available in the wider hospital who provided a valuable service for residents. Volunteers files showed that the provider had obtained a Garda vetting disclosure for all volunteers with relevant staff very aware of the need to ensure that such a disclosure was in place before a volunteer took up any role in the centre.

However, role descriptions for volunteers were not clear, and increased oversight of their work in the units of the designated centre were required to ensure staff were aware of volunteer tasks and allocations.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Improvements were seen in the management of complaints since the previous inspection. Complaints management was now a standing item on the agenda of the clinical governance team, but as discussed above in Regulation 23, it was not possible to identify the level of review and actions taken on foot of complaints in the designated centre as discussion related to the wider hospital campus, rather than the designated centre.

An information leaflet informing residents and relatives about how to make a complaint had been developed, but was not easily available on the day of the

inspection.

There were disparities in the number of complaints reported between units, and these had not been explored by the management team. As such it was not possible to determine if this was a reporting issue, or a failure to address complaints raised.

Judgment: Not compliant

Quality and safety

Improvements were required to ensure care was person centred and would enhance the well-being of all residents living in the centre. Previously identified non-compliances in the quality and safety regulations persisted on this inspection. Improvements continued to be required in:

- Residents' rights.
- Residents access to and control of personal possessions.
- The management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
- Arrangements for visitors.
- Fire precautions.
- Premises.

Residents' records confirmed that their needs were assessed prior to admission, and when they arrived at the centre care plans were developed. A number of care plans reviewed provided details on residents' needs, but did not set out their preferences in relation to how care was to be delivered. A comprehensive activity programme was available throughout the wider campus, with some specific groups taking place in the units of the designated centre. However, it was not clear how this programme or groups were influenced by the identified recreational interests and social needs of the residents living in each unit.

Inspectors focused on the Oaks and Cedars Units on this inspection. These units continue to provide accommodation for 27 residents on each unit in a mixture of single and multi-occupancy rooms. A number of residents had lived in the multi-occupancy rooms for several years. Inspectors found that the current layout of the multi-occupancy rooms and the number of residents sharing the en-suite facilities in these rooms did not ensure that the privacy and dignity of residents were maintained at all times. For example in the multi-occupancy rooms the en-suite facilities were shared by four or five residents. Some residents had previously told inspectors that they had to wait long periods to use the toilet or shower facilities when they were occupied by other residents. On this inspection records in the centre showed some residents continued to find this frustrating and it could trigger episodes of responsive behaviours. When a resident was receiving personal care,

their conversation and activity could be clearly overheard by the other people in the room.

Residents had access to radio televisions and newspapers. However, throughout the inspection inspectors observed that residents occupying the multi-occupancy rooms may be impacted by other residents' media choices. Records showed that some residents in these rooms found the noise levels from other residents' televisions and radios to be intrusive in their daily lives. This was being managed by the provision of headphones, however if residents did not wish to use headphones they would have their opportunities to enjoy TV and radio restricted.

The centre had not taken any additional actions to ensure that residents were safeguarded from harm since the last inspection. While all staff and volunteers working in the centre had Gardai vetting in place and attended mandatory training in relation to the centre's safeguarding procedures, there were ongoing incidents in the multi-occupancy rooms related to lack of privacy. When concerns had been raised records showed that this had been investigated by the person in charge and where the concern had been upheld, a safeguarding plan was agreed with the resident. Some safeguarding plans included plans for residents to transfer to alternative designated centres.

Again on this inspection, inspectors observed that residents often kept clothes and personal possessions in plastic bags and in suitcases when they did not have enough room in the single wardrobe and locker that were allocated to each resident. There were personal possessions cluttered on windowsills and on the surfaces above wardrobes.

The general maintenance of the units of the designated centre required improvement. There were signs of wear and tear where the walls and skirting boards had been damaged and not repaired. In addition, an area designated as a fire escape route was being used as a storage area for residents' belongings. Storage facilities remained inadequate on the units. Equipment was being stored on corridors which blocked access to the handrails and created a trip hazard, for example blood pressure monitors, and batteries being charged along corridors.

While it is acknowledged that some improvements had been made since the last inspection the inspectors, were not assured that fire precautions in the designated centre would ensure the safety of residents and staff.

The inspectors were advised that further extensive upgrade works identified in the fire safety risk assessment completed in February 2019, were due to commence shortly and are to be completed by the end of 2019, with the upgrading of the fire detection and alarm system and fire doors to common areas throughout the greater building due to be completed by the end of March 2020. However as discussed in the capacity and capability section of this report, information was given at the end of the inspection day by the management team which indicated the compartmentation works on units had been completed. Clarifications were sought the day following this inspection, and the response received indicated that these works had not been completed.

Regulation 11: Visits

Visits were not restricted unless a specific reason and risk was clearly outlined.

In the units with a majority of multi-occupancy rooms (four or five residents) the visiting and family spaces required improvement to ensure they were fully accessible, comfortable and inviting.

There was a family room available on Oaks unit that was seen to be in use on the day of inspection. However, in Cedars Unit the family room was not in use, and access to it in the morning was obstructed by the storage of wheelchairs. Improvement in access to these rooms remained outstanding from the last inspection.

There was adequate communal space on the wider premises; for example a café and other spaces, but residents required a level of independence or support to be able to utilise these facilities.

Judgment: Substantially compliant

Regulation 12: Personal possessions

There were inadequate facilities for residents to store their clothes and possessions in the multi-occupancy bedrooms on Oaks and Cedars Units (10 bedrooms in total for 48 residents). As a consequence:

- residents were very restricted in what personal belongings they could have beside their bed space and as a result there was limited personalisation of bed spaces for these residents
- residents in these units had piles of clothes and possessions on window sills, in boxes, and cluttered around their bed spaces
- residents did not have sufficient control over their own clothing, due to limitations of storage and the collection of laundry
- multi-occupancy rooms were untidy and difficult to navigate if you required an aid to mobilise
- multi-occupancy rooms lacked ventilation as the accumulation of belongings

on window sills impacted on the ability to open windows.

While the issue of lack of storage had been raised by residents and discussed at a residents meeting, no action had been taken to address the issue by the time this inspection had taken place.

These issues remained outstanding from the previous inspection.

Judgment: Not compliant

Regulation 17: Premises

The premises of the designated centre does not meet regulatory requirements.

The multi-occupancy rooms were not of a suitable size or layout for the residents who lived there as evidenced by:

- inadequate private accommodation for residents (privacy screening was available but beds were close together)
- lack of opportunity to have private conversations and conduct activities in private
- insufficient storage facilities for residents' belongings.

The number of accessible bathrooms was inadequate for the residents of multi-occupancy rooms. Residents reported having to wait to use facilities.

There was a lack of pleasant seating areas away from bedrooms and dining rooms on two of the three units. There was also insufficient storage for equipment and clinical appliances, and consequently equipment and residents' belongings were inappropriately stored in bedrooms and ensuites.

In addition, the premises was not maintained or cleaned to the required standard. Inspectors observed the poor state of repair of some rooms and corridors, an odour of stagnant water in some internal rooms and foul odours in some ensuites.

A number of these issues remained outstanding from the previous inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

At the time of inspection the registered provider had not taken adequate precautions

to ensure that residents were protected from the risk of fire, or provided adequate procedures for the evacuation of residents.

Significant improvements were required to comply with the requirements of the regulations to ensure that residents and staff were adequately protected from the risk of fire.

The service was non-compliant with the regulations in the following areas:

Inspectors were not assured that adequate precautions were being taken against the risk of fire. For example:

- Interim fire safety measures that were proposed by the provider since the last inspection were not being effectively implemented.
- Oxygen supplies within the Oaks unit were inappropriately stored in a general storage room.
- The daily fire marshall checks identified in the 'Fire incident management action card' were not being implemented

Inspectors were not assured that adequate means of escape were being provided throughout the centre. For example:

- It was observed that the travel distances to compartment boundaries, and the distance between cross corridor doors, along the escape corridors within all three units exceeded the maximum distances recommended for phased horizontal evacuation. The provider has advised that the works required to address this matter are due to commence shortly and are to be completed by the end of 2019.

Inspectors were not assured that adequate arrangements had been made for reviewing fire precautions.

- The fire safety policy, evacuation plan and emergency plans were dated 13 May 2019. They were not specific to the centre and did not include:
    - The findings of the fire safety risk assessment completed in February 2019, and the identified risks and their impact on the safety of residents and staff pending the completion of upgrade works that are due for completion by the end of 2019.
    - The identified lack of effective compartmentation or sub compartmentation and fire containment within the units and its impact on the evacuation strategy.
    - The identification of interim arrangements that may help to ensure the safe evacuation of residents, and staff assisting with their evacuation, pending the completion of upgrade works required in the centre.
    - The policy documents within each unit dated back to 2014 and were not updated in line with the May 2019 policy documents.

Inspectors were not assured that staff working in the centre were adequately prepared for the procedure to be followed in the case of fire and for the safe and

timely evacuation of residents.

- It was observed by inspectors that the largest compartment in the centre has 27 residents most of whom have high evacuation assistance needs. Evacuation drill records were not available to provide assurance that the procedures or staff or evacuation resources in place to evacuate this compartment in a safe and timely fashion were adequate.
- A complete compartment evacuation had not been practiced during fire drills using daytime and night time staffing levels.
- Following the inspection, an additional drill report was submitted. However, it was based on evacuation to inadequately protected sub compartments within the units.
- As identified during the previous inspection, ski sheets have been fitted to a number of beds, however staff indicated that bed evacuation was commonly used. Clarification on the preferred evacuation methods should be provided to all staff.

The registered provider did not make adequate arrangements for detecting and containing fires:

- The fire safety risk assessment completed in February 2019 identified that fire containment measures were inadequate in all three units with works required to doors, compartment walls, escape corridor walls and void spaces. The inspectors were advised that the works required to achieve adequate containment were due to commence shortly and are to be completed by the end of 2019.
- The fire detection and alarm system and fire doors in the common circulation areas, used as part of the escape routes from each unit, were inadequate. The inspectors were advised that the works identified in a fire safety assessment report prepared in May 2017, recommending the upgrading of the fire detection and alarm system and fire doors to common areas throughout the greater building would be completed by the end of March 2020.

Inspectors were not assured that adequate arrangements had been made for evacuating all persons from the centre in a timely manner with the staff and equipment resources available. For example:

- The increased risks to the safety of residents and staff arising from the inadequate fire containment measures identified in each unit have not been addressed in the evacuation procedures or fire precautions. Inspectors spoke to staff who were unaware of the ineffective fire containment or how it may affect the evacuation of the unit.
- The evacuation plan requires full compartment evacuation within each unit. This procedure has not been practiced, or demonstrated to be adequate using either daytime or night time staff levels.
- Fire drills had not been conducted to identify how long it will take to evacuate all residents from each compartment, and in turn to assess if the evacuation times are adequate to ensure the safety of residents and staff.

- Satisfactory interim arrangements that ensure the safe evacuation of residents and the safety of staff assisting with their evacuation, pending the completion of upgrade works, have not been identified or implemented.

While it was observed that the fire procedures are prominently displayed a zone plan had not been displayed next to the fire alarm panel.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A suite of evidence-based assessment tools were in use to identify residents needs and to develop care plans. In the sample of care plans seen, sufficient detail was provided to guide staff to provide some aspects of care.

Assessments were completed to identify residents social and recreational needs and their ability to engage. However the details and information given was limited, and there was no evidence that this information was used to generate a care plan to meet residents' social needs.

Daily records of residents' attendance at activities were maintained, however there was no record of the quality of engagement or the link between residents' social assessments and their routines.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Care plans that set out how to support residents who experienced responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had improved since the last inspection.

Equipment which offered the least amount of restriction, for example low beds, was available and in use in the centre.

A review of care plans showed that the majority of triggers for responsive behaviour were identified as related to multi-occupancy rooms, and the residents proximity to others and the clutter in their environment. However, inspectors were not assured that steps had been taken to address these issues. Responses were seen to focused on offering residents opportunities to communicate with staff and to leave their bedroom area, but this was further restricting their rights to privacy.

Judgment: Not compliant

Regulation 8: Protection

There was a policy in place, and staff were fully trained to protect residents from abuse. In cases where an allegation was made, the person in charge had investigated or nominated a suitable person to investigate the identified issues.

Of the incidents notified to the Chief Inspector, approximately half of the incidents in 2019 to date where allegations of abuse were made related to allegations arising from interactions between residents in multi-occupancy bedrooms. Inspectors were not assured that reasonable measures were being taken by the provider to protect residents from abuse.

Judgment: Not compliant

Regulation 9: Residents' rights

Throughout the inspection it was noted that some residents spent long periods of time in bed, or sitting by their bed and not engaged in activity. Although the registered provider had provided facilities and opportunities for recreation these were shared with the main hospital and mainly located externally to the three units of the designated centre. This meant that residents who were less mobile may be restricted in attending.

Although some specific activities took place on each unit of the centre, on the day of the inspection these did not meet the needs of those residents who remained in bed or beside their beds throughout the day. The person in charge informed inspectors that there were plans to train staff to provide activities to residents with dementia and higher level cognitive impairment but this had yet to be implemented.

The majority of residents in Oaks and Cedar units lived in multi-occupancy rooms shared by four or five residents. These rooms were seen to negatively impact on residents and did not provide residents with the opportunities to:

- undertake personal activities in private.
- communicate freely and listen to their TV or radio without headphones
- exercise choice in their daily routine due to the lack of personal space, privacy and the needs of other residents in the surrounding beds
- exercise their right to privacy as bedroom doors were open throughout the inspection, and staff were observed entering without knocking or seeking

permission.

A residents council meeting had occurred, however it is attended only by a small number of residents who represent their unit. The minutes indicated that several pertinent topics were raised, but no actions were listed, and no personnel were identified as responsible for the actions. There was no evidence that minutes from the residents' meeting were discussed at the clinical governance meetings. A residents' survey had also been carried out, but the response rate was low, despite an accessible version of the questionnaire being available. The results were recently compiled in a list format, and had not yet been discussed at management level.

Judgment: Not compliant

Regulation 27: Infection control

Procedures to ensure appropriate infection control measures were in place required improvement. During the inspection it was noted that both communal and residents' personal areas, for example the space around their beds, were not clean. These areas were pointed out to the person in charge who observed that improvements were required.

In addition several ensuite facilities required immediate attention to deep clean and remove

- engrained dirt and organic matter from toilets, raised toilet seats, walls and shower areas
- extensive dust on ledges and items such as sharps bins used to collect used razors

Inspectors observed staff assisting residents to use bathroom facilities that were not clean and malodourous without making any effort to address t he situation. When this was brought to the attention of more senior staff on the unit immediate arrangements were made for cleaning staff to address these issues

Extractor fans in two ensuites were out of order, as these ensuites did not have windows there was no ventilation of these areas in the absence of the extractor fan. As a result there was a strong offensive smell emanating from these ensuites

Judgment: Not 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant
Regulation 27: Infection control	Not compliant

Compliance Plan for The Royal Hospital Donnybrook OSV-0000478

Inspection ID: MON-0027510

Date of inspection: 14/08/2019

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: As per feedback form – a previous HIQA inspection of Dec 2018's finding was that staffing was compliant. There has been no reduction to staffing levels since then. There was in fact an addition of 1 HCA 17.30 – 20.00 hr to the staffing levels, seven days. The inspector has reviewed the compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Person Centered Training commenced in May 2019 and all nursing and healthcare assistant staff assigned to the Designated Centre will attend Person Centered Communication training by 31.12.2019. Monthly Fire Training sessions continue. An external fire consultancy has assigned a new fire trainer to the site. The findings of HIQA and Dublin Fire Brigade inspections have been shared with this trainer. It has been specifically requested that an emphasis is placed on education regarding Fire Compartmentalisation and the use of evacuation aids. The hospital will also enhance the weekly drills in every ward in the actual use of ski-sheets for horizontal and vertical evacuation, as well as the use of 'sledges' for vertical evacuation. Designated Areas will be provided with training equipment and will be required to conduct a physical drill simulating the evacuation of a resident by these methods. This requirement will be rolled out by October 31st 2019.	

The inspector has reviewed the compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Annual Review for 2018 has been completed on 11th September 2019. The Clinical Governance Group report now reflects quality audits specifically related to the Designated Centre as opposed to being included in the whole campus report. All quality groups reporting to The Clinical Governance Steering Group now report separately for the Designated Centre including identifying trends, actions required, persons responsible and follow up outcomes. The new interim CEO is mandating an Emergency Planning team to meet fortnightly for the next quarter, to review all policies, procedures and training plans relating to Fire management, Emergency Planning, Evacuation and Business Continuity across all hospital services including the Designated centre. Related documents will be modified to contain specific sections for the HIQA designated areas. The Hospital will raise the requirement for having a dedicated person-in-charge for the designated centre with the HSE at meeting on October 10th.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose has been updated and now includes clearer information regarding the numbers and location of beds within the Designated Centre. This also highlights that although 66 beds are registered, RHD maintain a maximum occupancy level of 64.

Regulation 30: Volunteers	Substantially Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers: Detailed role descriptions for volunteers and Community Employment Scheme staff who are allocated specific roles will be developed by the 31st October 2019. A Standard Operating Procedure will be developed in order for staff to have greater oversight of Volunteers and Community Employment Scheme Staff tasks and allocations, and to record feedback regarding resident interaction with activities by 31st October 2019.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: From August 2019 complaints from the Designated Centre is specifically a standing item on the Clinical Governance Steering Group agenda. From September 2019 the Person in Charge reviews all complaints from the Designated Centre monthly with each Clinical Nurse Manager including review of locally held complaint logs, in order to explore and identify any disparities between units.	
Regulation 11: Visits	Substantially Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: RHD fully recognises the inadequacy of the current premises with regards to privacy and dignity for our residents and their visitors, the restrictions this places on available private visiting spaces and the issues highlighted previously. The Friends of the Royal Hospital recently presented monies to RHD specifically for the refurbishment of the visitor rooms on Oaks and Cedars Wards. This will include improved accessibility. The Clinical Nurse Managers are coordinating locally with input from residents also. It is anticipated works will commence by year end 2019.	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: RHD fully recognises the inadequacy of the current premises with regards to privacy and	

dignity for our residents and their visitors, the restrictions this places on storage space and the issues highlighted previously. In the short term: a) RHD will consult with residents and staff on their storage requirements b) explore storage options that are compatible with a hospital environment c) prepare budget estimates to provide the solutions identified and d) seek the required funding from The Friends of The Royal Hospital Donnybrook. These steps will be complete by end of November 2019. In the longer term, RHD is exploring options to develop a purpose built suitable environment for residents.

The inspector has reviewed the compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
RHD fully recognises the inadequacy of the current premises with regards to privacy and dignity for residents and the restrictions this imposes on Residents. The urgent requirement for investment in the unit will be raised with the HSE at a meeting on October 10th. As with the actions proposed for storage, RHD will cost the works to repair, paint and decorate Oaks and Cedar and seek the funding to address this need by end of 2020. In the medium term, if no alternative to the current environment is available, the Hospital will comply with the statutory regulations and reduce occupancy in multi-occupancy rooms to four residents, in accordance with the timeframe prescribed by those regulations.

The inspector has reviewed the compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Since our provider meeting in March, the Hospital has engaged a Fire safety consultancy. They devised a prioritised remedial plan, as provided to HIQA and to Dublin Fire Brigade. We have been implementing the plan and have based procedures in accordance with the advice received.

As per our Urgent Compliance Plan presented in August:

• A fire stopping and sealing consultant was appointed and commenced on site on August 22nd. These works were completed and certified for all three designated areas on August 30th, rendering all hospital procedures and training valid in respect of progressive horizontal evacuation.
• During this period the hospital operated an hourly Fire watch in all ward and corridor areas on a 24-hour basis. From certification of the works, patrols are being conducted on a 2 hourly basis in all wards, including the vacant ward, over 24 hours.
• Electronic swipes have been fitted across the hospital to improve security patrol compliance, monitoring and reporting.
• We implemented a weekly programme of timed, full evacuation drills for each of the designated wards for four weeks. A total of 12 such drills have now been completed. These alternated between daytime and out-of-hours scenarios. The drills established baseline evacuation times of both sub-compartments and entire wards. They indicate that the 12 bed Rowans unit can be evacuated in its entirety in less than 5 minutes. In the larger wards, beds/chairs were evacuated in less than 8 minutes.

The Hospital will continue to progress the overall plan for hospital wide systems

The hospital has:
• Upgraded the Fire Alarm and Detection Systems in the designated areas to the required L1 standard
• Ensured that the current Emergency lighting is fully functioning in designated areas and associated escape routes
• Upgraded priority doors to enhance compartmentalisation in designated areas
• Obtained certification from our Fire Consultants for these priority works, which has been submitted to HIQA and Dublin Fire Brigade
• Progressed tenders to award stage for the entire hospital wide upgrade of the Fire Alarm and Detection System and Emergency Lighting system and passive systems remedial works.
• Maintained hospital-wide out-of-hours security patrols for the purposes of fire safety as outlined. These will continue (with enhanced recording), until the Fire Consultant certifies that they can be discontinued.
• Increased the frequency of fire drills
• Increased the frequency of fire training for ward staff
• Is enhancing week-end drills for ward staff on the use of patient evacuation equipment, with a physical simulation of evacuation required. This is be introduced by end of October 2019.

The expenditure on the tender items requires Board approval and is on the agenda for the next meeting on September 26th.
The successful tender for the remedial doors and structure works contains a programme estimate of 6 weeks (that programme to be shortened in-line with the additional works that were accelerated and certified on Aug 30th.)
The successful tender for the FDAS and EL contains a programme estimate of 30 weeks.
Ongoing compliance requires continuous attention to Fire Safety issues and the hospital will continue to address this through the existing organisation structures, with the

support of an external Fire Consultancy.

The Hospital has introduced arrangements, with dedicated clerical time, to collect, collate and review all Fire Register documents, including electronic reports, Ward & Department Fire Marshal checks and maintenance dockets, on a routine basis.

Senior Management continues to engage with ward managers, highlighting the recent HIQA findings, to ensure that the role and duties of the local Fire Marshal are properly executed.

The interim CEO is establishing an Emergency Planning group to review all relevant policies, procedures and training programmes.

The inspector has reviewed the compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All staff will attend Person Centered Communication by 31st Dec 2019. A full care plan review of each Resident will be undertaken by the Clinical Nurse Managers in consultation with each resident, by 30th November 2019. A survey will be developed by the end of November, to identify resident preferences for social activities. With the result of the surveys, RHD will develop an enhanced and person centered programme of activities, which will be enabled by the development of an SOP and greater oversight of volunteers and Community Employment Scheme staff. A document in the residents care plan will be developed and updated to reflect feedback from volunteers and residents on activities which they have participated in.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing

behaviour that is challenging:
RHD fully recognises the inadequacy of the current premises with regards to privacy and dignity for our residents and the issues highlighted previously. All behaviour which is challenging is documented, reported and immediate management interventions implemented to insure safety of all residents. Behaviours are discussed at the monthly Incident Review Group meetings which are attended by senior management and further remedial interventions identified and actioned. Separate MDT meetings where appropriate are convened to discuss additional measures. RHD offer ongoing education and training and support to staff in managing residents with responsive behaviours. Residents are supported by the Multidisciplinary team which includes medical social work and psychology.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All staff attend mandatory Safeguarding training and all safeguarding concerns are reported to HIQA and the HSE Safeguarding Protection Team. Safeguarding plans are in place for all concerns. Residents are supported by the Multidisciplinary team including Medical Social Worker and psychology.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
As per feedback form- Resident Council meetings take place quarterly. These recommenced in March 2019, following the return of a staff member from leave. These meetings are attended by representative of each ward and are not intended for all residents to attend. Any resident can be a representative. From September 2019 the Resident Council meetings are a standing item on the Clinical Governance Steering Group meeting, where issues raised and actions taken are noted and escalated to the Clinical Governance Group of the Board. 14 volunteers attended Life Stories education in August 2019 which is intended to focus activities on residents with cognitive impairment on a 1:1 basis. The activity schedule will undergo review and this will be completed by 31st October 2019 and will focus on those residents who do not or cannot partake in group activities or who prefer to remain in their bedrooms throughout the day. In smaller rooms, bedroom doors are closed unless it is the Resident's wish that they remain open. A resident's survey was conducted in July 2019 and this will be repeated every two months ongoing. The results of this were discussed and actioned at the Clinical Governance Steering Group in August 2019 and it is now a standing item on that agenda. RHD fully recognises the inadequacy of the current premises with regards to privacy and

dignity for our residents and the issues highlighted previously. Residents and family are invited to attend meetings at unit level on a quarterly basis.

The inspector has reviewed the compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Local hygiene audits are now conducted monthly by the Clinical Nurse Manager and Cleaning Supervisor. These audits show compliance of 94% in September 2019. Issues identified at ward level by staff are actioned immediately by cleaning staff. Bathrooms are not used to store any items. Deep cleaning of each bedroom is carried out weekly and monitored by Clinical Nurse Managers. The extractor fans were examined by hospital maintenance immediately after inspection and found that they were turned off and not broken. They are now working.

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 11(2)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	31/12/2019
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in	Not Compliant	Red	29/11/2019

	particular, that a resident uses and retains control over his or her clothes.			
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Not Compliant	Red	29/11/2019
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	01/09/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/12/2019
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to	Not Compliant	Orange	01/01/2022

	the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/03/2020
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	01/01/2020
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Red	01/01/2020
Regulation 23(c)	The registered provider shall ensure that	Not Compliant	Orange	31/12/2019

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Orange	11/09/2019
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Orange	01/01/2020
Regulation 23(f)	The registered provider shall ensure that that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the Chief Inspector.	Not Compliant	Red	29/11/2019
Regulation 27	The registered	Not Compliant	Orange	01/09/2019

	provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/11/2019
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/11/2019
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	21/08/2019
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the	Not Compliant	Red	21/08/2019

	designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2019
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Red	21/08/2019
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	30/11/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	01/09/2019
Regulation 30(a)	The person in	Substantially	Yellow	31/10/2019

	charge shall ensure that people involved on a voluntary basis with the designated centre have their roles and responsibilities set out in writing.	Compliant		
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	31/10/2019
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/11/2019
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	Substantially Compliant	Yellow	30/11/2019

	it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	01/01/2022
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	01/01/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	31/12/2019
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other	Not Compliant	Red	01/01/2020

	residents.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Red	01/01/2020
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident radio, television, newspapers and other media.	Substantially Compliant	Yellow	01/01/2022
Regulation 9(3)(c)(iv)	A registered provider shall, in so far as is reasonably practical, ensure that a resident voluntary groups, community resources and events.	Substantially Compliant	Yellow	31/12/2019
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	31/12/2019