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:	Sacred Heart Hospital Castlebar
Name of provider:	Health Service Executive
Address of centre:	Pontoon Road, Castlebar, Mayo
Type of inspection:	Unannounced
Date of inspection:	11 August 2022
Centre ID:	OSV-0005730
Fieldwork ID:	MON-0036465

About the designated centre

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

Sacred Heart Hospital is a purpose-built facility completed in 2018 that can accommodate 74 residents who require long-term residential care. Care is provided for people with a range of needs: low, medium, high and maximum dependency and people who have dementia or palliative care needs. This centre is a modern two-storey building and is located adjacent to the original Sacred Heart Hospital premises. It is a short drive from shops and business premises in Castlebar. It is comprised of two self contained units. The Ross unit is located on the ground floor and the Carra unit on the upper floor. There is lift access between floors. There are 35 single rooms and one double room, all with full en-suite facilities, on each floor. The centre has a large safe garden area off the ground floor. This has several access points and was well-cultivated with flowers, trees and shrubs to make it interesting for residents. The philosophy of care as described in the statement of purpose is to use a holistic approach in partnership with residents and their families to meet residents' health and individual needs in a sensitive and caring manner while balancing risk with safety.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	61

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 11 August 2022	09:15hrs to 18:15hrs	Michael Dunne	Lead
Thursday 11 August 2022	09:15hrs to 18:15hrs	Rachel Seoighthe	Support

What residents told us and what inspectors observed

The overall feedback from residents was that they were happy living in the centre. Inspectors observed that staff in the centre on the day of the inspection were familiar with the resident needs and their preferences.

On arrival to the centre, the inspectors were guided through the infection prevention and control measures necessary on entering the designated centre. The systems included hand hygiene and temperature monitoring. Following an opening meeting with the assistant director of nursing, the inspectors were guided on a tour of the premises.

The Sacred Heart Hospital is a two-storey purpose-built premises built around a large internal courtyard. The designated centre is located within the Sacred Heart Hospital and comprises two units, the Ross unit and the Carra unit. Resident accommodation is located on both floors, the Ross Unit on the ground floor, and in the Carra Unit which is located on the first floor. There is lift and stair access between the units.

Inspectors observed that residents had unrestricted access to the courtyard and many residents were enjoying the outside space throughout the day of the inspection. Residents were observed tending to flower beds and told inspectors how much they enjoyed the garden.

The corridors within the centre were long and wide and provided adequate space for walking. Corridors were also decorated with brightly coloured, distinctive wall murals. Inspectors were told these were an effective feature to support residents with way-finding. Inspectors observed a number of display cabinets which contained old and vintage items. These were used to support reminiscence therapy.

The design and layout of the Ross Unit on the ground floor comprised of two small sitting rooms and one large sitting room. The dining room led out to a secure garden. There was an adequate amount of comfortable seating and furniture. Inspectors were shown to a smaller sitting room, which was being used for physiotherapy and relaxation. Inspectors observed that residents were participating in a physiotherapy session. Residents were being supported to use a range of exercise equipment to promote their mobility and rehabilitation.

A number of communal rooms in the centre were also decorated with wall murals which depicted images of interest to the residents. The centres much loved dog added to the homely feel of the centre.

The inspectors saw resident bedrooms were very personalised, with items such as, artwork, family pictures, and soft furnishings. Bedroom doors also were decorated to residents taste. Bedrooms were spacious and there was sufficient storage space, including lockable storage units. Bedrooms were fitted with ceiling hoists to support

resident mobility.

Residents had unrestricted access to a large chapel, located on the ground floor of the hospital. Inspectors observed that many residents were being supported to attend a religious service on the day of the inspection.

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 on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to follow up on the actions the registered provider had undertaken following the findings of the last inspection in September 2021.

Inspector's found that the governance, management and oversight of the service required actions to ensure that the service was safe, effective and suitable for the needs of the residents living in the designated centre. While some actions had been taken to address findings from the last inspection they were not effective in bringing the designated centre into compliance with the regulations and inspectors found repeated non compliance under governance and management, record keeping, and care planning. In addition inspectors found poor compliance in relation to the allocation of staffing, staff training and development, contracts for the provision of services, complaint's management, notification of incidents and records relating to volunteers. These findings are discussed in more detail under the relevant regulations.

The inspection was facilitated by an assistant director of nursing as both the person in charge and registered provider were unavailable to participate in the inspection. While there was a clearly defined management structure within the centre, the roles and responsibilities for some staff were not always clearly defined. For example records reviewed by the inspectors indicated that some housekeeping staff on the roster had been allocated to work in other units of the main hospital which were not part of the designated centre. The allocation of staff between the designated centre and the main hospital did not ensure that there were sufficient housekeeping staff on duty in the designated centre. Furthermore senior staff were not able to explain how staff were allocated and inspectors were not assured that there was sufficient communication between the management teams to ensure staff were appropriately deployed and that there were enough staff with the right skills and knowledge working in the designated centre.

The centre had encountered an outbreak of COVID-19 in March 2022 which

impacted 21 residents and a number of staff. On the day of the inspection there were two members of staff positive with COVID-19 who were away from the centre and there were no residents found to be positive or suspected with the infection.

The provider of the centre is the Health Service Executive and the person in charge is supported in their role by a general manager of older people services, a team of clinical staff which includes an assistant director of nursing, clinical nurse managers and staff nurses. Additional support is provided by a team of health care assistants, household, catering, administration and maintenance personnel.

Inspectors found that although the registered provider had systems in place to audit the service, information gathered under these monitoring systems did not translate into better outcomes for the residents or improve the quality of the service. For example poor compliance regarding the application of infection prevention and control standards had been identified in a recent audit however effective interventions had not been implemented by the management team to improve compliance in the identified areas. A number of the findings of this inspection reflected the findings of the centre's audit and an immediate action was issued by inspectors on the day of the inspection due to poor hygiene standards found in one of the centres sluice rooms.

Inspectors were not assured that the allocation of the number and skill mix of staff available on the day of the inspection was sufficient to meet the needs of the residents. A particular concern was the limited availability of household staff allocated to one of the units on the day of the inspection where significant infection prevention and control non compliances were found. In addition staff training records showed that a significant number of staff did not have access to appropriate training as described under Regulation 16.

A review of schedule 2 records found that not all information was in place to comply with the regulations, in addition, records relating to the use of volunteers also required actions to reach compliance with the regulations.Overall inspectors found that significant improvements were required regarding the maintenance of records. Some records made available to inspectors to review were either not updated, missing or stored in incorrect locations, for example inspectors found referral information for a care service located in a fire maintenance file. The use of accurate information by the provider is a key component in determining the delivery of effective services for residents.

While there was a complaints policy and procedure in place, records provided to inspectors to review indicated that this policy was not consistently followed.

Regulation 15: Staffing

Staffing resources found on the day of the inspection were not consistent with the numbers of staff described in the designated centre's statement of purpose. Inspectors were informed that two housekeeping staff were allocated to each unit

on a daily basis. A review of rosters and the allocation sheet indicated that one staff member was available for a half a day on one of the units.

Inspector's were informed that additional staff to facilitate weekend activities had been provided since the last inspection, however from conversations with the staff team and a review of rosters it was evident that this resource was only in place every other saturday per month. As a result there were not enough staff to ensure that residents had access to meaningful activities at weekends.

Judgment: Not compliant

Regulation 16: Training and staff development

From a review of the training records available the inspectors found that not all staff had been facilitated to attend mandatory training as follows;

9 staff had not completed safeguarding residents from abuse training
10 staff had not completed fire safety training

Training records also identified the need for staff training in the management of responsive behaviours, in order to bring about improved outcomes for residents as discussed under Regulation 7. This training had not been made available at the time of the inspection.

The inspectors found that house-keeping staff were not appropriately supervised. This was evidenced by the following inspection findings;

- inadequate standards of cleaning of vacated residents' bedrooms and communal bathrooms in the centre.
- inadequate standards of cleaning of housekeeping and sluice rooms.

Judgment: Not compliant

Regulation 21: Records

Inspectors found that records relating to roster management were poorly organised. The designated centre's roster was inaccurate and did not reflect the staff on duty in the designated centre. In addition shifts that were covered by agency workers were not included on the roster.

The allocation of staff resources to other roles were not defined and the management team on the day of the inspection were not clear about the staff that had been allocated to work outside of the designated centre but were included on the roster. The allocation of both catering and hygiene staff across both units was

confusing as records on the allocation sheet did not correspond on the respective roster for that unit.

Cleaning records were not well maintained and did not provide an accurate record of what cleaning schedules had been completed.

Fire safety checks and records in the designated centre were not well-maintained. Inspectors found gaps in weekly checks for fire safety.

A sample of three staff files were reviewed by inspectors. Not all staff files reviewed by the inspectors were compliant with Schedule 2 of the regulations. For example:

- one staff member did not have any written references on file. This staff member had a confirmation of employment from previous employers only.
- one staff member did not have a detailed employment history in their file.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had maintained a contract of insurance against injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

There was a management structure in place, however some roles within that structure were not well defined and did not provide clarity of authority and accountability. For example the person in charge was rostered to work full time in the designated centre but they had significant additional roles and responsibilities for the management of staff and services outside of the designated centre.

The management systems reviewed on the day of the inspection did not provide assurances that the service provided was safe, appropriate and consistent. This was evidenced by:

- A lack of governance and management processes. For example records showed that there had not been a governance meeting during the months of April, May and June 2022. As a result inspectors were not assured that the management team had appropriate monitoring and communication systems in place to ensure the service was well managed.
- Poor oversight of cleaning practices relating to infection prevent and control meant that the standard of cleaning in one unit was not adequate.

- Inconsistent monitoring of fire safety with a number of gaps identified in weekly checks which did not ensure that residents were adequately protected in the event of a potential fire emergency. These inconsistencies in daily and weekly checks had not been identified by the management team.
- The management of the staffing resource was not robust and did not ensure there were sufficient resources allocated to all areas of the service.
- While there was an auditing system in place, there was ineffective monitoring of action plans to ensure that the improvement actions identified had been implemented and had led to the required improvements in the service.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed a number of contracts for the provision of services. A number of these documents did not identify the frequency upon which the resident paid their contribution towards their rent charge i.e weekly or monthly. This was not in line with the designated centres own arrangements.

The type of room made available to the resident upon admission was not recorded on some of the contracts for example: if it was a single or a double room being offered.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose which was available for inspectors to review, however this document required updating to reflect an accurate description of the numbers of staff available in the designated centre and their individual roles,

- The whole time equivalents (this is the number of staff who would be employed if all staff were employed on a full-time basis) for staff were not accurate. Two part-time clinical nurse managers were not identified on the statement of purpose.
- The person in charge provided management support to a non registered service located on the grounds of the designated centre, this was not reflected in the whole time equivalents numbers described in the statement of purpose.

Judgment: Substantially compliant

Regulation 30: Volunteers

A review of information relating to volunteers working in the designated centre indicated that

- Not all volunteers had their roles and responsibilities set out in writing as required by the regulations.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Whilst the majority of notifications were submitted within the specified time-frames, the centre had not informed the Chief Inspector of a safe-guarding incident as required by the regulations. The inspector acknowledged that internal measures and appropriate actions were taken at the time and the incident had been investigated. This notification was submitted to the the inspectors following the inspection.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints procedure did not meet the requirements of the regulations in that:

- there was not always evidence that complaints were reviewed and closed off by the designated person responsible for complaints.
- The satisfaction of the complainant was not recorded for four complaints reviewed.

Judgment: Substantially compliant

Quality and safety

The inspectors observed that the interactions between residents and staff were kind and respectful throughout the inspection. Residents were satisfied with the quality of care they received and staff were observed to respond promptly to residents requests for assistance . Nonetheless, inspectors found that non-compliance in

relation to infection prevention and control and fire safety impacted on residents' safety and well-being. Further action was also required to ensure compliance with assessment and care planning and the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

The inspectors were assured that residents' health care needs were met to a good standard. There was daily access to a medical officer. There were appropriate referral arrangements in place to services such as dietetics, speech and language therapy, occupational therapy and podiatry. Residents' records evidenced that a comprehensive assessment was carried out for each resident prior to admission. Validated assessment tools were used to identify clinical risks such as risk of falls, pressure ulceration and malnutrition. However, the assessments did not inform person centred care plans , as these were often completed using a generic template which did not provide sufficient information to ensure that staff were able to deliver individualised care.

Activities in the centre included art, music and bingo and gardening. The activities board was displayed along the corridor and in the communal areas in the centre. Inspectors observed residents being supported by activities staff to attend the garden area. Inspectors also observed a group of residents participating in an indoor activity where interactive games were projected onto a table. Inspectors observed that residents were really engaged and enjoyed these activities. However, a review of staff rosters indicated that opportunities for social engagement such as these were limited at the weekends, due to a reduction in staffing levels.

Resident's rights were generally upheld in the centre. Resident's meetings were held regularly and inspectors viewed a small number of questionnaires containing feedback from residents in relation to the service. Residents had access to an external advocacy service.

Inspectors observed that the centre was not clean in a number of areas which had the potential to impact the effectiveness of infection prevention and control within the centre. This was evidenced by :

- Insufficient systems in place to enable staff to distinguish between clean and dirty equipment
- Many items of equipment and boxes were seen stored on floors in the storeroom and household rooms. This practice hindered the cleaning of floor surfaces and increased the risk of the build up of dust and debris.
- Items stored in some store rooms were not appropriately segregated. For example residents' medical equipment was stored with household supplies which increased risk of cross contamination.
- The monitoring and supervision of cleaning processes in the centre had not identified a number of non compliances found on this inspection..

Inspectors were not assured that all staff in the centre had received suitable training in fire prevention and emergency procedures, including on the evacuation procedures in the centre. Records of staff attendance at fire safety training did not

reference all staff.

Although, residents at risk of experiencing responsive behaviours were well supported, behaviour support care plans did not provide sufficient detail to guide staff. While staff demonstrated commitment to minimal restraint use, the policy and procedure in place had not been updated in line with national guidance and therefore was not an effective guide for staff.

Inspectors found that the registered provider had ensured visiting arrangements were in place for residents to meet with their visitors as they wished. Visits were encouraged with appropriate precautions to manage and mitigate the risk of introduction of COVID-19 infection into the designated centre.

Regulation 13: End of life

There was a comprehensive end-of-life policy in place. Support and advice was available from the palliative home care team. Religious sacraments were available to all residents as desired. Families were facilitated to be with a resident when they were at end of life.

Judgment: Compliant

Regulation 17: Premises

A resident sitting room located on the ground floor of the designated sitting centre had been re designated as a staff room to enable the provider to maintain staff segregation during a COVID-19 outbreak. At the time of the inspection there were no positive COVID-19 cases in the centre however the sitting room had not been returned for resident use.

Judgment: Substantially compliant

Regulation 27: Infection control

The registered provider did not ensure that procedures consistent with the standards for the prevention and control of health care associated infections published by the Authority were implemented by staff. For example the oversight and management of environmental cleaning ,and the processes for cleaning and storing residents' equipment needed to be improved. This was evidenced by:

- A residents chair was inappropriately stored beside a visibly unclean toilet in a

communal bathroom. This increased the risk of cross contamination.

- Residents equipment which was visibly unclean was stored on the floor of the sluice room, this did not facilitate effective cleaning of the floor.
- Hygiene supplies were stored on the floor of the house-keeping room which did not facilitate effective cleaning of the floor.
- Lockable storage for potentially hazardous cleaning solutions were not available in the house-keeping room
- Systems in place to ensure segregation of medical equipment from general supplies required review as there was a risk of cross contamination.
- A number of toilets, sinks and shower traps were visibly unclean.
- Inappropriate storage of sharps containers on a personal care trolley
- Inspectors observed that a bedroom vacated by a resident was not appropriately cleaned
- There was no system in place to differentiate between clean and dirty equipment, for example staff could not verify that a communal shower trolley had been cleaned after use.
- Floor and wall surfaces in the internal waste storage room were visibly unclean. A large clinical waste bin was observed to be unlocked and open in the internal waste storage room. This had been identified during an internal inspection previously.
- An immediate action was issued to the centre due to the condition of a sluicing sink which was unclean and had the potential to cause harm to the residents due to the risk of cross contamination.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider did not ensure that adequate precautions were in place against the risk of fire and that residents were sufficiently protected in the event of a fire emergency. These included:

- That means of escape were maintained and adequately supervised. Inspectors found a number of cardboard box items stored adjacent to a fire exit on the ground floor. A large blue bin used for the storage of waste was also located in this area. These items had the potential to negatively impact upon the emergency evacuation route.
- A direction sign indicating the location of the nearest fire exit on Carra unit was missing.
- The provider was unable to provide inspectors with confirmation of the fire compartment boundaries in the designated centre. Boundary doors between different compartments are rated as offering 60 minutes protection, however a number of fire doors located on a corridor in the Carra unit were found to offer 30 minutes protection.
- Some fire doors did not close properly and as such there was a risk that they would not be able to offer sufficient protection against the spread of smoke

between compartments in the event of a fire emergency.
- A significant number of staff were not up to date with their mandatory fire safety training.
- Weekly checks to ensure fire exits and fire doors were fit for purpose were not complete and there was no record of the required checks being completed for a number of weeks since the last inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of residents care plans. Each resident had a completed comprehensive assessment of their health, personal and social care needs. Inspectors found that the quality of the care plans was inconsistent. Some care plans described resident's care needs and personal preferences in a detailed and person-centred manner, while other care plans lacked the detail required to guide staff to deliver effective, person-centred care.

For example:

- a number of nutritional care plans contained minimal detail in relation to the residents personal preferences and nutritional needs and did not provide the information required to deliver person-centred care.
- a number of end of life care plans contained minimal detail in relation to the emotional, social, psychological and spiritual needs of the residents. Therefore there was a risk that those needs would not be met.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had daily access to a medical officer. Allied health professionals were available such as dietitian, physiotherapist, occupational therapist, speech and language therapy. Residents had access to specialist input from the psychiatry of old age, a geriatrician and the palliative care team as and when required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

From a review of the training records available the inspectors found that not all staff had been facilitated to access training in the management of responsive behaviours. Therefore inspectors were not assured that staff had up to date knowledge and skills, appropriate to their role to respond to and manage responsive behaviours.

There was a restraints policy in place however, this was not up to date and did not include best practice guidance relating to the appropriate use of chemical restraints.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Overall residents' right to privacy and dignity were respected by the staff team. Inspectors observed staff and residents interactions throughout the day and found them to be based on respect for the individual taking into account the needs of the residents.

While there was support for residents to access activities in the designated centre inspectors observed the weekly activity schedule to cover Monday to Friday only. Although the registered provider had made efforts to provide additional activity support during the weekends this was not a consistent service. This is described in more detail under Regulation 15 staffing.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Sacred Heart Hospital Castlebar OSV-0005730

Inspection ID: MON-0036465

Date of inspection: 11/08/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Statement of Purpose and Function updated post inspection, pending at inspection due to the commencement of new CNM's. WTEs now correct in SOP. There is a differentiation in the SOP between the staffing for full occupancy and staffing where there is not full occupancy. Occupancy levels are aligned to standard care staffing levels All staff will utilize the one sign in system at ward level and be reviewed by the person in charge of the ward to ensure that the number of staff that have been allocated to a particular area have signed in and are accounted for on the roster. In addition where due to absences the allocated staff are not available , the Nurse Manager in Charge will re-allocate available staff as necessary Interviews took place in-house on 10/09/2022 and recruitment underway to ensure all residents have the opportunity to engage in meaningful weekend activities every weekend.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All training records have been reviewed and training dates for outstanding training for staff inputted into training matrix . Fire training ongoing and held on Monday 05/09/2022. Further dates for staff whose fire training I outstanding booked. Fire Warden training for CNM's booked.	

Designated name with duty of updating fire book in each ward and arrangement in place for when they are on leave in place.

CPI Mappa training ongoing in house. Staff completing management of Violence and Aggression training on HSELand in the meantime.

Support Services Manager completing spot checks on all cleaning in the designated centre which includes vacant rooms, communal bathrooms and sluice areas . The level of checking has been increased since the inspection . Nurse Management has set up hygiene audit as part of the 2002/2023 Audit Programme

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
All rostered staff have been inputted into roster sign in system for each area. Lohan system previously only used for Nurses and Healthcare Assistants now includes Hygiene personnel, catering staff and activities personnel. Agency staff will be identified on sign in sheets on the unit, thus capturing all staff working in each area at any time.

Catering and Hygiene staff are now allocated to each unit of the Designated Centre and corresponds with respective rosters for that unit.

Ward managers/Nurse in Charge will review the staff on duty on a daily basis to confirm all rostered staff are on duty and make any required adjustments if they are not

Those working outside the Designated Centre will be identified on the roster as being on a Business Absence with the amount of hours identified on the roster. Nursing Admin sign in the same manner as all staff members.

Cleaning records have been reviewed. A full hygiene audit was completed post inspection. Support Services manager completing spot checks to ensure all cleaning and cleaning schedules are completed, supplemented by management audits.

Fire Warden training for all CNM's on 14/09/2022. Fire registers have been updated since inspection. Checks that had been logged on loose sheets have now been filed and full completion of fire register books commenced from August 2022.

An audit of staff files will be completed to identify any outstanding information to ensure complete files. Outstanding references and Employment history will be requested from the National Recruitment Office and placed in staff files in-house.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Those working out the Designated Centre will be identified on the roster as being on a Business Absence with the amount of hours identified on the roster. Nursing Admin sign in as for all staff members.

Post Outbreak governance meetings have now resumed. Meeting held on 24/08/2022 and 21/09/2022. These meetings will continue monthly.

Cleaning records have been reviewed. A full hygiene audit was completed post inspection. Support Services manager completing spot checks to ensure all cleaning schedules are completed, supported by management audits.

Fire Warden training booked for all CNM's. Fire registers have been updated since inspection. Checks that had been logged on loose sheets have now been filed and full completion of fire register books commenced from August 2022

All rostered staff have been inputted into roster sign in system for each area. Lohan system previously only used for Nurses and Healthcare Assistants now includes Hygiene personnel, catering staff and activities personnel. Agency staff will be identified on sign in sheets on the unit, thus capturing all staff working in each area at any time.

While there was an auditing system in place, there was ineffective monitoring of action plans to ensure that the improvement actions identified had been implemented and had led to the required improvements in the service

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
Contracts of Care review completed. All contracts now includes accommodation type i.e. single or double room and frequency and amount of contribution towards resident's charges.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose and Function updated post inspection, pending at inspection due to the commencement of new CNM's. WTEs now correct in SOP. There is a differentiation in the SOP between the staffing for full occupancy and staffing where there is not full occupancy. Occupancy levels are aligned to standard care staffing levels. Two part time Clinical Nurse Managers included in WTE.

Those working outside of the Designated Centre will continue to be identified on the roster as being on a Business Absence (BA) with the amount of hours identified on the roster. Nursing Admin will continue to sign in, as for all staff members.
The person in charge provides management support to the Rehabilitation Unit which is also located on the grounds of the designated Centre and this is reflected in the SOP. It will be reflected in the rosters as sign for business absence (BA).

PIC has no role as PPIM in any external Designated Centre. Full governance for unit is as follows:

PIC/DON
Ross, CNM2 and CNM1
Carra: CNM2 and CNM1
A/DON overseeing Both Units.
Night CNM1 on every night.

The Rehabilitation Unit has its own management structure reporting to the DON. Note the PIC only supports Rehabilitation unit on an average of about 10% of weekly working time.

Regulation 30: Volunteers	Substantially Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:
All Volunteers now have their roles and responsibilities set out on file.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All CNM's undertaking Designated Officer Safeguarding Training at present. Reiteration given to all Clinical Managers of the importance of notifying notifiable events in the correct time frame and will be further discussed at CNM meeting on the 20.09.2022. The PIC will monitor the process to ensure that it is completed monthly at the CNM meetings.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Complaints policy has been updated and each unit has a complaints folder where any complaint is logged. The PIC will collect all complaints and review and close off all complaints with in the time frame as per policy. Satisfaction of complaint, if received, will be recorded and complaints closed off.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The resident sitting room on each suite has been returned for resident and family use only. Staff are currently back using the staff tea rooms on each floor.	
Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: Sluice Room was thoroughly cleaned on receipt of the immediate action notice and is kept clean as part of the standard cleaning Programme Support Services manager completing spot checks to ensure all cleaning schedules are completed and following up with hygiene team, supported by management audit.	

Commencing September 5th 2022, all members of the hygiene team are now working days therefore the cleaning has been re-organised to ensure all non-daily and deep cleaning tasks are covered plus monitoring and oversight that the cleaning program is being implemented

The chair that was stored in the communal bathroom (awaiting repair) has been repaired and stored in the store room. Items for repair are taken from the unit and left in a storage area for repair. Staff have been reminded not to store items in communal bathrooms and this will be monitored by Ward Managers/Nurse in Charge

Larger items for cleaning are stored off the unit in a designated area and returned once steamed cleaned.

Toilets in communal areas are checked frequently during the day to ensure they are clean after a resident uses them.

A falls mat that had been placed in the sluice room has been removed and floors thoroughly cleaned.

All boxes stored on shelving units to enable effective cleaning of floors.

Items stored on the floor of store and house hold rooms has now been removed and stored on shelved units to enable to cleaning of floors. Further shelving units have been supplied to enable further storage.

Next point segregation of medical & household supplies have been segregated and stored separately.

Swipe card entry into hazardous cleaning solutions storage areas and lockable chemical presses ordered for both the Ross and Carra units.

Toilets, sinks, taps and shower areas have been descaled.

A sharps container has been removed from personal care trolleys; this was for the disposal of razors. This has been removed and is now stored in the sluice room.

Empty rooms are checked daily and cleaned as is necessary.

A review of all commode usage has been completed and individual commodes purchased for each resident who requires one. A cleaning schedule for these commodes has been devised. One spare commode is kept for emergency situations to prevent crossover contamination. This commode will be decontaminated on return to sluice area and will be cleaned daily as part of the Sluice room cleaning programme.

Tagging system will be introduced to identify equipment as clean.

Internal waste storage area is swipe card entry only. Deep clean of area undertaken and clinical waste bins closed and locked. CNM's will audit the bin area to ensure that the

clinical bins are kept closed.

Cleaning records have been reviewed. A full hygiene audit was completed post inspection. Support Services manager completing spot checks to ensure all cleaning schedules are completed, all evidence documented, which is further supported by management audits

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The cardboard boxes and blue recycling bin stored in an alcove beside the fire exit have been moved and signage erected that this area must be kept clear at all times.
This will be audited as part of the fire safety audit.

Direction sign indicating the location of the nearest fire exit has been replaced.

A review of all evacuation procedures under way by fire officer at present. Compartments identified.

Fire Officer on site and evaluation of compartments have been identified. A review of all evacuation procedures under way by fire officer at present. Compartments identified. Signage reflecting the positions of FD 60 doors have been erected and clearly identifies compartments. FD 30doors breaks up the compartment on the corridors but do not reflect a compartment. This has been identified to staff at fire training.

All fire doors have been readjusted to close with a tight seal.
All training records have been reviewed and dates inputted into training matrix.

Fire training ongoing and held on Monday 05/09/2022. Further dates for fire training booked, Fire Warden training for CNM's also booked.

Fire registers have been updated since inspection. Checks that had been logged on loose sheets have now been filed and full completion of fire register books commenced from August 2022.

The CNM2 and in their absence the CNM1 will be responsible for completing the fire registers on a weekly basis on each ward.

Regulation 5: Individual assessment	Substantially Compliant

and care plan	

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Night CNM's to complete a care plan audit to identify that all care plans provide sufficient information. Generic care plans will be utilized as a guide for interventions on completing care planning on responsive behaviours and the use of minimal restraint. Further review Nutritional Care plans will be completed and amended and End of Life Care plans to reflect emotional, social, psychological and spiritual needs.

Night CNM's to complete a care plan audit to identify that all care plans provide sufficient information. Generic care plans will be utilized as a guide for interventions on completing care planning.

Night CNM's to complete a care plan audit to identify that all care plans provide sufficient information. Generic care plans will be utilized as a guide for interventions on completing care planning on responsive behaviours and the use of minimal restraint.

The Night CNM's will also review the care plans to identify any trends in terms of those care plans that were not to the standard, further to which individual guidance will be provided as well as monitoring to ensure the required standard is achieved and maintained.

Restraint policy will be updated.

CPI Mappa training ongoing in house to enable staff to deal effectively with responsive behaviours. Staff also asked to complete management of Violence and Aggression on HSELand.

Communication tool to be utilized to identify discomfort with social or physical environment. Abbey pain scale used daily to identify expressions of pain. (PG 12 of 29)

Expressions of interest were requested among existing HCA staff and following a positive response interviews took place on 10/09/2022 and in-house recruitment is currently underway regarding additional activities personnel to cover meaningful weekend activities.

All training records have been reviewed and dates inputted into training matrix.

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:
CPI Mappa training ongoing in house next date booked for 13/09/2022 to enable staff to deal effectively with responsive behaviours. Staff have all been asked to complete management of Violence and Aggression on HSELand.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	20/09/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/11/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	20/09/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Substantially Compliant	Yellow	20/09/2022

	provide premises which conform to the matters set out in Schedule 6.			
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	30/11/2022
Regulation 21(2)	Records kept in accordance with this section and set out in Schedule 2 shall be retained for a period of not less then 7 years after the staff member has ceased to be employed in the designated centre concerned.	Not Compliant	Orange	30/11/2022
Regulation 21(4)	Records kept in accordance with this section and set out in paragraphs (6), (9), (10), (11) and (12) of Schedule 4, shall be retained for a period of not less than 4 years from the date of their making.	Not Compliant	Orange	30/11/2022
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	20/09/2022
Regulation 23(b)	The registered provider shall ensure that there	Substantially Compliant	Yellow	20/09/2022

	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.			
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	20/09/2022
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 centre.	Substantially Compliant	Yellow	20/09/2022
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the	Substantially Compliant	Yellow	20/09/2022

	resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.			
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	20/09/2022
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	20/09/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	20/09/2022
Regulation 30(a)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre have their roles	Substantially Compliant	Yellow	20/09/2022

	and responsibilities set out in writing.			
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	20/09/2022
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Not Compliant	Orange	20/09/2022
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a	Substantially Compliant	Yellow	20/09/2022

	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.	Substantially Compliant	Yellow	20/09/2022
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	30/11/2022