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

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|---|---|
| Name of designated centre: | Kiltipper Woods Care Centre |
| Name of provider: | Stanford Woods Care Centre Limited |
| Address of centre: | Kiltipper Road, Tallaght, Dublin 24 |
| Type of inspection: | Announced |
| Date of inspection: | 04 April 2024 |
| Centre ID: | OSV-0000053 |
| Fieldwork ID: | MON-0042957 |

## About the designated centre

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

Kiltipper Woods Care Centre is purpose-built and was established in 2004. The centre provides 24-hour nursing care seven days per week and is designed to ensure the comfort and safety of residents in a home-like environment. The centre can accommodate 121 residents, both male and female. Residents have access to amenities and a host of recreational activities, providing a warm and friendly atmosphere. The services and expertise of skilled and friendly staff enhance the quality of life for all residents who live in the centre. The centre comprises of residential accommodation primarily in single en-suite bedrooms and a number of double en-suite bedrooms, a day care centre, a rehabilitation hydrotherapy department and a coffee shop. Kiltipper Woods is situated at the foot of the Dublin Mountains close to the M 50 and is serviced by the Luas Red Line in Tallaght and the 54A bus route. The care centre is also situated close to shops, public houses, restaurants, sports grounds and many other amenities.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 120 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

**1. Capacity and capability of the service:**

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

**2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Thursday 4 April 2024 | 08:52hrs to 18:12hrs | Karen McMahon | Lead |
| Thursday 4 April 2024 | 08:52hrs to 18:12hrs | Niamh Moore | Support |

## What residents told us and what inspectors observed

From what inspectors observed and from what the residents told them, residents were happy residing in the centre and received a good standard of care. The overall feedback was that the premises was lovely, the food was tasty and that the staff were very friendly and caring.

On the day of the inspection the inspectors were met by the receptionist who guided them through the sign-in procedure. The inspectors were then joined by the person in charge. A brief introductory meeting took place with the person in charge and members of the operational and clinical management team. After the meeting the person in charge accompanied the inspectors on a walk around the premises.

The centre is set out over two large levels, split into six units with a mix of single and multi-occupancy rooms. The centre was observed by inspectors to be clean and well maintained. Each unit has a variety of communal areas for use, including dining facilities. These rooms were seen to be clean, bright, comfortable and tastefully decorated, suited to the purpose of their use.

Many residents were seen up and mobilising around the centre. Residents were well-presented and neatly-dressed. Inspectors observed that residents had personalised their rooms with pictures, flowers, plants and other personal items. Various corridors of the centre displayed artwork, photography work and poetry all done by past and present residents of the centre. Information boards displayed information on activities, complaints and advocacy services.

On the Elm unit a recent application to vary had been granted to reflect changes to the floor plan that included the conversion of a sitting room and a nurses station to two single en suite bedrooms and the conversion of two store rooms to two small sitting rooms, suited to residents enjoying some quiet time or to receive their visitors in private. The completed works were observed to be used and enjoyed by residents.

On the Maple unit inspectors observed that there was no suitable communal space for residents to receive their visitors in private, if they so choose. However the person in charge informed inspectors that residents and their visitors had access to all of the communal spaces located within the designated centre.

There were two enclosed gardens and a small enclosed courtyard available to residents in the centre. These outside spaces were easily accessed through doors on the ground floor. All the external spaces had raised flower beds and appropriate out door furniture for residents' use. Paths around the gardens ensured the garden was accessible to wheelchair users residing in the centre. A designated smoking area was located in a covered hut in the larger garden area and was seen to have the relevant fire safety equipment and call bell facilities.

Residents could attend the individual dining rooms or have their meals in their bedroom if they preferred. The daily menu was displayed on the tables in the dining room and on the notice boards throughout the units. Residents were offered a choice of options the day prior and inspectors were told that if a resident changed their meal preference on the day this would be facilitated.

Inspectors observed the dining experience at lunch time and saw that the meals provided were of a high quality and well presented. There were four options for the main meal at lunch time to include beef, lamb, fish and salads. Assistance was provided by staff for residents who required additional support and these interactions were observed to be kind and respectful. The meal time was seen to be a social occasion where staff spent time talking to residents. Feedback from residents was positive. They reported to enjoy the meals and that portions were plentiful. One resident told inspectors that "the food is just perfect" reporting they particularly enjoyed the fish options available.

There were a number of activity coordinators working within the designated centre and there was an activity schedule available. On the day of the inspection, a variety of activities were observed taking place. On one unit, which was specific to the care of residents with dementia, inspectors observed residents participating in ball drumming which was clearly been enjoyed by the residents. Other activities observed included art and live music.

Staff told inspectors that on a Friday there is Kiltipper woods care centre FM, their own radio station. Family members can send in requests for well wishes, birthdays or special occasions and inspectors were told that family and friends living abroad enjoyed utilising this service for their loved ones and residents enjoyed hearing the requests and messages.

Inspectors observed numerous interactions where staff were gentle, patient and kind to residents. One resident told inspectors "awh it's lovely here, staff are great." Another resident told inspectors they were so happy living here and that there was always activities to participate in, if you wanted too. Residents' had the opportunity to provide feedback on the service they received through resident meetings and resident questionnaires.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

## Capacity and capability

Overall, the provider aimed to provide a good service and support residents living in

the designated centre to receive a good standard of care. Residents' care needs were well met. However, this inspection found that improvements were required to the governance and managements systems in place to ensure that a safe service was consistently provided for residents living in the designated centre.

This was an announced inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013). The registered provider of Kiltipper Woods Care Centre was Stanford Woods Care Centre limited.There was an established management team with clear roles and responsibilities, and clear deputising arrangements were in place when the person in charge was absent.

On the day of the inspection, inspectors found that there was sufficient staffing levels and skill mix in place. A member of the senior clinical management team was present every day, including weekends. Inspectors were informed that there was one current vacancy for an activity co-ordinator.

There was an ongoing mandatory training programme in the centre. The training matrix provided to inspectors recorded overall high levels of attendance at mandatory training such as infection control and safeguarding. There was a training schedule in place for the year to ensure all trainings were kept up to date. The provider had a comprehensive induction programme for new staff, that included completion of a detailed induction workbook. However it was found on the day of the inspection that one induction workbook was not on site for viewing.

There was an audit schedule in place and regular auditing was seen to occur, through this the registered provider identified areas for quality improvements. However, inspectors found that some audits were not always leading to quality improvements to ensure the service provided was safe, consistent and effectively monitored. This is further discussed under Regulation 23: Governance and Management.

A review of contracts in place for residents of long term admissions overall met the criteria of Regulation 24: Contract for provision of services. For example, information was agreed in writing with each resident on their admission to the designated centre, including the terms and the fees, on which they should reside in Kiltipper Woods Care Centre under. However, residents of short term admissions referred to as "Interim Care Beds" were only provided with information relating to their stay and were not given a written agreement. Managers told inspectors that fees for these beds were agreed with the Health Service Executive. However, in line with the criteria of the regulations all residents should have an agreement in writing. This is further discussed under the regulation.

There was an accessible complaints policy and procedure in place to facilitate residents and or their family members lodge a formal complaint should they wish to do so. The policy clearly described the steps to be taken in order to register a formal complaint. This policy also identified details of the complaints officer, timescales for a complaint to be investigated and details on the appeal process should the complainant be unhappy with the investigation conclusion.

The complaints log was made available to the inspectors for review. There were no current open complaints. A number of the closed complaints were reviewed. Inspectors found one of these complaints reported an alleged safeguarding concern in respect of an act of neglect and omission of care. While the allegation had been appropriately investigated and dealt with, under the complaints procedure, the allegation had not been recognised by the registered provider as a safe-guarding concern and they had not submitted the relevant notifications, as set out in Schedule 4 of the regulations, to the chief inspector. Furthermore two additional safe-guarding incidents were identified on the day of inspection that had not been notified to the Chief Inspector within the required time frames.

## Regulation 15: Staffing

There was a sufficient number and skill mix of staff available on the day of the inspection.

Judgment: Compliant

## Regulation 16: Training and staff development

A review of the training records found that all staff members had access to a variety of training according to their roles and responsibilities.

Judgment: Compliant

## Regulation 23: Governance and management

Gaps were identified in the management systems in place to ensure the service provided was safe, consistent and effectively monitored. The inspectors identified the following concerns:

- The systems that were in place to protect residents from abuse had failed to recognise two incidents and an allegation made as a complaint as safeguarding concerns. As a result these incidents were not followed up in line with the provider's own safeguarding policy to ensure residents were protected.
- Auditing was not always leading to quality improvements. A review of the falls audit identified three residents with a high number of unwitnessed falls. However, there was no trending of information around these falls or appropriate action taken to investigate why these residents had recurrent falls, to facilitate putting appropriate supports in place for them, with the aim

of reducing falls incidence and the risk of possible injury associated with these recurrent falls.
- The oversight of the admissions procedure for short term residents did not ensure that each resident's end of life wishes and preferences were recorded in their care records so that staff had the information they needed to ensure resident's wishes were met.
- The oversight of staff induction records did not ensure that these records were kept up to date and available on site.

Judgment: Not compliant

## Regulation 24: Contract for the provision of services

Residents on short stay admissions did not have a contract in place. This meant that there was no agreement in writing with the registered provider and each resident, on their admission to the designated centre, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom that the resident shall reside in.

Judgment: Not compliant

## Regulation 31: Notification of incidents

The person in charge had not submitted three notifications of safeguarding incidents within three working days of their occurrence as set out under Schedule 4 of the regulations.

Judgment: Not compliant

## Regulation 34: Complaints procedure

There was a policy in place that was reflective of regulatory requirements. There was information about the complaints process displayed on the walls in the centre.

Judgment: Compliant

## Regulation 4: Written policies and procedures

The registered provider maintained a suite of policies and procedures to comply with the requirements of schedule 5 of the regulations.

Judgment: Compliant

## Quality and safety

Inspectors found that residents were receiving a good standard of care that supported and encouraged them to actively enjoy a good quality of life within Kiltipper Woods Care Centre. Residents were found to be receiving care and support in line with their needs and preferences. However improvements were required in relation to care planning and health care as discussed under Regulation 5 Assessment and Care Planning and Regulation 6 Health care.

Staff working in the centre were committed to providing quality care to residents and inspectors observed that the staff treated residents with respect and kindness throughout the inspection.

Inspectors reviewed a selection of assessments and care plans on the day of inspection. Inspectors found two care records where residents with assessed needs did not have the corresponding care plans in place. In addition, gaps were found in the assessment and care plan documentation for a number of residents admitted for short stay.

Overall records showed that residents had access to medical care in line with their assessed needs. A general practitioner attended the designated centre six days a week. There was on site support from physiotherapists and occupational therapists. Appropriate medical and health care referrals were made to specialist services such as psychiatry, speech and language therapy, dieticians and community services such as chiropody. Records evidenced that referrals were timely and residents received prompt support form these specialist services when needed. Records showed that resident's care plans were updated to ensure that residents received the recommended treatments following referral. However some improvements were required to ensure that emergency medical care was sought for residents if this was identified as their treatment wishes in the event of sudden deterioration in their health.

Inspectors found that residents were offered and had access to adequate quantities of food and drink that was properly prepared, cooked and served.

The residents' guide for the designated centre was available and recently updated in April 2024. This guide contained all of the required information in line with regulatory requirements.

The risk management policy was requested prior to the on site inspection and

review. The policy included all the required information in line with the regulations.

## Regulation 18: Food and nutrition

Inspectors found that each resident's needs in relation to hydration and nutrition were met. For example:

- Residents had access to fresh drinking water at all times including in bedrooms.
- Choice was offered at mealtimes, including for special dietary requirements.
- Where necessary, residents were assisted with their meals in a respectful and dignified manner.

Judgment: Compliant

## Regulation 20: Information for residents

The resident information guide included a summary of services and facilities available, the terms and conditions relating to residence and contact details of independent advocacy services available to residents.

Judgment: Compliant

## Regulation 26: Risk management

The risk management policy had been reviewed in March 2024. This policy outlined the risk management systems for the designated centre including a system in place for responding to emergencies.

Judgment: Compliant

## Regulation 5: Individual assessment and care plan

Records reviewed did not evidence that the registered provider had arranged to meet the assessed needs of each resident. For example:

- The pre-assessment and care plan for residents on short stay admissions did not assess or record their end-of-life care preferences for treatments included emergency medical treatments. This created a risk that staff would not have the information they needed to ensure that resident's treatment wishes were followed.
- Two residents who were involved in safeguarding incidents did not have a safeguarding care plan in place. Therefore there was no record of the safeguarding risk posed to the residents' concerned and what steps staff needed to take to protect the resident.

Judgment: Not compliant

## Regulation 6: Health care

The provider's emergency procedures were not effective in ensuring that residents had access to emergency medical treatments in line with any medical directives that were in place for that resident. This included a high standard of evidence based nursing care in the event of a sudden medical emergency happening in the centre.

Judgment: Not compliant

## Regulation 8: Protection

While staff had access to safeguarding training, this training was not effective. Despite a high record of attendance at safeguarding training inspectors saw three records where safeguarding incidents had not been recognised and responded to in line with the registered providers safeguarding policy.This failure to recognise safeguarding concerns creates a significant risk for residents.

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 | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Contract for the provision of services | Not compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Compliant |
| Regulation 4: Written policies and procedures | Compliant |
| **Quality and safety** | |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 20: Information for residents | Compliant |
| Regulation 26: Risk management | Compliant |
| Regulation 5: Individual assessment and care plan | Not compliant |
| Regulation 6: Health care | Not compliant |
| Regulation 8: Protection | Not compliant |

# Compliance Plan for Kiltipper Woods Care Centre OSV-0000053

## Inspection ID: MON-0042957

## Date of inspection: 04/04/2024

**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 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>A full systems review has been completed to ensure that all residents are safe and free from any form of safeguarding concern in line with the centre's policy and procedures on safeguarding. The areas identified by HIQA Inspectors such as the non-intentional / inappropriate peer to peer physical interaction between the two cognitively impaired residents and also where a resident consistently declines care which could be regarded as an omission of personal care, has been addressed and have been followed up as per actions outlined below in Regulation 8 section.<br>To ensure all staff recognise a safeguarding incident or any allegation of abuse made as a complaint as a safeguarding concerns , additioanal safeguarding information sessions which included further training on our safeguarding policy has been provided by the Person in Charge. The definations and indicators of safeguarding concerns or allegations of abuse were further explained to staff to ensure they have an indept understanding of our managemnt systems and our Safeguarding Policy in place to support staff in recognising, invesigating and reponding effectively to any safeguaring incidents or any allegation of abuse. Staff are aware that safeguarding incidents should be managed in line with our Safeguarding Policy to ensure residents are protected from any form of safeguarding incident. Where an incident of non-intentional / inappropriate peer to peer physical interaction between the two cognitively impaired residents occurs, this incident will be managed as a safeguarding incident and management and staff are aware of adhering to our safeguarding policy on recognising, invesigating and reponding effectively to any such incidents .<br>An MDT meeting was conducted to explore various options that could be negotiated and implemented to support the residents understanding of the benefits to them of participating and accepting personal care. The flexible options chosen and agreed with the resident are being monitored by our management and staff to ensure the best and most effective outcome is being achieved for the resident . The residents care plan has been updated with the flexible options and strategies implemented and as agreed with the resident and family . All Safeguarding incidents will be reported to HIQA in line with | |

regualtory requirements.
The falls identified by the HIQA Inspectors had already been discussed at our previous MDT falls committee meeting and existing control measures to maintain safety of the residents were reviewed and discussed at the meeting with the aim of further reducing falls incidences or risk of harm or injury for these residents.
We will continue to review and trend the information gathered from the auditing process to ensure audits are effective in leading to quality improvements.
The admission procedure has been reviewed to ensure all resident records are updated with any medical directives and in so far as possible include their end-of-life care preferences.

All staff have been reminded that staff induction records must be up-to-date and always kept on site for review and inspection.

| Regulation 24: Contract for the provision of services | Not Compliant |
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Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
As acknowledged by the inspectors on the day, short-term residents were provided with information relating to their stay. This information included a full list of services which short-term residents could expect to be provided with during their stay, in addition a detailed listing of costs for services not covered by the HSE funding is provided to all short-term residents. A resident guide is also provided which as acknowledged by the inspectors "The resident information guide included a summary of services and facilities available; the terms and conditions relating to residence and contact details of independent advocacy services available to residents."

We have implemented a contract of care for the provision of services between the registered provider and each short stay resident, stating the terms and conditions, to also include terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom that the resident shall reside in

| Regulation 31: Notification of incidents | Not Compliant |
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All future incidents where a resident consistently declines showers/ personal care or change of clothing despite much encouragement / persuasion, and which could be

regarded as a risk of an alleged safeguarding concern in respect of an act of neglect / omission of care will in future be notified to HIQA.

All future incidents where there is a non-intentional / inappropriate peer to peer physical interaction between residents due to the person's cognitive and medical condition, this type of interaction will be notified to HIQA as a safeguarding case within the specified timeframe of three days.

| Regulation 5: Individual assessment and care plan | Not Compliant |
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The pre-admission assessment form for residents on short stay admissions will, with the participation and consent of the resident, include any medical directives and in so far as possible include their end-of-life care preferences.
Short stay resident's care plan will all include emergency medical treatments as stated by the resident and the discharging hospital.
Residents who are deemed at risk of or who are involved in any safeguarding incident have a safeguarding care plan in place which clearly outlines to staff the preventative measures in place and to take for each individual resident to ensure their protection and safety.
All safeguarding plans have been reviewed and updated to ensure clear directives are provided to staff relating to the management and the care of residents with assessed safeguarding needs.
There will be on-going monitoring and oversight of resident safeguarding plans by the PIC and the Senior Management team on a weekly basis to ensure that control measures are effective.

| Regulation 6: Health care | Not Compliant |
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Outline how you are going to come into compliance with Regulation 6: Health care:
Actions taken to include the following.
Reinforcing the importance of adherence to all the centre's policy procedures and guidelines by staff to ensure safe and effective services are provided to residents and in accordance with any medical directives already in place on admission. Emphasising the importance of adherence to professional nursing standards and evidence-based nursing care.

The continued clinical observation and monitoring of vital signs and the use of (stop and watch early warning assessment) in the detection and response to clinical changes or deterioration of residents will continue to be communicated to all staff and updates provided at shift handovers.

Staff education and training and on-going professional development will continue to be provided to support staff in their role and responsibilities and practice.

| Regulation 8: Protection | Not Compliant |
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Outline how you are going to come into compliance with Regulation 8: Protection:
All staff have received training in safeguarding, and this will continue to be provided on an on-going basis, On the day of inspection the three safeguarding incidents identified were acknowledged by the Inspectors to be appropriately investigated and dealt with, under the complaint's procedure. We will in future notify HIQA of any safeguarding incidents which could be regarded as an omission of care, and of any non-intentional inappropriate peer to peer physical interaction between residents.

The following issues have been addressed:
Where a complaint is made by a second or third party about a concern of an omission of care or neglect of a resident' care despite the fact that the resident has repeatedly refused that care / intervention offered, clarification has been provided to staff that this type of incident must be managed as a safeguarding matter as well as being addressed through the general complaints process. All such safeguarding issues arising will be notified to HIQA.
Where a resident is identified as being at risk of self- neglect due to their consistent refusal to have personal care provided despite all efforts afforded by the staff, in such circumstances a safeguarding care plan will continue to be completed and updated as appropriate. Where an incident of non-intentional / inappropriate peer to peer physical interaction between the two cognitively impaired residents occurs, this incident will be managed as a safeguarding incident.
Control measures to protect all residents from any type of harm or injury will continue to be implemented as part of the centre's safeguarding policy and procedures which were reviewed by HIQA inspectors and deemed in line with standard and regulatory requirements.
To ensure all staff recognise a safeguarding incident such as a resident at risk of self-neglect / omission of care due to their consistent refusal to have personal care provided despite all efforts afforded by the staff, or resident peer to peer inappropriate interaction , additioanal safeguarding training and information sessions which included further training on our safeguarding policy has been provided to staff by the Person in Charge. The broader definations and indicators of safeguarding concerns or allegations of abuse were further explained to staff to ensure they have an indept knowledge and understanding of our Safeguarding Policy and are fully aware of recognising and responding effectively to any safeguaring incidents or any allegation of abuse in line

with our Policy on Safeguarding. On going training on safeguarding will continue with a focus on responding to any safegusaring incident in line with our safeguading Policy

## 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 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 | 12/04/2024 |
| Regulation 24(1) | The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that | Not Compliant | Orange | 10/04/2024 |

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| | centre. | | | |
| 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 | 05/04/2024 |
| 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). | Not Compliant | Orange | 10/04/2024 |
| Regulation 6(1) | The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident. | Not Compliant | Orange | 10/04/2024 |
| Regulation 8(2) | The measures referred to in paragraph (1) shall include staff | Not Compliant | Orange | 10/04/2024 |

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| | training in relation to the detection and prevention of and responses to abuse. | | | |