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:	Anna Gaynor House
Name of provider:	Our Lady's Hospice and Care Services DAC
Address of centre:	Our Lady’s Hospice & Care Services, Harold's Cross, Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	17 April 2024
Centre ID:	OSV-0000465
Fieldwork ID:	MON-0042736

About the designated centre

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

Anna Gaynor House is a designated centre in south Dublin city which provides full time nursing care and support for up to 89 adult male and female residents. Residents are supported in single, twin and triple occupancy bedrooms across four units in a single storey building. The service provides care primarily for residents who require a high level of care. The centre avails of modern resources to promote and provide appropriate care and facilities for its residents. Residents are supported by a team of qualified nursing and support staff with centre management based on-site. Residents living in this service have on-site access when required to clinical services including geriatrician, physiotherapist, dietitian and occupational therapist. The centre premises includes large communal living and dining areas as well as multiple external courtyards and gardens on the site.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	84

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 17 April 2024	10:00hrs to 18:00hrs	Lisa Walsh	Lead
Thursday 18 April 2024	10:20hrs to 14:30hrs	Lisa Walsh	Lead
Wednesday 17 April 2024	10:00hrs to 18:00hrs	Aisling Coffey	Support
Thursday 18 April 2024	10:20hrs to 14:30hrs	Aisling Coffey	Support

What residents told us and what inspectors observed

Inspectors spoke with several residents in the designated centre to gain insight into their living experience in Anna Gaynor House. Inspectors also spent time observing interactions between staff and residents and reviewing a range of documentation. The overall feedback from residents was that they were content living in the centre. Residents were complimentary of the staff and the care they received. Throughout the day, inspectors observed staff to be kind and patient with residents. Although the residents received good care and were well supported by staff, areas that required action were identified, which will be further discussed in the report below.

Following an introductory meeting with the clinical nurse manager and person in charge, inspectors were guided on a tour of the premises to review the reconfigured multi-occupancy bedrooms. The centre is divided into four units, each set out over one floor. The units are named St Michael's, St Benedict's, Marymount, and Mary Aikenhead. Residents are supported in single, twin, and triple-occupancy bedrooms. Each unit also has a lounge/dining room.

The reconfiguration of nine triple bedrooms in St Benedict's and St Michael's, which the registered provider committed to in the compliance plan from the last inspection, was complete. The bedrooms were nicely decorated with sufficient floor space. Each resident could access their belongings in private with new wardrobes and privacy screens. Residents spoken with said they were happy with the reconfiguration of the bedrooms.

It was observed that some areas of the centre required attention. These findings will be discussed further within the report under Regulations 17: Premises and 27: Infection control. Resident bedrooms were personalised with photographs, flowers, books and other items of personal significance. Residents reported to inspectors that they were satisfied with their bedrooms. Three single occupancy bedrooms in the centre were held for residents who required isolation facilities or were approaching the end of life. Residents approaching the end of their lives and sharing a room were given the choice to move to one of these private rooms to ensure appropriate care and comfort was provided. Families were also consulted where appropriate. Family and friends of the resident were informed of the resident's condition and permitted to be with the resident, with sleeping accommodation provided as required. The centre's design and layout supported residents' free movement, with wide corridors and sufficient handrails. Improvements to the centre were observed; for example, new clinical hand wash sinks were installed in the corridors.

The area outside the entrances to Marymount, St Benedict's and Mary Aikenhead is named the central square. While the provider installed screens surrounding two seating areas to provide residents and visitors with a more relaxed and private environment. They were continuing to progress renovations to make the area more inviting. Next to the central square, there was a prayer room and a library area.

There was an activity schedule in place for residents each day. There were two activity staff on the inspection day and a team of volunteers for 84 residents. Large group activities took place in Anna Gaynor Hall, located on the corridor connecting the main entrance to the four units. All residents were offered the choice of attending these activities and were brought from their unit to activities taking place throughout the centre. Residents reported an improvement in activities at the weekends and spoke about different music events that had been organised, which they really enjoyed. A resident described how the staff supported them to creatively engage with an activity they had not been able to do but enjoyed. Some residents and visitors also spoke about enjoying the one-to-one activities, such as walking or getting a coffee.

On day one of the inspection, SONAS took place in the morning on one of the units, and residents attended mass in a chapel on the campus in the afternoon. There was also a hairdresser available for residents to attend. However, there were no scheduled activities in the afternoon within the centre. On day two of the inspection, a large group of residents and volunteers sang in Anna Gaynor Hall while one of the volunteers played the piano. Inspectors observed residents who did not attend the activities watching television in their bedrooms. Inspectors were informed that one-to-one activities took place in the four units for residents who chose not to attend the large group activities. However, there were gaps in how these one-to-one activities were recorded and evidenced.

Overall, the feedback from visitors who spoke with inspectors was that they were happy with the care provided to residents, with one visitor saying that the care provided was ''excellent''. Another visitor commented, ''It is amazing here, and I'd highly recommend them''. Visitors were also complimentary about the access to healthcare services. There was mixed feedback from visitors about activities. A visitor told inspectors that there were few activities available in the evening. However, the majority of visitors were happy with the activities available to residents.

Inspectors observed mealtimes in the dining rooms. In three of the four units, inspectors observed the majority of residents choose to eat in their bedrooms, with a small number of residents eating in the dining rooms. The fourth dining room had a pleasant atmosphere where residents, staff, and volunteers chatted while music played in the background. There were three meal options at lunchtime for residents to choose from. Staff and volunteers provided discreet and respectful assistance where required. Overall, residents were complimentary of the quality and quantity of food on offer, with one resident stating the food was ''lovely'' and that there was ''plenty of it''. Residents spoken with said there had been an improvement in the food since the last inspection. Menu options were discussed at the residents' meeting. A food service group had been established, which the chef and nursing team attended. The resident survey was used to inform decisions made by this group.

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

Capacity and capability

While the centre had established governance and management systems in place to oversee the quality of care delivered to residents, some actions were required to ensure that the service provided was in line with the regulations at all times. This inspection found that some improvements were required in relation to Regulation 5: Individual assessment and care plan, Regulation 7: Managing behaviour that is challenging, Regulation 9: Residents' rights, Regulation 23: Governance and management, Regulation 17: Premises, Regulation 27: Infection control, Regulation 21: Records, Regulation 30: Volunteers and Regulation 34: Complaints procedure.

This was an unannounced inspection to assess the ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 as amended and to review the registered provider's compliance plan following the previous inspection of 10 August 2023. As a consequence of regulatory non-compliance with Regulation 17: Premises, which was updated in 2022, there was an additional restrictive condition attached to the registration of the designated centre. Condition 4 required the provider to reconfigure all triple bedrooms to afford each resident 7.4m2 of floor space, including their bed, chair and personal storage space. These works were due for completion by 24 March 2024. During this inspection, inspectors found that the registered provider had complied with condition 4 and had completed these works.

The registered provider is Our Lady's Hospice and Care Services DAC. The centre had a clearly defined management structure, and staff members knew their roles and responsibilities. The person in charge worked full-time in the centre, was responsible for overall governance and reported to the registered provider representative, the Chief Executive Officer. A team of medical staff, clinical nurse managers (CNMs), registered nurses, healthcare assistants, activities staff, health and social care professionals, catering, housekeeping, administration and maintenance staff supported the person in charge. In the absence of the person in charge, the CNM3 deputised.

The registered provider put systems in place to monitor the quality and safety of care. Communication systems were in place between the registered provider and management within the centre. Governance meetings reviewed matters including incident and risk management, infection prevention and control (IPC), health and safety, staff training, resident and family engagement, complaints and quality improvement. The centre had systems for tracking and trending incidents occurring and conducted investigations to understand and share learning regarding the causal and contributing factors for such incidents. The person in charge had an oversight

tool where risk factors affecting each resident's quality and safety were routinely updated and available for review.

There was documentary evidence of audit and oversight systems within the centre to ensure the service was safe, appropriate, consistent and effectively monitored. Staff within the centre routinely collected and analysed data concerning environmental hygiene, infection prevention and control, falls and restrictive practices to identify trends, evaluate the effectiveness of care delivery, enhance safety and promote quality improvement. This data collection was used to identify risks and the development of time-bound action plans to address any deficits. An annual review of the quality and safety of care delivered to residents was completed for 2023. Residents and families had been consulted in the preparation of this review. This review identified the improvements completed in 2023 and the improvement plans for 2024. Notwithstanding these assurance systems, action was required in some areas, which will be discussed under Regulation 23: Governance and management.

There were sufficient staff on duty to meet the needs of residents living in the centre on the inspection day. The centre had a staff team that was supported in performing their duties. They knew the needs of the residents in their care and respected their wishes and preferences. Staff were supervised by the CNM1 and CNM2 allocated to each unit.

Staff had access to appropriate training and development to support them in their respective roles. Records reviewed documented high levels of compliance with mandatory training in areas including safeguarding, infection prevention and control, and fire safety.

Staff files were reviewed. All staff files contained Garda Siochana (police) vetting and identification. However, the personnel files did not contain all of the documentation required to ensure safe and effective recruitment practices which will be discussed under Regulation 21: Records.

There was a large number of volunteers available in the centre who provided a valuable service for residents. Volunteers files and other records showed that the provider had obtained a Garda Siochana (police) vetting disclosure for all volunteers and that volunteers received supervision and support in their role. Notwithstanding this good practice, some improvements were required to comply fully with the regulation, which will be outlined under Regulation 30: Volunteers.

The centre displayed its complaints procedure prominently throughout the centre. Information posters on advocacy services to support residents in making complaints were also displayed. Residents and families said they could raise a complaint with any staff member and were confident in doing so if necessary. Staff were knowledgeable about the centre's complaints procedure. The complaint's officer maintained a record of complaints received, how they were managed, the outcome of complaints investigations and actions taken on foot of receiving a complaint. While inspectors identified some good practice, there were some gaps in complaints

management practices where actions were required to comply fully with Regulation 34: Complaints procedure.

Regulation 15: Staffing

On the inspection day, staffing was sufficient to meet the residents' needs. The registered provider ensured that the number and skill mix of staff were appropriate. At night, there were a minimum of eight registered nurses in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

A comprehensive training programme was available to staff in the centre to support them in their roles. There was full compliance with training concerning safeguarding vulnerable adults at risk of abuse, fire safety and infection control.

Judgment: Compliant

Regulation 21: Records

Inspectors found that residents' records were not securely stored. Efforts had been made to improve the storage of residents' records since the previous inspection. The provider had installed compartments close to each resident's bedside to store the records. However, inspectors were not assured that the storage was safe as the compartments could not be locked, meaning the residents' records were not secure.

A review of four personnel files found evidence of the staff member's identity and Garda Síochána (police) vetting disclosures. However, the personnel files did not contain all of the documentation required under Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). For example:

- Two personnel files did not contain full employment histories.
- Two personnel files did not have evidence of the staff member's address
- Two personnel files did not have a written reference from the staff member's most recent employer.

Judgment: Substantially compliant

Regulation 23: Governance and management

While the registered provider had several assurance systems in place to monitor the quality and safety of the service provided, action was required in the following areas:

- The auditing system was not fully effective in identifying risks and driving quality improvement. For example, the call bell audits did not identify the number of inaccessible call bells found by inspectors on the inspection day. Similarly, the environmental hygiene audits did not identify the gaps in the cleaning of resident crash mats.
- The oversight systems to monitor care planning did not ensure that each resident had an up-to-date care plan to meet their identified needs.
- The systems for recognising statutory notifications that need to be notified to the Chief Inspector of Social Services had not ensured that all required notifications had been made.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed a sample of residents' contracts and found that they set out the allocated bedroom number and occupancy. The contracts outlined the service to be provided and the fees to be charged, as well as referencing other services the residents may choose to avail of for an additional cost, such as hairdressing.

Judgment: Compliant

Regulation 30: Volunteers

There were a large number of volunteers operating in the centre. All volunteers had Garda Siochana (police) vetting disclosures on file, however, their roles and responsibilities had not been set out in writing.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had not reported all of the restrictive practices used in the centre to the Office of the Chief Inspector as required by the regulations. This included the use of PRN medication (medicines only taken when the need arises) as a restrictive practice.

Judgment: Not compliant

Regulation 34: Complaints procedure

Some actions were required to ensure compliance with the regulation, for example:

- The centre's complaints procedure, displayed throughout the centre, needed to reference a person as the review officer and the timeframes in which the review officer would provide a written response to the complainant.
- In the case of one compliant, the complaint's officer had not provided a written response to the complainant as to whether or not their compliant had been upheld, the reasons for the decision, any improvement recommended and details of the review process as required under Regulation 34(2)(c).
- Evidence of the training undertaken by the nominated complaints officer and review officer to support them in managing complaints was unavailable for inspectors to review on inspection day and after the inspection.

Judgment: Substantially compliant

Quality and safety

While inspectors observed kind and compassionate staff treating the residents with dignity and respect, the systems overseeing the service's quality and safety in some areas required improvement. Residents told inspectors that they felt safe and happy living in the centre. Staff were observed to speak with residents in a kind and respectful manner, and to know their needs well. Further action was required to ensure effective delivery of care in relation to individual assessment and care planning, managing behaviour that is challenging, residents' rights, premises and infection control.

A sample of care plans and assessments for residents were reviewed. Validated assessment tools were used, and care plans were documented as being updated at four monthly intervals in line with regulations. Improvements were required to ensure that care plans reflected the care needs of the resident following assessment. Action was also required to ensure care was delivered in line with each resident's care plan, as outlined further under Regulation 5: Individual assessment and care plan.

The designated centre had an up-to-date policy on the use of restraints and a restraints register in place. Inspectors observed that efforts were being made to reduce the use of restraints for some residents following a multi-disciplinary review. However, not all restrictive practice was recognised and on review of records available there was no evidence that the least restrictive form of restraint had been trialled first. Residents care plans to respond to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) were in place, however, they were not always person-centred, some using standard wording. A number of staff had not undertaken training in managing behaviour that is challenging, however, training had been organised to address this. This is further discussed under Regulation 7: Managing Behaviour that is Challenging.

Residents were facilitated to exercise their civil, political and religious rights, with access to pastoral care who engaged with residents from all religious backgrounds. Residents were observed watching television in their bedrooms and in the communal areas. Some residents were also observed reading newspapers. Residents have access to independent advocacy, with residents also having a presentation from independent advocacy services. There is a resident's committee which meets every quarter for residents to raise any concerns. This is facilitated by the volunteer coordinator who is assisted by the activity coordinator.

Residents who attended the organised group activities, for example, sing and music in the large hall were seen to enjoy this. There were two activity staff on the inspection day and several volunteers who supported the activity staff throughout the day, who were seen to have a good relationship with the residents. Volunteers also supported activities on the weekends. There was an activities programme in place that included things like mass, SONAS, bingo, arts and crafts and music, which residents said they enjoyed. Improvements were observed since the last inspection, with more activities were now available on the weekends, and there is positive feedback from residents about this. However, where group activities took place in one area of the centre, no activities were observed taking place in the other units for those residents who chose not to attend the group activity, this is further detailed under Regulation 9: Residents rights.

Overall, the premises were in a good state of repair and met the needs of residents. The centre was found to be warm and bright. The communal areas in the main part of the centre were filled with art work created by residents and the communal areas in each unit were pleasantly decorated. Inspectors observed some improvements to the centre's layout since the last inspection. For example, fridges that had been located in residents' living areas on two units were now removed, and some of the chairs had been replaced. Furthermore, the temperature regulation in medication treatment rooms was resolved. However, some further areas of improvement in relation to premises were identified.

Following the inspection in August 2023, the registered provider had committed to reconfiguring nine triple bedrooms by March 2024. All triple bedrooms had been reconfigured to a high standard and were nicely decorated. Each resident in the triple bedrooms had their own ceiling-mounted television, a wardrobe in their own

private space and privacy screens to ensure residents could undertake their activities in private and support the residents' right to privacy when accessing their possessions. In addition, there were locked medicines cabinets had been installed next to each residents bed.

Overall, there was effective management and monitoring of infection prevention and control practices within the centre. In general, the centre was clean, and the storage was well-organised. The centre used a tagging system to identify equipment that had been cleaned. Staff were observed to have good hygiene practices. The centre had access to infection prevention control specialist nursing expertise. Notwithstanding this, the cleanliness of resident equipment required improvement to minimise the risk of transmitting a healthcare-associated infection, which will be discussed under Regulation 27: Infection Control.

Regulation 17: Premises

Inspectors found that the centre provided a premises which was mostly in conformance with Schedule 6 of the regulations, however, improvements were required, for example:

- Several residents were found not to have call bell access. Inspectors observed multiple call bells that were not within the reach of residents, meaning residents were unable to summon assistance if required.
- There were areas of wear and tear throughout the corridors of the centre and some residents' bedrooms.
- A toilet and sink on St Benedict's Unit were found to be leaking. These matters were brought to the attention of the nurse in charge, who made arrangements for their repair.
- Inspectors observed two leaks in the ceiling of the designated centre and other parts of the ceiling had brown staining and cracked plaster from a previous leak.

Judgment: Substantially compliant

Regulation 27: Infection control

Action was required in some areas to ensure residents were protected from infection and to comply with the National Standards for Infection Prevention and Control in Community Services (2018).

- The oversight of cleaning practices regarding residents' crash mats required review. A sample of crash mats were observed to be both torn and visibly dirty with footprints and other debris. While the crash mats were on a cleaning schedule, gaps were noted in these schedules, indicating the mats

were not being cleaned as frequently as required. Furthermore, tears on the crash mats would prevent effect cleaning.
- Inspectors found some shared toiletry products in some communal shower rooms. Sharing toiletries presents a risk of cross-contamination.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While each resident had care plans in place to cover their health and social care needs, some gaps were identified in the assessment and care plans of some residents. For example:

- Some care plans did not reflect the resident's care needs. For example, inspectors observed a residents call bell which was out of their reach. Staff informed inspectors that the resident was unable to use their call bell and they were on safety checks every 10 minutes. However, their care plan said the resident "may not use the call bell" and to check the resident "every hour". In addition to this, no record of any safety checks was kept.
- A resident had nutrition care plan in place which detailed their swallow assessment. However, the care plan did not include all of the residents assessed needs.
- A resident's risk of falling had increased, however their care plan had not been updated to reflect this increased need.
- Some care plans did not reflect an appropriate, detailed, individualised management plan to guide staff practice to ensure residents' care needs were met. For example, some care plans were a standard template with the resident's name inserted into them.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Residents predisposed to episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) had a responsive behaviour care plan. Residents also had a behaviour observation chart, such as the Antecedent, Behaviour, and Consequence chart, in place. However, the care plans in relation to responsive behaviours were not person-centred and did not always describe the behaviours, potential triggers for such behaviours, and de-escalation techniques to guide staff in safe care delivery.

Not all staff had up to date knowledge and skills appropriate to their role to respond to and manage behaviour that is challenging as they had not undertaken training. The training course had recently been changed to reflect the needs of residents in the centre. The person in charge was aware of this training gap and had a robust plan to address this need and train all relevant staff promptly.

The centre's usage of restraint was not in accordance with national policy published by the Department of Health or the centre's restraint policy, which required that consideration of all alternative interventions must be explored and deemed inappropriate before a decision on an episode of restraint may be taken. There was no documented evidence that alternatives had been trailed before the restrictive device was used. However, inspectors observed that efforts were being made to reduce the use of restraints for some residents following a multi-disciplinary review. Furthermore, the restraint register did not include the use of medication as a form of restrictive practice.

Judgment: Substantially compliant

Regulation 9: Residents' rights

There was an activity programme in place with activity staff working daily and supported by volunteers. Inspectors observed that where group activities took place in one area of the centre, no activities were observed taking place in the other units for those residents who chose not to attend the group activity. For example:

- On the morning of the first inspection day, SONAS took place in one of the units, and several residents attended. However, inspectors did not observe other opportunities for the remaining residents to participate in meaningful activation.
- In the afternoon of the first inspection day, residents attended mass in a chapel on campus, and staff brought those who wished to attend. Similarly, there were no scheduled activities in the afternoon for the residents who chose not to attend mass.
- Residents and volunteers sang in Anna Gaynor Hall on the second inspection day. However, inspectors observed residents who did not wish to sing in their bedrooms watching television.

Inspectors were informed that one-to-one activities also took place; however, there were gaps in these records meaning such activities were not always recorded.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 30: Volunteers	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Anna Gaynor House OSV-0000465

Inspection ID: MON-0042736

Date of inspection: 18/04/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A new magnet lock will be added to all of the document holders in the resident's rooms and the staff will have a magnet release tool to be able to access the folders kept inside. A new magnet lock has been sourced and we are awaiting delivery and trial to ensure they are sufficient and then the remaining locks will be purchased if the trial is successful. Completion date: 31st July 2024 HR have completed a review of all relevant personnel files and have been updated to ensure they contain all of the documentation required under Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Completion date: 24th May 2024	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Introduce a new safety check record, provide training for staff on the use of the form and then commission a call bell audit and review of safety checks that are in place for residents who cannot use a call bell. Completion date: 31st October 2024	

Ensure the cleaning of crash mats for individual residents is recorded in the cleaning schedules and are also checked for integrity during cleaning and replaced where necessary.

Completion date: 31st July 2024

An enhanced assurance process to oversee the quality of person-centred care planning will be introduced to complement existing ways of working supported through a team consisting of the Clinical Facilitator, Quality and Patient Safety Lead, the ADON/PIC, CNM3 and the unit CNM2s.

Completion date: Ongoing - commencing June 2024 (Introduction completed 30th June 2024)

A full MDT review is underway to review the use of psychotropic medications for residents and whether it is medicinal or a restrictive practice (chemical restraint). The review will be completed prior to the next quarterly NF39 submissions due at the end of July 2024 for Quarter 2.

Completion date: 31st July 2024

Regulation 30: Volunteers	Substantially Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:
All volunteers working in Anna Gaynor House will receive a document outlining their roles and responsibilities while they are volunteering in the unit and a copy will be kept in their Volunteer file.

Completion date: 30th June 2024

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
A full MDT review is underway to review the use of psychotropic medications for residents and whether it is medicinal or a restrictive practice (chemical restraint). The review will be completed prior to the next quarterly NF39 submissions due at the end of July 2024 for Quarter 2.

Completion date 31st July 2024

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints procedure is to be updated to include the information relevant to the review officer

Completion date: 31st August 2024

Procedure for complaints management and recording is being reviewed to ensure compliance.

Completion date: 31st August 2024

Updated training for the complaints officer and review officer has been booked

Completion date: 31st August 2024

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Introduce a new safety check record, provide training for staff on the use of the form and then commission a call bell audit and review of safety checks that are in place for residents who cannot use a call bell.

Completion date: 31st October 2024

Maintenance of communal areas and residents' rooms ongoing (wear and tear)
Availability of resident's rooms will impact the ability to refresh the rooms. Communal areas will be prioristised and residents' rooms will be painted when they are unoccupied.

Completion date: 31st October 2024

Toilet and sink on St Benedict's Unit have been repaired

Completion date: 24th May 2024

The roof has been reviewed and leaks repaired. The ceilings and plaster will be painted by the facilities team.

Completion date: 30th June 2024

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Ensure the cleaning of crash mats for individual residents is recorded in the cleaning schedules and are also checked for integrity during cleaning and replaced where necessary. Audit planned for the cleaning schedules for each unit.

Completion date: 31st July 2024

Staff reminded in all wards to remove personal toiletry products from communal shower rooms after use by each resident and CNM2 to monitor work practices.

Completion date: 24th May 2024

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:
Introduce a new safety check record, provide training for staff on the use of the form and then commission a call bell audit and review of safety checks that are in place for residents who cannot use a call bell.

Completion date: 31st October 2024

An enhanced assurance process to oversee the quality of person-centred care planning will be introduced to complement existing ways of working supported through a team consisting of the Clinical Facilitator, Quality and Patient Safety Lead, the ADON/PIC, CNM3 and the unit CNM2s.

Completion date: Ongoing - commencing June 2024 (Introduction completed 30th June 2024)

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
A full MDT review is underway to review the use of psychotropic medications for residents and whether it is medicinal or a restrictive practice (chemical restraint). The review will be completed prior to the next quarterly NF39 submissions due at the end of July 2024 for Quarter 2.

Completion date 31st July 2024

An enhanced assurance process to oversee the quality of person-centred care planning will be introduced to complement existing ways of working supported through a team consisting of the Clinical Facilitator, Quality and Patient Safety Lead, the ADON/PIC, CNM3 and the unit CNM2s.

Completion date: Ongoing - commencing June 2024 (Introduction completed 30th June 2024)

Training plan in place for staff to ensure up to date knowledge and skills appropriate to their role to respond to and manage behaviour that is challenging.

Completion date: 31st October 2024

Restraint risk assessment tool to be edited to include decision making tree prior to implementation of a restraint intervention and also evidences the stepwise method of trialing the least restrictive method first. The MDT will also ensure documentation of the ongoing evaluation of each resident's restrictive practices and the review and de-escalation where appropriate.

Completion date: 30th September 2024

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Review underway for the activities programme of planned events by the activities team. CNMs on the wards ensuring all staff are documenting activity sessions with the residents

in the Universal Healthcare Record. Activities staff to ensure all sessions are recorded in the Universal Healthcare Record or on PAS.

Completion date: 30th June 2024

The OTs and Activities Team in conjunction with the unit staff are rolling out a Quality Improvement Initiative to introduce the 'This is Me' document for all residents to aid staff in creating person centred activities plans for each resident.

Completion date: 30th September 2024

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 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.	Substantially Compliant	Yellow	31/10/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	24/05/2024
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	31/07/2024
Regulation 23(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	31/10/2024

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
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.	Substantially Compliant	Yellow	31/07/2024
Regulation 30(a)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre have their roles and responsibilities set out in writing.	Substantially Compliant	Yellow	30/06/2024
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Not Compliant	Orange	31/07/2024
Regulation 34(2)(c)	The registered provider shall ensure that the complaints	Substantially Compliant	Yellow	31/08/2024

	procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.			
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).	Substantially Compliant	Yellow	31/08/2024
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.	Substantially Compliant	Yellow	31/08/2024
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the	Substantially Compliant	Yellow	31/08/2024

	outcome of the review.			
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Substantially Compliant	Yellow	31/08/2024
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	31/10/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/10/2024
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate	Substantially Compliant	Yellow	31/10/2024

	to their role, to respond to and manage behaviour that is challenging.			
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.	Substantially Compliant	Yellow	31/10/2024
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	31/10/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/09/2024