



Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Sacred Heart Residence
Name of provider:	Little Sisters of the Poor
Address of centre:	Little Sisters of the Poor, Sybil Hill Road, Raheny, Dublin 5
Type of inspection:	Unannounced
Date of inspection:	21 April 2021
Centre ID:	OSV-0000157
Fieldwork ID:	MON-0032728

About the designated centre

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

Sacred Heart Residence is owned and operated by the Little Sisters of the Poor, and is located near St. Anne's Park in Killester on the northside of Dublin. The centre can accommodate 86 residents, both male and female over the age of 65, with low to maximum dependency levels. Residents are accommodated in 84 single bedrooms and 1 double bedroom, all with en suite facilities. Other facilities available to residents include sitting rooms, a shop, tea bar and a chapel.

The person in charge is supported by the registered provider representative, a chief nursing officer, a clinical nurse manager. There is team of registered nurses and healthcare assistants who provide care to the residents in the centre. Allied health professionals are contracted to provide specialist services to the residents in accordance with their wishes and needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	71
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 21 April 2021	09:10hrs to 17:55hrs	Niamh Moore	Lead
Wednesday 21 April 2021	09:10hrs to 17:55hrs	Margaret Keaveney	Support
Wednesday 21 April 2021	09:10hrs to 17:55hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

From what residents told us and what inspectors observed, residents were happy with the care they received within the centre and were observed to be content in the company of staff. Overall, inspectors observed a relaxed and happy environment.

The inspection was unannounced. Inspectors followed the centres COVID-19 infection prevention and control protocols on entering the centre. This included hand sanitising, donning personal protective equipment (PPE), recording temperatures and a questionnaire.

The centre is a large building set out over four floors. The person in charge (PIC) accompanied two of the inspectors on a walk around the centre. The design and layout of the building was spacious and ensured the privacy of the residents. Communal areas were organised to allow residents to relax and socially distance safely. During this tour, the inspectors met and spoke with residents in the corridors and in day rooms. Residents said that they enjoyed the view from the centres windows and balconies. They said that they got great pleasure from watching the birds, squirrels and seeing the trees change with the seasons.

There was a chapel available to residents for private prayer and residents were also supported to participate in religious services remotely, for example mass was broadcast daily to residents televisions.

Residents had access to a library and a large auditorium for entertainment. Resident COVID-19 vaccinations had recently been administered in the auditorium. Inspectors saw from resident meeting records that plans were in place to begin using it again for residents' entertainment, in the near future.

The centre had closed one of the units on the third floor which had eight vacant bedrooms. Inspectors were informed that this area was designated as the isolation area in the event of the centre experiencing an outbreak of COVID-19. These bedrooms were used to cohort residents for suspected or positive COVID-19 cases.

The centre was pleasantly decorated. The living and dining areas had a homely atmosphere which allowed residents to relax and socialise. Residents were offered a choice regarding the food they ate and where they wished to eat their meals. For example residents could chose to eat in their bedrooms or in a number of dining rooms. The dining tables were set with decorative tablecloths and fine crockery and mealtimes were observed to be a social occasion. Residents confirmed that they enjoyed the meals provided.

Resident's bedrooms were large with ample space to store their possessions, including a lockable safe to secure their personal belongings. Residents had access to a television and radio in their bedroom. Inspectors observed that many residents

had decorated their bedrooms with furniture and other personal items.

While the centre was decorated well, there were some areas including flooring, woodwork and tiling that required repainting and maintenance works.

On the day of the inspection, inspectors observed residents to be well presented, content and relaxed. Residents who spoke with inspectors said that they were happy in the centre. They reported that they enjoyed the garden and the great care and attention from staff. Residents said that they felt safe and could talk to staff openly. Residents were seen to spend time in small groups in communal areas or walking along the corridors.

Staff who spoke with inspectors were knowledgeable about residents and their needs. Inspectors spent time in communal areas observing interactions and found that staff were respectful of the privacy and dignity of residents. Staff were seen to knock on residents' bedroom doors before entering and were gentle in their approach with residents.

Residents had opportunities to meet with management about the running of the centre. A review of the last resident meeting minutes showed that visits, food and an upcoming animation event in the centre's auditorium had been discussed. Other meeting minutes recorded residents' appreciation of how the centre had facilitated residents to maintain personal relationships with family and others using social media platforms when in-person visits were prohibited.

Residents that inspectors spoke with said that they were aware how to make a complaint and felt comfortable in doing so. Staff spoken with knew how to manage complaints received but were not recording verbal complaints as was the practice stated in the policy.

Inspectors saw that there were no activities taking place on the day of inspection. Staff told inspectors that on nice days, visitors would bring residents out for a walk within the grounds of the designated centre. Three residents that inspectors spoke with said that they were unhappy with the current level of activities available to them. One reported that they had very much enjoyed the group activities held before the COVID pandemic and hoped that they would resume shortly.

Inspectors were told that the centre had been gifted a cargo bike prior to the COVID-19 pandemic. It had been operated by a volunteer to take residents on short travel and leisure trips outside of the centre. The person in charge told inspectors that the centre hoped to resume this activity as soon as it was safe to do so.

The inspectors saw hairdressing facilities in the centre. The person in charge informed them that since the start of pandemic the hairdresser had not attended the centre but resident's hair care needs were now being looked after by a staff member.

While residents reported to be happy with the care and service they received, inspectors found that there were gaps in oversight arrangements in a number of areas in the centre. The next two sections of the report present the findings of this

inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Inspectors found that the overall governance and management systems in the centre were insufficient to ensure effective oversight for the sustainable and safe delivery of care. Inspectors were not assured that the current resources were sufficient to meet the needs of residents, in areas such as cleaning and provision of meaningful activities for residents. There were gaps identified during this inspection which were not identified within the audit tools being used to give the provider assurances that best practice was in place and was effective which is further discussed under Regulation 23: Governance and Management.

Inspectors reviewed progress on the compliance plan received in response to an inspection held in the centre in November 2020. While some improvements had occurred, inspectors were unable to find evidence that stated compliance plan actions from the previous inspection had been completed. For example, there were repeat findings of non compliance regarding training records, governance and management, and risk management.

Sacred Heart Residence is operated by the Little Sisters of the Poor. The governance structure of the centre includes the board of management, the registered provider representative, the person in charge and a chief nursing officer. Additionally, there was a team of a clinical nurse manager, nurses, care assistants, religious sisters, administration, housekeeping, maintenance and kitchen staff employed in the centre

There was insufficient oversight of records within the centre. Inspectors reviewed the staffing records of four staff members to ensure that safe and effective recruitment practices were in place. Each record reviewed did not meet one or more of the requirements set out in Schedule 2 of Statutory Instrument No. 415/2013 The Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016. In addition the rosters and training records available on the day of inspection were not accurate, which is a repeat finding from the previous inspection.

The centre had a COVID-19 contingency and preparedness plan which had recently been reviewed in April 2021. This plan detailed succession planning if key management personnel were unable to attend work, and to ensure the centre remained sufficiently resourced with staff and equipment. Staff spoken with on the day of the inspection were also familiar with this plan and where it was located.

The complaints procedure was prominently displayed at the entrance of the centre. The inspectors found that the designated centre was not following their own policies, for example they were not recording all complaints under the complaints

policy.

An induction programme was in place to support new staff working in the centre. Staff reported to be well supervised and to have received sufficient training for their roles. 15 staff were trained to take swabs for the detection of COVID-19.

There was an annual review of the quality and safety of care delivered to residents in 2020. This review was completed in consultation with residents and there was an action plan to address any findings.

Regulation 15: Staffing

There were sufficient staff resources to meet the assessed clinical needs of residents and having regard to the size and layout of the centre. However there were insufficient staff to deliver cleaning at weekends and to deliver activities. The dedicated activity staff role remained vacant and other staff did not cover this role.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training records showed that 12% of staff were overdue or required training in manual handling and 15% of staff were overdue or required training in safeguarding.

Judgment: Substantially compliant

Regulation 21: Records

The copy of staff duty records seen did not show all the staff that worked in the centre, as required by schedule 4 of the regulations. For example, records did not show the hours worked by the catering manager and administration staff.

Following the previous inspection, improvements were seen where a system was put in place to monitor staff training, however records were not kept up to date.

Inspectors reviewed a sample of four staff records under schedule 2 Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Records reviewed contained up to date Garda Vetting disclosures. However, improvements were necessary as:

- A staff member did not have confirmation of their registration with the Nurse and Midwifery Board of Ireland. When highlighted to the provider this member of staff was immediately sent off duty.
- Two records did not include written references.
- Three records did not detail a full employment history with satisfactory explanation of any gaps.
- One record did not contain evidence of the employees' identity and another record contained no evidence of an employee's address.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that there were sufficient resources to ensure the effective delivery of clinical care in accordance with the statement of purpose. However as previously stated within this report, inspectors were not assured that there was sufficient staff for the provision of cleaning or to facilitate recreation. This was not in line with the centres statement of purpose dated November 2020.

There was a defined management structure in place within the centre, however some areas of responsibility and authority were unclear. While management meetings occurred on a weekly basis, inspectors were not assured that systems were effective to ensure there was sufficient oversight across some areas within the centre, particularly in the area of recruitment and clinical care. For example, on the day of inspection inspectors found:

- The systems to assure availability of records kept in respect of each member of staff and records of the hours worked by each staff member were not in place.
- Inspectors acknowledged that some improvement was found, however accurate training records were not available on the day of inspection. This was a repeat finding from the previous inspection and inspectors were not assured the centres compliance plan had been effectively addressed.
- Clinical audits completed did not have sufficient senior management oversight. For example, a nutrition audit completed in March 2021 had identified improvements required which had not been effectively addressed.
- While the centre had commenced work on their risk register, it was unclear on the day of inspection who was responsible for areas of clinical risk.
- Gaps were found in schedule 2 records for a newly recruited staff member, this indicated that recruitment was not sufficiently vigorous. Strong recruitment processes are an important element of ensuring safety and protection for older adults.
- The complaints management checklist devised following the previous inspection had not been completed.

The centre had an audit schedule for 2021. Inspectors found that the audits that

had occurred were not sufficiently robust as there were gaps identified during the inspection which were not identified in the infection control audit tool being used to give the provider assurances that best practice was in place and was effective.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centre had a complaints policy which met the criteria of the regulations. The centre displayed the complaints procedure in a prominent position.

Inspectors reviewed the complaints register for the centre. There was one complaint seen for 2021 which had been managed satisfactorily.

Judgment: Compliant

Quality and safety

The findings of this inspection showed that the management and staff strived to provide a good quality of life for the residents living in the centre. Inspectors found that residents reported to be happy with the service they received. However, there were improvements required in the management of the premises, risks, infection control, individual assessment and care planning and to ensure residents had opportunities to participate in recreation.

Alcohol-based hand rub, and PPE supplies were available and information posters to support IPC practices were clearly displayed throughout the centre to promote social distancing and correct usage of PPE and hand hygiene measures. While infection prevention and control processes and procedures were in place and the centre was generally clean, there were areas identified which required review.

Residents had access to televisions and radios within the centre. Residents' privacy and dignity were upheld in the centre through staff policies and practices. Inspectors observed positive engagement and happy conversations between staff and residents on the day of the inspection. Residents were regularly consulted about the running of the centre, via surveys, meetings and had access to an advocacy service.

Staff used a variety of accredited assessment tools to guide and inform each resident's care plan. Assessments included those on risk of falling, manual handling, and malnutrition. Assessments were seen to guide the completion of relevant and personalised care plans. However gaps were found in pre-assessments and in social

care plans.

Residents had regular access to general practitioners who continued to review care needs in person or remotely. Residents also had continued access to other allied health professionals including an onsite physiotherapist. Access to allied health professions such as dietitians, chiropody, tissue viability nurses, speech and language therapies and services were available to residents. Recommendations from these healthcare services was evident in care and support plans where required.

Inspectors found that while there were care plans in place for residents who displayed behaviours that challenge, these records had insufficient guidance available to direct staff on how to care for residents in accordance with national policy as published on the website of the Department of Health.

While there were cleaning check lists in place, there were gaps seen in records to show that rooms that had been cleaned was overseen by the unit manager. There was no scheduled cleaning system for the cleaning of soft furnishings, such as curtains and seating.

There was no dedicated activities co-ordinator employed in the centre since August 2020, despite a recruitment campaign by the centre. Inspectors were informed that the centre's nursing and healthcare assistants were completing the activity schedule with residents Monday to Saturday. However inspectors did not see any evidence of any activities happening on the day of inspection and this differed from what residents and staff told inspectors.

Inspectors observed numerous indoor visits happening on the day of the inspection and that such visits were facilitated in either the residents' bedroom or in a comfortable, dedicated private room with facilities for refreshment. There was a supply of PPE available to visitors and appropriate amenities in place for putting on and taking off PPE as required.

Regulation 11: Visits

At the time of the inspection residents could receive visitors and the centre was following the latest Health Protection and Surveillance Centre guidance.

Judgment: Compliant

Regulation 17: Premises

Improvements were required in the following areas which impacted on cleanliness and the safety of residents.

- Flooring damaged under the door of a storeroom was covered with tape and the floor was damaged in one cleaner's room, which could result in floors not being cleaned effectively.
- Missing wall tiles in chiropody room, a ladies toilet, two assisted bathrooms and two sluice rooms.
- In one treatment room, there was no splash back behind the hand hygiene sink where the wall was seen to be damaged and could not be cleaned effectively.
- Records showed that the temperature of one medication fridge was not maintained at the correct temperature on a number of occasions, this had not been reported by staff for repair.

Storage practices in the centre required review from an infection prevention and control or a resident rights perspective; for example

- Inappropriate storage of boxes on floors in a storeroom on the ground floor and storage of wheelchairs, commodes, two linen trollies and lifting equipment in three assisted bathrooms and one toilet.

Judgment: Substantially compliant

Regulation 26: Risk management

The centre had a risk management policy which was revised in January 2020. This policy identified the provider representative as the nominated person who has responsibility to manage risks within the centre. However, inspectors found that this policy was not specific to this centre, for example it referenced another designated centre. The control measures recorded to manage the risk of abuse in the designated centre did not reflect the safeguarding policy of the centre. Inspectors reviewed the centre's safety statement which was reviewed in March 2021.

Judgment: Not compliant

Regulation 27: Infection control

There were issues fundamental to good infection prevention and control practices which required improvement:

- Gaps were seen in staff temperature checks and therefore not in line with current guidance which required monitoring twice during a work shift.
- Staff hand hygiene practices required review as four staff were seen to wear watches, one wore nail varnish, and one staff wore a stoned ring. There was no alcohol-based hand rub in one treatment room. This meant that they

could not effectively clean their hands.

- Sterile dressings were observed to be opened with part of the dressing removed, and the remaining opened dressing packs stored among the dressing stocks which could result in a risk to residents if these non-sterile dressings were used.
- Used and un-used razors and personal hygiene products, such as creams, were stored together and unlabelled which could pose a risk of cross infection to residents.
- Manual handling hoist slings were used by multiple residents and two bins seen were not hands free which could result in cross contamination.
- The bath in one assisted bathroom was very dusty.
- In one bedroom that was vacant, Inspectors were informed that it had been cleaned and was ready for a new admission. However, it had personal items from the previous resident in the bathroom.
- Sluice hoppers in two cleaner rooms on the first floor were not clean, with no hand hygiene sink or alcohol-based hand rub available for staff to clean their hands.
- While there were bedpan washers in the centre, these had not been serviced to ensure that bedpans and urinals could be effectively cleaned.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors found that a pre- assessment was not completed prior to a resident's admission for two residents. This meant that the provider could not identify and ensure the centre could meet the residents' needs as a result the care plans could not be developed. Care plans reviewed were not completed within 48 hours of the residents' admission.

Inspectors reviewed recreational and social care plans for individual residents. These plans were generic and did not detail personalised information and inspectors were not assured that these care plans provided sufficient information, particularly if residents were being supported by staff who are unfamiliar with their assessed needs, preferences, and interests.

Judgment: Substantially compliant

Regulation 6: Health care

Inspectors found that residents were provided with timely access to their own or the centre's general practitioner (GP).

Referrals were seen to take place to allied health professionals with timely access for residents to these services. Where recommendations were made these had been updated in residents' care plans.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Inspectors reviewed documentation relating to risk assessments and care plans on physical and environmental restraints. Inspectors found that overall, for residents who had a physical or environmental restraint such as a bed rail, consent forms and care plans were seen to evidence their use.

Inspectors reviewed documentation relating to PRN (as required) medication given to two residents. Records showed that when PRN medication was administered, improvements were required to ensure that there was evidence of trying alternative means to manage the behaviours that challenge prior to giving this medication. Inspectors also found that as the medication was not seen as a restrictive practice, and was not subject to review or evaluation.

Judgment: Substantially compliant

Regulation 8: Protection

There was a safeguarding policy available in the centre which had been updated recently.

Records showed that there were two safeguarding incidents this year. One had been investigated fully and responded to appropriately. The second allegation was on-going since February, where the provider was seen to take the appropriate action.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors reviewed the minutes of residents' meetings with management, which showed that their views on the running of the centre were welcome and used to improve services for all residents within the centre. Residents could also express their views and preferences by means of a comments box.

At the time of the inspection, there was no activity co-ordinator employed in the

centre. Inspectors did not see any evidence of activities occurring on the day of inspection, and from previously mentioned within this report residents were unhappy with the provision of activities within the centre.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Substantially 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 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Sacred Heart Residence OSV-0000157

Inspection ID: MON-0032728

Date of inspection: 21/04/2021

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider’s response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <p>Housekeeping staff at weekends: At Time of the inspection there was deficit of 16 hours of housekeeping times split between 2 units in the Home. Since inspection 8 of these hours have been filled. We are in the process of recruiting adequate staff to fill the remaining hours.</p> <p>Activities Staff: We are currently in the process of recruiting an activities coordinate and envisage the post being filled by the by 31st August</p> <p>Home’s activity programme: Since the inspection we have commenced the provision of daily activities.</p>	
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>Since the inspection, training records have been updated to reflect all training completed. Since the inspection, training has been provided to staff for infection prevention and control, Safeguarding & manual handling. Furthermore, further training has been scheduled for these topics so that all staff will have received training by the 9th July.</p>	

Regulation 21: Records	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:</p> <p>Rosters: Since the inspection, rosters have been created to record the hours worked of all employees. This includes the hours of the administration staff and those of the Head Chef.</p> <p>Training Records: As outlined under regulation 16, since the inspection, training records have been updated to reflect all training completed.</p> <p>Staff Records: Since the inspection, an audit of personnel files has been completed by the regional Human Resources manager. Scheduled auditing of files is now in place. Any deficits identified in the audits will be followed up to ensure that all files are in compliance with the regulations.</p>	
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>Staff Rosters: As outlined under regulation 21, since the inspection, rosters have been created to record the hours worked of all employees. This includes the hours of the administration staff and those of the Head Chef. The RPR has reviewed the roster templates of all areas of the Home to ensure that they allow for the recording of the worked hours of all staff in the Home.</p> <p>Staff Records: As outlined in regulation 21, since the inspection the RPR has arranged an audit of all personnel files to ensure compliance with Schedule 2 health act 2007. This audit was conducted by regional Human Resources manager who has provided the RPR with report and action plan.</p> <p>The RPR has reminded the Personnel office that new employees should only take up employment when all mandated documentation is on file.</p> <p>Training Records: The RPR will monitor the compliance with training through use of a monthly compliance</p>	

report that will be generated by the personnel office and submitted by to the RPR.

Clinical audits:

Each step of the Clinical Audits continues to be monitored and signed off by the PIC
Clinical audits will continue to be completed in line with the Home's audit schedule.

Risk Management Policy:

Since the inspection, the risk management policy has been reviewed to ensure that it is centre-specific.

Clinical Risk Register:

At the time of inspection, a clinical risk register was available in electronic format. Since the inspection, a hard copy of this register has been printed and stored in a designated folder available for inspection.

Complaints management checklist:

The complaints management checklist has been completed for all written complaints received to date.

Since the last inspection, the current PIC has decided to step down from her role. The chief nursing officer will be acting as PIC, in line with his terms and conditions of employment. A recruitment process is underway to fill this position on a permanent basis.

Regulation 17: Premises

Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Repairs to the rooms identified in the report.

Since the inspection, work has commenced to address the findings of the HIQA report in relation to the premises, to include broken and missing tiles, damaged flooring and missing splash back.

The work will be completed by the 31st August 2021.

Fridge with incorrect temperature:

The fridge will be replaced by 18/06/2021.

Storage:

Since the inspection, the boxes on the floor of the store room on ground floor have been removed.

Since the inspection, suitable store rooms have been identified for resident care equipment. Staff have been instructed to store equipment in the designated storage areas.

Regulation 26: Risk management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management:</p> <p>Risk management policy: Since the inspection, the risk management policy has been reviewed to ensure that it is centre-specific.</p> <p>Clinical Risk register: As per regulation 23, at the time of inspection, a clinical risk register was available in electronic format. Since the inspection, a hard copy of this register has been printed and stored in a designated folder available for inspection.</p> <p>Control measures regarding safeguarding: The control management measures for safeguarding in the risk management policy have been updated to reflect the centre's safeguarding policy.</p>	
Regulation 27: Infection control	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Infection control:</p> <p>Staff adherence to Hand Hygiene Policy: Since the inspection, This matter has been raised at staff meetings This instruction will also be emphasized at infection control training. A more robust hand hygiene audit tool is now in use.</p> <p>Alcohol rub dispensers will be made available in each treatment room.</p> <p>Sterile dressings: Any opened dressings found in the treatment room have been discarded. Since inspection, nursing staff have been instructed to use single use items once only, to include sterile dressings. This will be monitored as part of the Home environmental hygiene audit.</p> <p>Personal care items in communal rooms Since inspection, all personal care hygiene products have been removed from communal areas and staff have been reminded both at meetings and infection control training that residents' personal care items must be stored in the resident's room. Notices have been placed in all communal bathrooms and toilets to remind staff to</p>	

remove any personal care items from these rooms following use.

Slings for individual residents:

Since inspection, additional slings have been ordered to ensure that each resident has their own hoist sling. These will be stored in the residents' room.

Bed pan washer:

Since the inspection, the bed pan washer has been repaired. This item will be added to the service contract in place for other electrical care items (e.g., beds, hoists etc).

Sluice Rooms:

Since inspection, housekeeping staff have been instructed to keep sluice rooms clean, and all sluice rooms have been fitted with alcohol gel dispensers.

Regulation 5: Individual assessment and care plan	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

Pre-admission assessments:
All prospective residents will undergo a documented, detailed pre-admission assessment. This will contain a decision on the home's assurance of its ability to care for this person in the event that they choose to be admitted here.

Care planning:
Further direction to and supervision of nursing staff will be provided to nursing staff to ensure that the assessments and care plans of residents are person-centred and comprehensive. This will include the introduction of an admissions checklist to ensure that core assessments and care plans are commenced in line with Home policy and regulations.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

Behaviour that is challenging care plans;
The care plans of residents with behaviour that is challenging will be reviewed to ensure that they contain accurate, detailed, person-centred interventions that address this

aspect of a resident's needs.

PRN psychotropic medication use:

Nursing staff are instructed to administer PRN psychotropic medication in line with the following protocol:

- Non-pharmacological approaches to ease agitation and distress are attempted in the first instance; these interventions should be documented and outcome recorded.
- PRN psychotropic medication is administered as prescribed;
- The resident's response to this medication is documented.

All Nursing staff will be reminded of this protocol.

Nurse managers currently monitor the administration of PRN psychotropic medications and will review nursing notes to ensure that this protocol is being practiced.

Regulation 9: Residents' rights	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Provision of Activities:

Since the inspection we have commenced the provision of daily activities.

The post of activities coordinator will be re-advertised with the aim to have the post filled on a fulltime basis.

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.	Substantially Compliant	Yellow	31/08/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	09/07/2021
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/08/2021
Regulation 21(1)	The registered	Not Compliant		11/06/2021

	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.		Orange	
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/08/2021
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	30/09/2021
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	30/09/2021
Regulation	The registered	Not Compliant	Orange	11/06/2021

26(1)(a)	provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.			
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	11/06/2021
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Not Compliant	Orange	11/06/2021
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Not Compliant	Orange	11/06/2021
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management	Not Compliant	Orange	11/06/2021

	policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.			
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.	Not Compliant	Orange	11/06/2021
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Not Compliant	Orange	11/06/2021
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Not Compliant	Orange	11/06/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the	Substantially Compliant	Yellow	30/06/2021

	standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
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 resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	31/05/2021
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	13/08/2021
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy	Substantially Compliant	Yellow	13/08/2021

	as published on the website of the Department of Health from time to time.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/08/2021