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:	St Brendan's Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Lake Road, Loughrea, Galway
Type of inspection:	Unannounced
Date of inspection:	06 January 2020
Centre ID:	OSV-0000633
Fieldwork ID:	MON-0028343

About the designated centre

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

St. Brendan's Community Nursing Unit is a purpose built residential care facility overlooking the lake in the town of Loughrea in County Galway. It provides twenty four hour nursing care for 100 people over the age of 18 years whose care needs range from low to maximum dependency. The building comprises four care areas. Sliabh Aughty and Crannogs on the upper floor and Knock Ash and Coorheen on the ground floor. Coorheen provides care for people with dementia. Each care area has 21 single rooms and two double rooms and all bedrooms have accessible en-suite toilet and bathroom facilities. There are two sitting/dining rooms in each care area. An additional quieter sitting room is located on the ground floor which has tea and coffee making facilities and additional visitors rooms are available in the day service area.Four beds are available for residents requiring respite care. There is also a palliative care suite supported by the hospice home care team available. Day Care Service is provided for up to 30 clients daily.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	79

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
Monday 6 January 2020	09:00hrs to 16:30hrs	Catherine Sweeney	Lead
Monday 6 January 2020	09:00hrs to 16:30hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Residents were observed to have high levels of dependency, some of whom remained in their bedrooms all day. Inspectors observed residents to be relaxed and contented in the company of staff.

Inspectors observed staff to be kind and respectful when communicating with residents. Residents were assisted with their meals in a discreet and respectful manner.

Capacity and capability

The Health Service Executive is the registered provider of this designated centre.

Significant interaction occurred with the registered provider (HSE) following the last inspection on the 25 September 2019 due to poor findings relating to staffing, training and development, fire safety, risk assessment and governance and management.

Given the concerns around fire safety on the previous inspection, an immediate action plan was requested and a report was made to the local Fire Authority. The subsequent action plan submitted by the provider did not provide the required assurance that the centre would be brought into regulatory compliance.

A provider meeting was held on 22 October 2019. The provider failed to produce a compliance plan which addressed the risks identified on the inspection and this resulted in a condition being proposed to be added to the centre's registration. The condition detailed that no new residents may be admitted to the designated centre until the centre has been inspected by Inspectors of Social Services and the registered provider is deemed to be operating the centre in accordance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The provider submitted a representation on 26 November 2019. This inspection was to examine if the proposed actions taken to address the regulatory non-compliance had been completed. The inspection also took account of unsolicited information received relating to residents being left in bed unnecessarily, poor or no meaningful communication with families prior to residents being transferred to hospital, complaints not being recorded and poor hygiene practices due to issues with the water supply. Inspectors found that the concerns outlined were partially substantiated.

While there were some improvements identified during this inspection, a number of areas had not improved and other areas of non-compliance were identified.

A recruitment process was in place for the appointment of a person in charge. This inspection was facilitated by a Clinical Nurse manager. The general manager for services for older people was also present and confirmed that a new person in charge would be in place by early 2020.

The centre is registered to accommodate 100 residents. There were 79 residents accommodated on the day of the inspection. A review of the rosters showed that the use of agency staff has been reduced and the skill mix on each unit took account of the allocation of agency staff, ensuring that they work with permanent staff at all times. However, although staffing levels were appropriate for the occupancy of the centre on the day of inspection, they would require further review and adjustment upwards when admissions re-commenced.

Poor practice continued in the governance and management of the centre. Inspectors found continuing significant gaps in the management systems used to ensure that safe, consistent care was delivered to residents.

Areas found non-compliant on the last inspection and repeated on this inspection included:

- governance and management,
- risk management,
- infection prevention and control,
- fire safety,
- individual assessment and care planning
- resident's rights.

Additional areas of non-compliance found on this inspection included the management of complaints, notifications, and medicines management.

Regulation 15: Staffing

The provider had conducted an analysis of staffing requirements since the last inspection. The analysis identified the requirement for whole time equivalent roles of two clinical nurse managers, nine nurses and five multi-task attendants. In the interim, staffing continued to be supported by agency staff. The provider informed inspectors that a recruitment plan was on-going. A person in charge was due to commence employment in early 2020.

A review of the rosters found that the use of agency staff had reduced since the

last inspection and that allocation of agency staff was made with regard to skill mix and resident safety.

The staffing level on the day of inspection was adequate for the number and the dependency of residents, however, the staffing level will require review and adjustment as occupancy increases.

Additional resources had been allocated to the cleaning team to facilitate the management plan associated with the contamination of the water supply with Legionella.

Judgment: Compliant

Regulation 16: Training and staff development

A training matrix was available for review. Mandatory training had been completed by most staff.

Fire safety training had been scheduled and delivered to all staff, including agency staff. A new fire safety system had been installed following the delivery of fire safety training. A revised training session on the updated fire system was established and had been completed by most staff. Eight maintenance workers had not received training in the updated fire system. This was a risk as the maintenance team formed part of the oversight group for the installation and maintenance of the new fire system.

Inspectors were also not assured that the fire safety training was adequate or complete as there was no up to date fire safety policy in place for review.

Furthermore, the management team had not received training in auditing, as identified in the compliance plan from the last inspection.

A review of the service agreement for all agency staff found that agency staff would be trained in areas including infection control, fire safety and safeguarding. This is a completed action from the last inspection.

All staff had received training in Infection control and hand hygiene.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems in place did not ensure that the service provided is safe,

appropriate and effectively monitored. This was evidenced by the following:

- Systems for communication were poor. Staff meeting notes did not identify who attended, actioned items or priority issues of non-compliance with the Health Act. Actions were not identified, delegated and followed up.
- Complaints management was poor with ineffective oversight of the process.
- A notification was not submitted to the Chief inspector in relation to an allegation of abuse, as required by the regulations
- Oversight of building maintenance was not comprehensive. For example, the auditing process in respect of the flushing procedure for the management of legionella, did not include all parts of the centre, therefore, the effectiveness of the procedure could not be guaranteed.
- Risk management systems in place were poor. For example, the poor practices employed by staff to obtain hot water for hygiene purposes had not been identified by the person in charge.
- Failure to adequately address the non-compliance found from the last inspection.
- The documentation system for recording care provided to residents was not robust. For example, the records for personal hygiene seen could not evidence that residents hygiene needs were being met in line with their assessed care needs.

The provider representative informed the inspectors that the organisational structure in the centre was impacted by staff absence and recruitment delays. While there was sufficient staff on duty on the day of the inspection, overall staffing levels required review prior to the commencement of new admissions to the centre and progress was needed to ensure the staffing compliment was in line with the information set out in the statement of purpose.

Judgment: Not compliant

Regulation 31: Notification of incidents

The Chief Inspector had received unsolicited information relating to a complaint that included an allegation of abuse. The management team confirmed that this complaint had been received in the centre. The person in charge failed to notify the Chief Inspector of this allegation of abuse.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors reviewed the complaints log and found that some complaints that had been received by the centre in relation to resident care had not been documented in line with the centres policy. For example, interventions that had been put in place to address the issues in the complaint had not been documented.

The information received in the complaint should have been identified as an allegation of abuse and management through the safeguarding procedures

Judgment: Not compliant

Quality and safety

Overall, improvements were required to ensure that residents received person-centered care in accordance with their individual assessed need, and in line with evidenced based practice.

The unsolicited information received by the Chief Inspector was partially substantiated by the observations of the inspectors on the day of inspection.

Following a previous inspection, an immediate action plan was issued to address non-compliance in Regulation 28, Fire Precautions. This inspection followed up on the actions taken. The registered provider had not made adequate arrangements for the detection of a fire. While the fire systems in the centre had been upgraded, the information required to appropriately detect a triggered sensor from the fire panel was not in place. There was no up-to-date fire policy available for review.

Overall, improvement was noted in the cleanliness of the centre. The centre was clean and clutter-free throughout. All staff had received up-to date training in infection control. Cleaning and Infection control policies had been reviewed and updated to reflect best practice guidelines.

The centre continues to manage the contamination of the water supply with legionella. A protocol was in place to manage the contamination and to protect residents. However, inspectors noted that some practices had developed as a result of the water restrictions that had been put in place, that were not in line with best practice, and posed a significant risk to both residents and staff. For example, staff were carrying hot water from the kitchen areas through the communal areas. A review of residents access to hot and cold water for washing was required. From records reviewed and discussion with staff, it could not be determined how often residents hygiene needs were met.

A review of a resident incident found that medicines, assessments and care planning documentation was not in line with professional guidelines.

Residents continue to be restricted in relation to their choice of dining area. The dining areas in the centre are small and do not accommodate all the residents in the centre. This is a on-going non-compliance which was due to be addressed by December 2019.

Regulation 26: Risk management

The risk policy was reviewed and found to be in compliance with Regulation 26. The risk register had been updated to include the risks outlined in the risk policy and the risks identified during the last inspection. Risks found on this inspection related to :

- Risks associated with carrying jugs of hot water from the kitchen to residents bedrooms has not been identified
- There was lack of appropriate supplies to ensure best practice around cleaning and disinfection.
- Lack of information on fire panel map with no up to date fire policy

These risks had not been added to the risk register.

Judgment: Not compliant

Regulation 27: Infection control

Improvement was noted in the general cleanliness of the centre. A cleaning schedule for bedrooms and toilet areas had been developed and was followed by cleaning staff. Cleaning staff had received training in infection control and cleaning procedures. All windows have been cleaned inside and out and an ongoing window cleaning schedule was in place.

The centre continues to manage the contamination of the water supply with legionella. Re-testing of the water supply is scheduled for January 2020. Access to washing facilities had been restricted since April 2019, with eighteen shower units fitted with filters to allow residents to shower safely. If a resident requires water to wash in their bedrooms, hot water was collected in jugs from the boiler in the kitchen and topped up with cold water from the drinking water dispenser. Staff confirmed that this was practice throughout the four units of the centre. An audit had been completed on the flushing procedure, however, not all parts of the centre had been included. Staff gave a commitment to repeat the audit.

The provision of residents hygiene needs was poorly recorded by nursing staff on their computerised system and by carers on a paper document. There were a number of gaps on the records reviewed. In some instances, when recorded that a resident refused, for example, a shower, there was no evidence if a shower was offered at a different time or on another day. For one resident, staff could not demonstrate if the resident had a shower in the previous month.

A cleaning audit had been completed by an external infection control nurse. Actions from this audit have been addressed. However, an action from the previous inspection to source appropriate cleaning equipment remained outstanding. Colour-coded clothes and mops have been ordered but were not in place on the day of inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had submitted an action plan detailing the urgent, immediate and required actions to be taken to ensure compliance with Regulation 28.

The fire safety system had been replaced in the centre on the 3 December 2019. A new fire panel had been installed and a repeater panel had been located in each unit and in the Kitchen/laundry area. The panel display was in large font and accessible to all staff. This system is fully addressable and identifies the room number of a triggered sensor. New location maps were displayed beside the main panel and beside each repeater panel. However, the new floor maps did not identify the room numbers and the previous floor maps identifying 'zones' from the old panel system were still in place. This system was confusing and disjointed and did not provide clear guidance to staff in relation to identifying a triggered sensor in the event of the alarm sounding.

Personal emergency evacuation plans were documented for each resident and these plans were filed and located beside each fire panel. However, the residents location was identified by their room number which was not included on the displayed floor plans.

An assessment of all the fire doors in the centre had been completed.

An updated fire safety policy was due to be in place on the 25 November 2019. The fire policy in place was dated October 2019 and reflected the old fire safety system. A new draft policy reviewed had not been updated to reflect the new fire safety system. The procedures in relation to responding to the fire alarm were not updated to reflect the new system. The fire safety policy and the procedure poster used inconsistent language to describe the person who would take the lead in the event of a fire. The policy refers to the 'Senior Nurse', one procedure poster refers to the 'clinical nurse manager/ nurse in charge/ lead nurse' while another refers to the 'fire

safety and operational lead'.

All staff had received fire safety and evacuation training since the last inspection. With the exception of maintenance staff, staff had also attended update training following the installation of the new panel. An induction check list, which included the fire safety procedure, was in place for all agency staff working in the centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

A review of the medicine record of a resident found that medicine was not being administered and documented in line with professional guidelines. For example, changes to a residents dose of medication was not clearly documented on the residents medicine chart, medical notes or nurses report.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Improvement is required to ensure that care plans are resident-centred and evidence based. A care plan for a resident with responsive behaviours did not identify possible triggers and appropriate interventions to be used to deliver care. The failure to identify these interventions resulted in the delayed treatment of a residents symptoms.

Judgment: Not compliant

Regulation 6: Health care

An infection control nurse has been sourced and an infection control audit had been completed. An action plan was in place to address the identified non-compliance's. This action had been addressed since the last inspection.

Judgment: Compliant

Regulation 9: Residents' rights

A review of the notice-boards in the centre found that improvements had been made to ensure that information for residents was easily accessible.

The dining room areas on each unit remained incorporated into the day room areas. These areas were small and could not accommodate all the residents in the unit. The residents did not have a choice of areas to have their meals. This is an on-going non-compliance which was due to be addressed by December 2019.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Brendan's Community Nursing Unit OSV-0000633

Inspection ID: MON-0028343

Date of inspection: 06/01/2020

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All maintenance assigned to St Brendans Loughrea has now completed additional site-specific fire panel training on site on 13th January 2020. • Site Specific Fire safety policy incorporating feedback from Director of Nursing (DON), Manager Older Persons, Estates Manager and Fire Officer is now in place and has been submitted to HIQA. It is available in all areas with staff briefed on same and standard sign off procedures implemented. • As part of the Community Healthcare Organisation (CHO) HIQA oversight measures, Quality and Patient Safety (QPS) are scheduled to provide training to all DON's at the 20th February DON's meeting on QPS including auditing. In addition Site Specific Training has been arranged by QPS team in auditing in March when the Clinical Nurse Manager's (CNM) for the 4 care areas will be in post, following completion of the recruitment process for two new CNM's. In the intern, the Quality Manager has been on site to advise on audit process.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Director of Nursing (DON) in post will review all meeting process and agree terms of reference. A standard Project Management approach will be implemented in respect of recording meetings and actions. Regulatory compliance will be a standing item on the agenda of staff meetings.	

• Terms of references has been developed for resident forums
• Complaints policy has been updated and staff training is arranged for staff on managing complaints. Review Officer in place. All complaints reviewed by DON and trends submitted to Head of Service on a monthly basis. Complaints are also reviewed as part of the Operation Managers regulatory compliance oversight process
• Notification omitted has now been submitted and going forward all notifiable events will be notified through the DON.
• Audit of flushing of clinical areas, undertaken during night duty, is scheduled for the week commencing 17th February.
• Hot water for hygiene purposes from kitchenettes ceased with immediate effect. Signs have been erected on all kitchenettes restricting access to catering staff. A protocol for accessing water for hygiene purposes was developed and has been signed off by the Dept of Public Health.
• All risks that are under review by the DON will be a standing item in Staff meetings and Clinical Nurse Managers (CNM) meetings. Quality Risk Manager will review risk management processes.
• Non-compliances from previous inspections and internal compliance reviews are all now part of an action plan with progress monitored through a Head of Services lead weekly teleconference. Funding was secured to complete actions from fire precautions and is implemented.
• An audit of documentation on hygiene has been completed covering 2018 and 2019, which concurred with HIQAs findings. Investigation of the outcome with staff suggested that the causal issues were not noting preferences in residents care plan, a lack of recording of hygiene episodes and residents response when hygiene offered. Learning from the audit was shared with staff and at the DON's meeting. Implementation of learning to be monitored by the CNMs and re-audited
• Recruitment of a total of 29 vacant posts approved to fill is progressing and is monitored at the weekly Head of Service led teleconference. One CNM 2 is now in post and the second has a scheduled start date of 9th March. Start dates are agreed for 2 nurses and four multi-task attendant posts.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All notifiable incidents will be notified as per regulation 31.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Complaints policy has been updated and was available on January 6th
• Staff training will be strengthened as part of complaints management and new policy. Further training is organised for complaints management on 20th and 27th February 2020.
• The training will incorporate ensuring that any and all negative feedback that falls within the definition of a complaint is recorded in the Complaints Log.
• All complaints will be reviewed by the relevant Clinical Nurse Manager (CNM) for the care area. The Director of Nursing (DON) will spot check the Complaints Logs to ensure complaints are resolved where possible and if abuse is any element of the complaint that is referred for addressing through the safeguarding procedures.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
• The practice of carrying jugs of water has ceased with immediate effect from Inspection. A protocol for accessing water for hygiene purposes was developed to incorporate infection control and health and safety concerns and is being implemented.
• All required cleaning equipment is now available on site including color coded cloths and mop heads.
• Fire panel maps in line with the standard for fire detection and alarm systems; IS 3218 2013 have been erected adjacent to the Fire panel.
• While not a specific requirement under Fire Safety Standards way finder maps incorporating room numbers are being prepared and will be erected in each of the care areas once received.
• Site Specific Fire Policy is now in place
• Risk register to be reviewed by Quality Safety Manager in conjunction with Director of Nursing.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Audit of flushing of clinical areas, undertaken during night duty, is scheduled for the week commencing 17th February
• Residents hygiene needs are now recorded daily. It should be noted that many residents do not like to avail of a shower but prefer assisted personal hygiene. Hygiene

preferences are to be reflected in Care Plans. Hygiene care when availed of or offered and refused to be recorded. Clinical Nurse manager (CNM) to monitor as part of Care Plan and Care oversight.
• Infection control audit by external auditor confirmed standard infection control standards were met. Increased staff in cleaning teams to support maintenance of this standard.
• Repeat external Infection control audits will be scheduled to ensure on-going compliance.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Fire panel maps in line with the standard for fire detection and alarm systems; IS 3218 2013 have been erected adjacent to the Fire panel
• While not a specific requirement under Fire Safety Standards way finder maps incorporating room numbers are being prepared and will be erected in each of the care areas once received.
• Site Specific Fire Policy is now in place incorporating :-
New Fire Safety System Procedures in relation to Responding Person who take the lead in the event of a fire.

• Maintenance staff completed additional site specific fire training on 13th January 2020.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The following procedure has now been agreed between DON, General Practitioner (GP) and Pharmacist:

• If medications dosage is altered or prescribed by fax the nurse transcribes the change or the new prescription into the residents medication chart.
• The alteration or the new prescription is checked by a second nurse and the first dose of this new prescription must be signed for by two nurses.
• The fax is retained and filed.
• Change of dosage will be recorded in the residents nursing notes.
• The GP checks and signs the prescription on the next visit to the unit.
• Compliance will be audited in three months.

• This procedure will also be communicated at staff meetings and the obligation to correctly record dose changes will be re-iterated. • Policy developed to guide the transcribing practice. • The learning from a Chief Pharmacist review of processes in another Community Healthcare Organisation designated centre will be implemented.

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: • Additional training on care plans is being provided on 24th February. This training is provides by the Link University Lecturer . • Residents with responsive behaviors have been reviewed and possible triggers identified through assessment charting. Challenging Behavioral Nurse specialist is scheduled to review client's supports in responsive behaviors. • Random sample of care plans of all residents with responsive behaviors has been completed, to ensure possible triggers are identifed and appropriate interventions are used to deliver care as well as agreed actions are currently being addressed.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • It is accepted that the dining rooms need to be enlarged however architectural challenges have presented to HSE Estates with a number of extension options explored. A final 3 option appraisal, involving internal reconfiguration, will be completed by 29th February 2020. In the interim we are looking at utilising small sitting rooms, the parlor and the day care dining facility for those residents for whom it would be suitable to reduce the numbers using the ward dining rooms. A final decision on an environmental or an operational solution will be made by 31/07/20.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/04/2020
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.	Not Compliant	Orange	31/07/2020
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	Orange	31/05/2020

Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/05/2020
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	30/04/2020
Regulation 27	The registered 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.	Not Compliant	Orange	30/04/2020
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2020
Regulation 29(2)	The person in charge shall facilitate the	Substantially Compliant	Yellow	30/06/2020

	pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	17/02/2020
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	31/03/2020
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health,	Not Compliant	Yellow	31/05/2020

	personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
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	Yellow	17/02/2020
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Yellow	30/11/2020