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:	Prague House Care Company Limited By Guarantee
Name of provider:	Prague House Care Company Limited By Guarantee
Address of centre:	Chapel Street, Freshford, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	26 February 2024
Centre ID:	OSV-0005447
Fieldwork ID:	MON-0038813

About the designated centre

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

Prague House is located on Chapel Street, Freshford, Co. Kilkenny. The centre is a two-storey building that is registered to accommodate 15 people. The management of Prague House is overseen by a Board of eight Directors. The centre caters for men and women from the age of 60 years. The statement of purpose states that the centre does not provide 24-hour nursing care, and provides low-medium dependency care 24 hours a day. The statement of purpose states that care is delivered in a homely, comfortable and hygienic environment. The centre manager is employed to work on a full-time basis. Residents do not require 24-hour nursing care, and care is provided by a team of trained healthcare professionals. According to the centre's statement of purpose, all applicants for admission must be mobile, and mentally competent at the time of admission. Each resident is provided with single bedroom accommodation.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 26 February 2024	10:00hrs to 18:00hrs	Mary Veale	Lead

What residents told us and what inspectors observed

This was an unannounced inspection which took place over one day. Based on the observation of the inspector, and discussions with residents and staff, Prague House was a nice place to live. There was a welcoming and homely atmosphere in the centre. The inspector spoke with eight residents living in the centre. Residents' rights and dignity were supported and promoted by kind and competent staff. Residents appeared to enjoy a good quality of life and had many opportunities for social engagement and meaningful activities.

On arrival the inspector signed the centres visitor's log. The inspector was met by a member of the care staff on the day of inspection. Following an introductory meeting with the person in charge to outline the format of the inspection, the inspector was guided on a tour of the premises. The inspector greeted, spoke with, and observed residents' in communal areas and in their bedrooms.

Prague House is located in the village of Freshford, Co. Kilkenny. Residents had access to the local shops, a church, the credit union, a post office, coffee shop, doctors surgery and local community groups.

The design and layout of the premises met the individual and communal needs of the residents. The centre was homely and clean, and the atmosphere was calm and relaxed. The building was well lit, warm and adequately ventilated throughout. Residents had access to an open plan dining and sitting room, a separate sitting room, a meeting room, conservatory and an oratory. The centre was registered to accommodate 15 residents. The building comprised of two levels with the ground floor accessible to residents. The first floor of the building was not part of the designated centre.

Residents were accommodated in 15 single rooms. The centre had two corridors- Achadh Úr and Cascade. 10 bedrooms were on the Achadh Úr corridor and five on the Cascade corridor. Two single rooms had an en-suite shower, toilet and wash hand basin. All of the remaining single rooms had wash hand basins. Residents' bedrooms were clean and tidy. Bedrooms were personalised and decorated in accordance with resident's wishes. Lockable locker storage space was available for all residents and personal storage space comprised of a locker, with build-in drawers and double wardrobes. All bedrooms were bright and had natural light. Residents had access to two shared shower rooms, and five toilets. Corridors had grab rails and were narrow but were observed to be easily assessable for the residents.

Residents had access to an enclosed courtyard yard and a garden to the rear of the building. There were two hens living in a secure area in the back garden which were cared for by a resident. The inspector was informed by residents and staff that funding was been sought to introduce a vegetable garden in the rear garden. The

centres designated smoking area was located outside, adjacent to the conservatory room.

The centre provided a laundry service for residents. All residents' whom the inspector spoke with on the day of inspection were happy with the laundry service and there were no reports of items of clothing missing.

Residents were very complimentary of the home cooked food and the dining experience in the centre. Residents' stated that the quality of food was excellent. The menus for all meals and snacks were conveniently displayed in the dining room. Jugs of water and cordial were available for residents in communal areas and bedrooms. The inspector observed the dining experience at dinner time. The dinner time meal was appetising and well present and the residents were not rushed. The dinner time experience was a social occasion where residents were seen to engage in conversations and enjoying each others company.

Residents' spoken with said they were very happy with the activities programme and told the inspector that the activities suited their social needs. The weekly activities programme was displayed in the open planned dining/sitting room. The inspector observed staff and residents having good humoured banter throughout the day and observed staff chatting with residents about their personal interests and family members. The inspector observed many residents walking around the corridor areas of the centre. The inspector observed residents reading newspapers, watching television, listening to the radio, and engaging in conversation. Books, games and magazines were available to residents. The inspector spoke with one resident who had their own car, who would regularly visit their family home and local towns. The inspector spoke to a resident as they were leaving the centre to attend a computer work shop in the local coffee shop. The resident told the inspector that the work shop took place every Monday and that they were enjoying learning new skills using their handheld smart device. Visits and outings were encouraged and practical precautions were in place to manage any associated risks. Residents informed the inspector that they would be attending the local polling station to vote in the upcoming referendum.

Residents' views and opinions were sought through resident meetings and satisfaction surveys and residents felt they could approach any member of staff if they had any issue or problem to be solved. Residents stated that the person in charge and all of the staff were very good at communicating changes, particularly relating to their medical and social care needs.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection to monitor the provider's 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 findings of the previous inspection of March 2023. Improvement had been made regarding individual assessment and care planning, residents rights, infection prevention and control and fire precautions since the last inspection. On this inspection, the inspector found that actions was required by the registered provider to address Regulation 23: governance and management, Regulation 28: fire precautions, and Regulation 31: notifications. Areas of Regulation 5: individual assessment and care planning, Regulation 7: managing behaviours that are challenging, Regulation 17: premises, Regulation 21: records, Regulation 24: contracts of provision, Regulation 27: infection prevention and control, and Regulation 34: complaints procedure required improvement.

Similar to findings of the previous inspections carried out in March 2023, October 2022 and April 2022, repeat non-compliance was found with regard to;

- Regulation 23: Governance and management
- Regulation 24: Contract of provisions
- Regulation 27: Infection prevention and control
- Regulation 28: Fire Precautions

The registered provider of Prague House was Prague House Care Company Limited by Guarantee. At the time of inspection there were eight directors, one of whom was the registered provider representative. Since the previous inspection there had been a change in person in charge in December 2023. The person in charge reported to the board, worked full time in the centre and was supported by an assistant manager and a team of nursing, care and support staff. The centre was established for the supported care of older people from the local, and surrounding areas. The centre provides care for low to medium dependent residents who do not require full time nursing care in accordance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 as amended.

There were sufficient staff on duty to meet the needs of residents living in the centre on the day of inspection. The centre had a well-established staff team who were supported to perform their respective roles and were knowledgeable of the needs of older persons in their care and respectful of their wishes and preferences.

There was an ongoing schedule of training in the centre. An extensive suite of mandatory training was available to all staff in the centre. Staff with whom the inspector spoke with, were knowledgeable regarding fire evacuation procedures and safe guarding procedures. Safe guarding training was scheduled to take place in the centre in the week following the inspection. The inspector was informed that no staff had received training in managing behaviours that are challenging due to the low support requirement of care in the centre. However; improvements were required in staff training this is discussed further under Regulation 7: managing behaviour that is challenging.

Management systems in place to monitor the centre's quality and safety required review. Records of board meetings and staff meetings which had taken place since the previous inspection were viewed on this inspection. Board meetings took place monthly and staff meetings took place quarterly in the centre. Agenda items on meeting minutes included key performance indicators (KPI's), fire safety, training, resident feedback, activities, links with the community and infection prevention. The person in charge submitted and discussed a monthly report to the board which included items such as staffing, training, safe guarding, behaviours that are challenging and resident feedback. There was a schedule of audits in the centre and since the previous inspection falls audits, fire safety audits, infection prevention and control audits, and medication management audits had been completed. The annual review for 2023 had been completed in line with the national standards. It set out the improvements completed in 2023 and improvement plans for 2024. Improvements were required in the over sight of auditing and tracking and trending of incidents, this is discussed further under Regulation 23: governance and management.

The centre did not have electronic records. All paper based documentation were well presented, organised and supported effective care and management systems in the centre. Most requested documents were readily available to the inspector throughout the day of inspection. Records available were appropriately maintained, safe and accessible. However; improvements were required in record keeping of fire servicing records and this is discussed further under Regulation 21: records.

A sample of resident's contract for the provision of services were viewed on inspection. Improvements required to the contracts of care are discussed further under Regulation 24: contact of service provision.

There was a record of accidents and incidents that took place in the centre. Some notifications were submitted appropriately to the office of the Chief Inspector of social services. However, there were a number of three day notifications that were not submitted. Subsequent to the inspection these notifications were submitted retrospectively. This is discussed further in this report under Regulation 31.

The registered provider had integrated the update to the regulations (S.I 628 of 2022), which came into effect on 1 March 2023, into the centre's complaints policy and procedure. The management team had a good understanding of their responsibility in this regard. There had been one complaint received since the previous inspection. The inspector reviewed the record of the complaint raised by the complainant. Details of the investigation completed and communication with the complainant were included. The complaints procedure was available in the main entrance area in the centre. Residents spoken with were aware of how and whom to make a complaint to. Further improvements were required to the complaints procedure, this is discussed further in this report under Regulation 34: Complaints procedures.

Regulation 14: Persons in charge

The person in charge worked full time in the centre and displayed good knowledge of the residents' needs and had a good oversight of the service. The person in charge was well known to residents and their families.

Judgment: Compliant

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the day of the inspection. On the day of inspection the person in charge was on duty from 9am to 5pm. Three healthcare assistants were working in the morning, one of the healthcare assistants was assigned to housekeeping duties only. An additional healthcare assistant was on duty on the day of inspection to provide additional assistance to residents attending outpatient appointments. Two healthcare assistants were assigned to the residents needs for the evening up to 9pm and one healthcare assistant worked from 9pm until 7:30 am.

Judgment: Compliant

Regulation 21: Records

Improvements were required to ensure records were maintained as set out in Schedule 2 and 4 of the Care and Welfare of Residents in Designated Centres for Older People Regulations 2013 (as amended). For example:

- A record of the maintenance of fire-fighting equipment was not available on the day of inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

Systems for monitoring the quality and safety of the service required review to ensure the systems were consistently informing ongoing safety improvements in the centre. For example:

- Improvements were required in the oversight of incidents in the centre. Incidents were recorded on a clinical incident form. A review of the incident forms on the day of inspection identified a number of statutory notifications

had not been submitted to the Office of the Chief Inspector since the previous inspection.
- The centres audit system required review. Audits viewed were not measured to inform ongoing quality and safety improvements in the centre. Although there was an audit schedule in place no audits had taken place in October, November and December 2023. There was no record of audits of care plans undertaken since the previous inspection.
- Further oversight was required of issues pertinent to records and fire safety as outlined further under the relevant regulations.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspector viewed a sample of four contracts of provision. One of the contracts of provision did not contained details of the cost of care or the bedroom on which the resident occupied .

Judgment: Substantially compliant

Regulation 30: Volunteers

Volunteer's attended the centre to enhance the quality of life of residents. Volunteers were supervised and had Garda vetting disclosures in place. Their roles and responsibilities were set out in writing.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of the records in relation to incidents in the centre showed that there were a number of incidents as set out in Schedule 4 of the regulations that were not notified to the office of the Chief Inspector within the required time frames. The person in charge submitted these notifications following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centres complaints policy and procedure required revision to meet amendments to the regulations that had come into effect in March 2023 (S.I. 628 of 2022). For example:

- Staff involved in the complaints procedure had not completed suitable training to deal with complaints.
- A complaint viewed by the inspector did not record if the complainant was satisfied with the outcome.

Judgment: Substantially compliant

Quality and safety

The inspector found that residents had a good quality of life living in Prague house. Residents lived in an unrestricted manner according to their needs and capabilities. Residents health, social care and spiritual needs were well catered for. Improvements were required in relation to individual assessment and care planning, managing behaviour that is challenging, premises, infection prevention and control and fire safety.

Residents' health and well-being was promoted and residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as psychiatry of old age, physiotherapy, dietitian and speech and language, as required. Residents attended their GP's in local practices. Services such as Care Doc, public health nurses, and nurse specialists attended the centre as required. Residents had access to local dental, optician and pharmacy services. Residents who were eligible for national screening programmes were also supported and encouraged to access these.

The centre had arrangements in place to protect residents from abuse. There was a site-specific policy on the protection of the resident from abuse to guide staff on the management of allegations of abuse. Safeguarding training had been provided to staff in the centre and staff were familiar with the types and signs of abuse and with the procedures for reporting concerns. All staff whom the inspector spoke with said that they would have no hesitation in reporting any concern regarding residents' safety or welfare to the centre's management team. The provider assured the inspector that all staff working in the centre and a volunteer had valid Garda vetting disclosures in place.

There was a comprehensive centre specific policy in place to guide care staff on the safe management of medications; this was up to date and based on evidence based practice. Medicines were administered in accordance with the prescriber's instructions in a timely manner. Medicines were stored securely in the centre and returned to pharmacy when no longer required as per the centres guidelines.

Controlled drugs balances were checked at each shift change as required by the Misuse of Drugs Regulations 1988 and in line with the centres policy on medication management. A pharmacist was available to residents to advise them on medications they were receiving.

Improvements were found in individual assessment and care planning since the previous inspection. The inspector observed that the resident's pre- admission assessments, nursing assessments and care plans were maintained on paper format. Residents' needs were comprehensively assessed prior to and following admission. Resident's assessments were undertaken using a variety of validated tools and care plans were developed following these assessments. Care plans viewed by the inspector were comprehensive and person- centred. Care plans were sufficiently detailed to guide staff in the provision of person-centred care and had been updated to reflect changes required in relation to incidents of infections and falls. There was evidence that the care plans were reviewed by staff. Consultation had taken place with the resident to review the care plan at intervals not exceeding 4 months. However; improvements were required to the resident's individual assessment and care plan, this is discussed further in this report under Regulation 5.

There was policy in place to inform management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort with their social or physical environment) and restrictive practices in the centre. There were no restrictive devices in use by residents living in the centre. From a review of the centres incident and accident forms, there were a number of incidents of peer to peer responsive behaviours incidents which had not been identified as requiring submission to the Office of the Chief inspector. Improvements were required in the management of behaviour that is challenging, this is discussed further in this report under Regulation 7.

The centre acted as a pension agent for four of the residents. Resident's had access to and control over their monies. Residents who were unable to manage their finances were assisted by a care representative or family member. All transactions were accounted for and double signed by the resident/representative and a staff member. Laundry was provided in the centre for residents and some residents chose to have their clothing laundered at home.

Improvements were found to the premises since the previous inspection. A call bell was available in the smoking shelter, the water stain to the ceiling in the sitting room had been addressed and old equipment had been removed from the garden. The centre was bright, clean and tidy. The building comprised of two levels with the ground floor accessible to residents. The first floor of the centre had been de-registered in 2022. The overall premises were designed and laid out to meet the needs of the residents. A schedule of maintenance works was ongoing, ensuring the centre was consistently maintained to a high standard. Alcohol hand gel was available in all communal rooms and corridors. Bedrooms were personalised and residents had ample space for their belongings. Overall the premises supported the privacy and comfort of residents. Grab rails were available in all corridor areas, bathroom, shower rooms and toilets. Residents has access to a call bells in their bedrooms, en-suite rooms, bathroom, shower rooms and toilets. However;

improvements were required to the centre premises which is discussed further in this report under Regulation 17: premises.

Although improvements were found in fire safety, there were repeated findings found in fire safety on this inspection. All bedrooms and compartments had automated door closures. All fire doors were checked over the day of inspection and were found to close properly to form a seal to contain smoke and fire. Fire training had been completed in December 2023 by all staff. Staff spoken with were familiar with the centres evacuation procedure. Improvements were found in fire drills records, records were detailed containing the number of residents evacuated, how long the evacuation took and learning identified to inform future drills. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation routes applicable to individual residents for day and night evacuations and their supervision requirements at the assembly point. There were fire evacuation maps displayed throughout the centre in corridor areas and residents bedrooms. There was evidence that fire safety was an agenda item at meetings taking place in the centre. There was a smoking shelter available for residents who smoked. A resident who smoked was risk assessed for their capability to smoke independently. A fire blanket, call bell and fire retardant ash tray were located in the designated smoking area and a fire extinguisher was located in the conservatory area adjacent to the smoking area. The service records for the centres fire alarm system were not available on the day of inspection and were submitted to the Office of the Chief Inspector following the inspection. Improvements were required in the services of fire equipment and oversight of the system of daily and weekly checking, of means of escape, fire safety equipment, and fire doors. This is discussed further in the report under Regulation 28.

Improvements were found in infection prevention and control since the previous inspection. A janitorial sink had been installed in an area which had been partitioned from the meeting room and staff room to allow for a separate household area. Soap dispensers and hand towels were available at all sink areas. Sufficient housekeeping resources were in place. Housekeeping staff were knowledgeable of correct cleaning and infection control procedures. Intensive cleaning schedules had been incorporated into the regular weekly cleaning programme in the centre. Used laundry was segregated in line with best practice guidelines and the centres laundry had a work way flow for dirty to clean laundry which prevented a risk of cross contamination. There was evidence that infection prevention control (IPC) and COVID-19 were agenda items on the minutes of the centres staff meetings and board of management meetings. IPC audits undertaken included, the environment and hand hygiene. There was an up to date IPC policies which included COVID 19. The PIC had undertaking infection prevention control (IPC) link nurse in the weeks prior to the inspection. However; improvements were required in relation to infection prevention and control, this will be discussed further under Regulation 27.

There was a rights based approach to care in this centre. Residents' rights, and choices were respected. Residents were actively involved in the organisation of the service. Regular resident meetings and informal feedback from residents informed the organisation of the service. The centre promoted the residents independence

and their rights. The residents had access to SAGE advocacy services. The advocacy service details were displayed in the reception area and the weekly activities planner was displayed in the dining room in the centre. Residents has access to daily national newspapers, weekly local newspapers, Internet services, books, televisions, and radio's. Mass took place in the centre weekly. Residents had access to a oratory room in the centre. The local link bus was available to residents twice daily to take them to Kilkenny city. Musicians attended the centre weekly.

Regulation 10: Communication difficulties

There were no residents who had communication difficulties on the day of inspection.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate space in their bedrooms to store their clothes and display their possessions. Residents clothes were laundered in the centre and the residents had access and control over their personal possessions and finances.

Judgment: Compliant

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example;

- Appropriate sluicing facilities were not available in the centre.

Judgment: Substantially compliant

Regulation 27: Infection control

Action were required to ensure the environment was as safe as possible for residents and staff. For example;

- Healthcare assistants had not completed cleaning training.

- The inspector was informed that the contents of urinals and urinary catheters were manually decanted into residents' toilets. This practice could result in an increase environmental contamination and cross infection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required by the provider to ensure that adequate arrangements were in place to protect residents from the risk of fire. For example:

- The oversight of the system for daily checking, of means of escape, fire safety equipment, and fire doors required review as there were gaps in the records.
- The servicing and maintenance records (carried out every three months) for the emergency lighting system for the past 12 months in the format prescribed by the Irish Standard for emergency lighting, I.S 3217:2013+A1:2017 records were not available on the day of inspection.
- The service records for the fire detection and alarm system did not identify the category of system provided.
- Assurance is required that the fire detection and alarm system is upgraded as recommended in the fire detection service record for March 2023.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was a centre specific policy in place to guide staff on the safe management of medications. Medicines were administered in accordance with the prescriber's instructions in a timely manner.Medicines were stored securely in the centre. Controlled drugs balances were checked at each shift change as required by the Misuse of Drugs Regulations 1988 and in line with the centres policy on medication management. A pharmacist was available to residents to advise them on medications they were receiving.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- a residents falls risk assessment had not been updated following a fall in line with the centres policy.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. GP's routinely attended the centre and were available to residents. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professional as appropriate.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff had not attended training in the management of responsive behaviours (How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Judgment: Substantially compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected in this centre. There was a focus on social interaction led by staff and residents had daily opportunities to participate in group or individual activities. Access to daily newspapers, television and radio was available. Details of advocacy groups was on display in the centre.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	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	Compliant

Compliance Plan for Prague House Care Company Limited By Guarantee OSV-0005447

Inspection ID: MON-0038813

Date of inspection: 26/02/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: (F.I of staff file accepted by inspector) A new comprehensive monitoring and tracking system has been established for the oversight of maintenance records. This is also now a standing item on the BOD management Meetings & managers' report. Service provider & PIC have sought written agreement for scheduled timely servicing and a revised system is established for accepting & storing servicing records. The servicing schedules are maintained jointly by Service provider & PIC to ensure oversight and prompt actioning of any recommendations. The maintenance records of the firefighting equipment are now available in the fire book from 2023. The servicing took place 12.04.23. Most recent servicing of firefighting equipment took place 11.04.24. This record is also available for review.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: PIC submitted the historical incidents to the Chief inspector. "Incidents" is a standing agenda for staff meetings and BOD meetings to ensure oversight.	

All staff attended a safeguarding workshop with HSE, which educated staff on how to recognize & what constitutes "peer to peer "concerns and how to respond to such circumstances.

PIC upskilled as a designated safeguarding officer 20.03.24.

Auditing schedule has been revised and is now reflective of the needs of the Centre. The frameworks of the auditing tools have also been revised and are now applicable to this Centre specifically.
The action plan frameworks now follow the SMART technique- to allow for measurable quality & safety improvements of the centre.
These action plan progressions are a standing item on the BOD meetings. Outstanding audits from Oct, Nov & Dec of 2023 have been completed and action plans have been devised using the new templates.

Furthermore, the auditing schedule for 2024 is in progress and the appropriate audits have been completed to date.

Fire safety compliance please see reg 28.

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:
All contracts of care have been reviewed & reissued. Each contract now includes Residents details, the cost of stay and their current room number. This task was completed 08.04.24 and is included for review annually by PIC.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
PIC submitted historical notifications. Following this, further actions have been taken to include.
1. Service Provider & PIC conducted a thorough review of our incident notification procedures to identify areas for improvement and streamlining the process to ensure timely reporting.

2. PIC has reinforced staff training and education on the importance of adherence to notification timelines, emphasising the significance of transparent communication and accountability. In circumstances whereby the PIC may be offsite, the supporting manager is now trained to submit notifications using the portal.
3. PIC has included additional checks and reviews within our quality assurance framework to monitor compliance with regulatory requirements and proactively identify any deviations.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Both the complaints officer and the review officer have now undertaken formal training in the handling of complaints. The certification for same has been added to their staff files.
PIC followed up with complainants who confirmed they were satisfied with the action taken by the PIC at the time the complaint was made. Signatories obtained from Current PIC, Complainant and Previous PIC are now in the complaints log record book.

The auditing of complaints will take place quarterly to identify gaps and areas for improvement. Most recent audit took place on the 15.03.24, action plan devised using SMART technique.
These will also be included in the BOD meetings to ensure quality improvement.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The following proposal will be submitted in an application to vary to the Chief inspector for review before any works commence.
The Service Provider & PIC sought external service expertise to ensure this proposal was the most reasonably practical means of including sluice facilities within the setting.

This area was deemed to be the area of the house that currently hosts the janitorial sink. The proposal is to move the janitorial sink to a new Household Store at the far side of the house, now noted on the floor plans as a sewing room.

The details of the sluice facilities proposal are as follows:

Design and Layout: The proposed sluice facilities is designed and laid out to facilitate efficient and safe waste disposal processes. This includes adequate space for

manoeuvring and segregation of clean and soiled areas to prevent cross-contamination.

Equipment and Fixtures: Sluice facilities will be equipped with sink with hot and cold running water,
Mixed machine: Bedpan washer disinfectors waste disposal (e.g., macerators),
Model BP 100 HSER.
Foot operated clinical waste & domestic waste bins.
Sharps box.
Stainless steel sink.
Wall mounted rack.
Liquid soap dispenser.
Wash hand basin & paper towel dispenser & peddle bin.
Extractor fan.
Lighting.
IPC/appropriate signage.

The flow of the room will run from Dirty to Clean.

All equipment will be maintained and serviced twice yearly to ensure proper functioning and hygiene standards.

Infection Control measures will adhere to strict IPC best practices to prevent the spread of infections. This includes regular cleaning and disinfection of surfaces, equipment, and fixtures, as well as the use of personal protective equipment (PPE) by staff when handling waste.
The physical works required include the following:
1 Dismantle, take out of service and remove the 2 no existing light fitting switches on western buttress wall
2 Supply and fit light switch on new division wall between Sluice facility room and entrance foyer. Break existing supply line to existing pendant fittings in Sluice facility room and link into new switch. Provide a new live line source to this switch from existing power supply to existing light fittings.
3 Replace existing pendant light fittings with surface mounted LED light fittings
4 Supply and fit an extractor fan in southern wall of the room. Include for exhaust louvre with gravity flap on outer wall and fit Xpelair or equivalent pull string operated fan on inner wall circa 2.1 m above floor level
5 Supply new power supply to the Bedpan washer. Include for a separate push to stop twist and spring to open wall mounted emergency stop button adjacent to the Bed Pan washer. Connect up bed pan washer.
6 Supply and install a new wall mounted heater on partition wall.
Supply new power supply to the wall mounted electric fan heater with pull cord.

7 Install additional smoke detectors in Sluice Room and entrance foyer as indicted in drawings. These shall be linked into the existing fire zone for this area but can link into the future Addressable system that may be installed in time up so that they can be linked into an addressable fire monitoring board.
8 Remove existing emergency light fitting over entrance foyer door and supply and install EXIT light fitting complying with PH Fire Safety regulations and linking into the PH fire alarm system. .

9 Supply and fit a 10l under sink water heater in the adjacent toilet room. The plumbing contractor shall connect it into the existing cold and hot water service lines
10 Earth bond all pipes and fittings in this area
11 Upgrade local distribution board with additional MCB's and ELCB for this area, Commission and test when completed in line with RECI requirements.
12 Insurances for proposed works
13 Documentation for Safety Certs etc

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
In house cleaning & decontamination training program took place 11.04.24, for all staff who are assigned cleaning duties.
This is a certified course ran by an external company. Certs provided & included in staff files.

Compliance for disposal of waste included in regulation 34 compliance commitment. These actions will allow the appropriate disposal of bodily fluids.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
As per the attached document from civil engineering consultancy, we are committed to the required works to meet current regulations. The terms of agreement have been made with the above external consultant. We now await a comprehensive report specifying the upgrading requirements for first floor developments and the subsequent upgrading of the entire home. This report we expect to be available to us by 24.06.24. Due to the complexities of this project, we expect have such works completed by 09.04.25.

Once received and discussions with the chief inspector have taken place an application to vary will be submitted.

Service provider & PIC have revised the daily, weekly and monthly checks relating to fire regulations. These tasks have been delegated appropriately within the team. PIC & Supporting Manager have weekly oversight of this and the service provider Monthly. This is to ensure quality improvement & compliance.
Fire Regulations are now included as a separate item on the BOD meetings and

manager's reports.

A fire safety audit has taken place March 2024 and will continue monthly for x3 months. Once satisfactory this will return to a quarterly audit.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Since the inspection, to date 33% of Residents care plans and assessments have been reviewed & updated. Our full complement of assessments & care plans will be completed by 30.04.24.

Further reviews and updates will occur every four months or sooner if there is a change in a resident's condition.

PIC has educated the team to repeat FRAT assessment post fall and this element is now highlighted on the incident report framework and the falls prevention policy will be discussed at the next staff meeting scheduled for June 2024.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
Responsive behaviors training took place on the 27.03.24 with 64% of staff attended this session. Certs are now included in each staff to show evidence of same.
This training will be held again in Q3 of 2024 to ensure the entirety of the staff are facilitated in upskilling.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	11/10/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	11/04/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Not Compliant	Orange	11/05/2024

	consistent and effectively monitored.			
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	11/04/2024
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Substantially Compliant	Yellow	11/04/2024
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	Substantially Compliant	Yellow	11/10/2024

	implemented by staff.			
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	09/04/2025
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	11/05/2024
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Substantially Compliant	Yellow	01/06/2024
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Substantially Compliant	Yellow	09/04/2024
Regulation 5(2)	The person in charge shall	Substantially Compliant	Yellow	01/06/2024

	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.			
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.	Substantially Compliant	Yellow	27/03/2024