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:	Heather House Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	St Mary's Health Campus, Gurranabraher, Cork
Type of inspection:	Unannounced
Date of inspection:	31 January 2024
Centre ID:	OSV-0000714
Fieldwork ID:	MON-0039139

About the designated centre

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

Heather House Community Nursing Unit is a purpose built, two storey premises. It was opened in 2011 and a 60-bedded extension was added in 2023. It is located on the grounds of St. Mary's Health Campus on the north side of Cork City. The centre is registered to accommodate 85 residents in three units, namely, Daisy on the first floor of the existing building, and Poppy and Lily in the new extension. Daisy is a 25 bedded unit with 17 single bedrooms, two twin bedrooms and one four bedded room; all of the bedrooms are en suite with shower, toilet and wash hand basin. Lily and Poppy are 30-bedded units. Each unit has its own sitting room, dining room and quiet room. Additional communal space include the quiet visitors' room alongside the main entrance, the prayer room, main activities room and the water lily games room. Residents have free access to two enclosed gardens with walkways around the house and one sheltered smoking area. Heather House Community Nursing Unit provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	63

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 31 January 2024	09:10hrs to 17:45hrs	Breeda Desmond	Lead
Wednesday 31 January 2024	09:10hrs to 17:45hrs	Caroline Connelly	Lead

What residents told us and what inspectors observed

From the inspector's observations and from speaking with residents and relatives, it was evident that residents were supported to enjoy a good quality of life and received a good standard of care from staff in the centre. Residents spoke positively about the management and staff in the centre. The inspectors met with the majority of the 63 residents living in the centre and spoke with twelve residents in more detail. The inspectors also met with six sets of visitors/relatives during the day. The relatives spoken with said that staff were kind and caring to both the residents and visitors and said there were no particular restrictions on visiting which they were glad about. Residents were seen to go out with relatives during the day and relatives told inspectors that it was good for their relative to get out. Observation throughout the inspection showed that staff were respectful, kind and actively engaged with residents and there was a commitment to promoting a rights-based approach to care delivery.

On arrival for this unannounced inspection, the inspectors were guided through the centre's risk management procedures by a member of staff, which included a signing in process and hand hygiene. An opening meeting was held with the person in charge which was followed by a walk-about the centre. Heather House Community Nursing Unit is a two-storey building situated on St Mary's Campus, Gurranabraher; the campus also accommodates community care, primary care and day services. In the designated centre there was a 60 bedded extension completed with adjoining corridors on both floors connecting the existing and new building. Primrose unit on the ground floor (GF) of the old building was temporarily closed for refurbishment. The three units open were Daisy on the first floor (FF) of the old building, and Lily (GF) and Poppy (FF), new building. The new main entrance was wheelchair accessible and opened into an expansive hall way with the new extension to the right and older building to the left.

Lily and Poppy were 30-bedded self-contained units and all bedrooms were single en suite bedrooms. There were low low beds, pressure relieving mattresses, specialist chairs, and all rooms including the assisted bathroom, had overhead hoists to assist residents when transferring from bed to chair or chair to shower. Orientation signage to rooms such as the day room and dining room were displayed around units to ally confusion and disorientation. The inspectors saw that there were only ten residents currently residing on Poppy unit with twenty beds empty on that unit. The inspectors visited Daisy which was a 25 bedded self-contained unit with 17 single, two twin and one four-bedded multi-occupancy bedrooms all with full en suite facilities of shower, toilet and wash-hand basin. Bedrooms could accommodate a bedside locker and armchair. The inspectors saw that residents in single bedrooms had double wardrobes for storing and hanging their clothes; residents in twin and multi-occupancy four-bedded rooms had only access to single wardrobes. The inspectors saw that storage was an issue on this unit as excess chairs and equipment were stored in the four bedded bedroom which prevented a homely feel to the room. Also in the unoccupied single isolation room the inspectors saw there

were two beds, numerous chairs and a hoist so this room would not be ready for occupancy if required. These excess items were removed during the inspection.

Inspectors observed that residents' bedrooms were seen to be decorated in accordance with residents' choice and preference; some had plants, flowers, mementos from home, paintings, soft furnishings and fairy lighting to brighten their bedroom space. Call bells were seen to be fitted in bedrooms, bathrooms and communal rooms. Additional toilet and specialist bath facilities were available on each floor. Communal spaces comprised the dining room, small quiet sitting room and a second larger sitting room. Sitting rooms on Daisy were pleasantly decorated and had comfortable seating; the larger sitting room had a fire place and large screen TV. Since the previous inspection the corridor walls and communal spaces on lily and Poppy were further decorated with paintings and murals giving a much more homely feel.

Additional communal areas on the ground floor beyond the reception area included the prayer room, the activities room, and Waterlily social centre with bookshelves with a variety of books and games. Also located on this corridor were administration and nursing administration offices, the hairdressers' room and main kitchen. Residents had good access to outdoor spaces. One of the garden spaces could be accessed from the activities room. The smoking shelter was located alongside the activities room and had a fire safety blanket, extinguisher and call bell. Access to the second enclosed courtyard was via the dining room on Lily unit. Residents could independently access this space with push-button controls, both inside and outside. Upstairs, there were balconies for residents to sit out and enjoy the fresh air. Re-enforced glass was mounted on top of walls to ensure residents safety while at the same time allowing for un-obstructed views of the city. Push-button control panels were available here to enable resident freely access and re-enter the building. Call bells were installed in the outdoor spaces for residents and staff to call for assistance should the need arise. Seating was required on these balconies to enable residents to relax and enjoy these spaces.

Inspectors met a resident who was heading down to the local shopping centre accompanied by a staff member. The resident described how they would stop for coffee and apple tart before returning to the centre. The staff member accompanying the resident confirmed that this was a regular occurrence for the resident and a nice treat for the staff to be in the social setting with the resident.

The inspectors observed the dining experience on the three different units. Tables were set prior to residents coming for their meal. The inspectors saw that there was only one care assistant in the dining room on Daisy unit, and that care staff was assisting individual residents to eat as well as supervising the other 14 residents present. Although many of the residents did not require assistance some residents required prompting with their meal, and the care staff was also requesting deserts for residents as some were getting up to leave without having their desert. The inspectors identified that further staff and supervision was required in the dining room at meal times.

During the walkabout, the inspectors observed lovely social interaction and banter

with staff and residents. Staff providing assistance to residents in their bedrooms actively engaged in a kind and respectful manner and chatted as they were assisting with personal care and during mealtime. The hairdresser was on site every Thursday and residents were seen to enjoy the catch-up and banter with the hairdresser. Two residents spoken with said they loved getting this hair done and felt so much better for it. Visitors were seen throughout the inspection calling to units and enjoying banter and conversation with staff and the management team.

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

This was a one day 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. Overall, the inspection found that there was a defined management structure in place but further oversight of the service was required. The inspectors reviewed the actions from the previous inspection and found that some actions were completed and others had not been taken. Further action was required to comply with the regulations in relation to residents' personal possessions, the premises, fire safety, policies and procedures, food and nutrition and managerial oversight. These will be detailed under the relevant regulations of this report.

Heather House Community Nursing Unit is a residential care setting operated by the Health Services Executive (HSE). The centre is currently registered to accommodate 85 residents but there were only 63 residents living in the centre on the day of the inspection. The person in charge was recently appointed to the role of person in charge, worked full-time in the centre and was supported by a new assistant director of nursing, three Clinical Nurse Managers 2 (CNM) and three CNM3's on night duty, a team of nursing, health care, household, catering, activity and maintenance staff.

At a more senior level, governance was provided by a general manager for older persons, who represented the provider. The service also had support from centralised departments, such as finance, human resources, fire and estates and practice development. There was evidence of good communication via quality and patient safety meetings, to discuss all areas of governance.

The centre was very well resourced in terms of staffing. The inspectors found that the levels and skill mix of staff, at the time of inspection, were sufficient to meet the care needs of the residents living in the centre. Clinical nurse managers provided clinical supervision and support to staff on each unit during the week and at night time. Although the person in charge, ADON and CNMs were all on duty Monday to Friday, these staff were not rotated to provide managerial cover at the weekends.

Although there was an on-call rota, there was no on-site managerial cover during the day at the weekends and this required review. Currently, Poppy unit which is registered for 30 residents had only opened up to accommodate 10 residents as recruitment was in progress for further staff so the other 20 beds could be opened.

There was a schedule of clinical audits in place in the centre to monitor the quality and safety of care provided to residents. Arrangements were in place to provide supervision and support to staff through senior management presence, induction processes and formal performance appraisals. However, further managerial oversight was required on areas of the service which is outlined under Regulation 23, Governance and management.

All requested documents were readily made available to the inspectors throughout the inspection. Staff files reviewed contained all the requirements under Schedule 2 of the regulations. The directory of residents was missing some of the required information which will be detailed under Regulation 19.

Regular management meetings were taking place to discuss key operational issues at the centre. Staff were seen to be knowledgeable about residents' care requirements and regular staff meetings took place. There were systems in place to manage clinical incidents and risk in the centre. Accidents and incidents in the centre were recorded, appropriate action was taken, and they were followed up and reviewed. Incidents, as detailed under Schedule 4 of the regulations, were generally notified to the Chief Inspector of Social Services within the required time-frame. However there was a late submission of one notification as outlined under Regulation 23.

Regulation 14: Persons in charge

The person in charge was full time in post; she had the necessary qualifications as required in the regulations. She actively engaged with the regulator; was knowledgeable regarding the role and responsibility as specified in the regulations, and engaged in the operational management and administration of the service.

Judgment: Compliant

Regulation 15: Staffing

The inspectors saw following an examination of the staff duty rota and communication with residents and staff that the staffing levels and skill mix of staff at the time of inspection were more than sufficient to meet the needs of the residents living in the centre. One of the 30 bedded units had four nursing staff, a CNM2 and four health care assistants and a staff member in catering to meet the

needs of 30 residents.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix was reviewed and showed that mandatory training was up to date. Additional training was scheduled to ensure that training remained in date.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was made available for inspection and this was contained in a bound book. Action was required as the name, address and telephone number of the GP, and the name, address and telephone of the residents' next of kin or any person authorised to act on behalf of the residents was not consistently recorded as required by the regulations .

Judgment: Substantially compliant

Regulation 21: Records

All records as set out in schedules 2, 3 & 4 were made available to the inspector. Retention periods were in line with the centres' policy and records were stored in a safe and accessible manner.

Judgment: Compliant

Regulation 23: Governance and management

Management systems, as required under Regulation 23(c), were not sufficiently robust to ensure the service provided was safe, appropriate, consistent and effectively monitored, specifically:

- inspectors were not assured that there was adequate oversight of fire safety precautions in the centre. Although the registered provider had carried out a risk assessment in November 2022, arrangements had not been put in place

to action the findings in a timely manner. The centre had a restrictive condition in place on their registration in relation to the completion of these essential fire works by 30 September 2023. The provider has not complied with this condition and a number of fire work remain outstanding'
- suitable adaptation such as smoking facilities were not available in the new building as agreed at the time of registration in January 2023
- there was a lack of action taken in relation to provision of suitable storage for residents in twin and multi-occupancy bedrooms as identified on numerous previous inspections of the centre; this is further outlined under Regulation 12: Personal Possessions,
- policies and procedures had not been updated as required on the previous inspection
- supervision of mealtimes required action as outlined under regulation 18
- although there was a large managerial team there was a lack of managerial staff on-site at the weekend
- there was a lack of understanding in relation to the submission of an notification of an allegation of misconduct which resulted in a very late submission of the notification.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints policy required updating to reflect the changes in the regulations in relation to complaints management and records, in particular in relation to -

- the recording of the investigation of complaints
- the actions taken on foot of a complaint, and
- satisfaction of the complainant.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

A number of Schedule 5 policies and procedures had not been updated to reflect current legislation and National Standards, this was a repeat finding from the previous inspection:

- there were discrepancies in the 'information sharing' piece relating to offences in the recruitment policy
- the temporary absence and discharge policy did not include information relating to the temporary absence to another healthcare facility
- the national transfer template, included in the policy, was the obsolete

template and did not include information such as infection history, antibiotic or drug resistant treatment or healthcare associated infection histories for example
- the communication policy was out of date as it was last reviewed in 2019.

Judgment: Substantially compliant

Quality and safety

Overall, residents were supported and encouraged to have a good quality of life in Heather House and they had access to appropriate social activities and to good quality healthcare. Residents spoke positively about the care they received and told inspectors they felt safe in the centre. Notwithstanding the positive findings, action was required in relation to the premises, personal possessions, fire safety and food and nutrition. These areas will be further detailed under the relevant regulations.

Residents had comprehensive access to general practitioner (GP) services, to a range of allied health professionals and out-patient services. Residents' records showed that comprehensive pre-admission assessments were carried out for each resident. Residents' nutritional and hydration needs were assessed and there was good evidence of regular review of residents' by a dietitian and timely intervention from speech and language therapy when required. However, action was required to ensure that there was further supervision of mealtimes in the centre, which will be further outlined under Regulation 18. The person in charge reported a lack of access to HSE occupational therapists and physiotherapists, and private therapists paid by the centre were currently providing a service to the residents.

A sample of residents' assessments and care plan records were reviewed. Residents physical, psychological and social care needs were comprehensively assessed on admission to the centre using validated assessment tools. The outcome of the assessments informed the development of care plans that generally provided guidance to staff on delivery of care to residents. However, there were mixed findings with care planning with some completed to a high standard, but there was no care plan to direct care for a resident with diabetes for example.

Arrangements were in place for the service to provide compassionate end-of-life care to residents in accordance with resident's preferences and wishes. There was a dedicated family room in the centre to provide families with facilities to be with their relative during their end of life. Staff had access to specialise palliative care services for additional support and guidance, to ensure residents end-of-life care needs could be met.

The needs and preferences of residents, who had difficulty communicating, were actively identified by staff and efforts made to support residents to communicate their views and needs directly. Residents who required supportive equipment to communicate were provided with such equipment. Residents care plans reflected

their communication needs and preferences. Residents were supported to continue to practice their religious faiths and had access to newspapers, radios and televisions. Information and contact details of advocacy services were displayed. The person in charge facilitated residents to access these advocacy services and care documentation supported this evidence.

Residents had access to activities on a daily basis. An external company was on site three days a week and a named staff member was allocated activities on the other days. Residents meetings were facilitated every three months and the person in charge had oversight of residents' meetings. There was evidence that they followed up on feedback from residents to ensure better outcomes for residents.

Residents had personal emergency evacuation plans to provide information on the individualised assistance they required in an emergency. Current fire safety certifications were in place for emergency lighting and emergency equipment. Daily fire safety checks were seen to be completed. Fire safety issues were identified in the inspection report from the 06 December 2022 resulting in a restrictive condition being attached to the registration of the centre for these works to be completed by the 30 September 2023. Although some of the works were completed, others were not completed. Also at the inspection in 2022, a new smoking shelter was planned for the new unit to facilitate residents on this side of the building, however, this was not yet available to residents at the time of the inspection. These and other fire safety issues are further detailed under Regulation 28, Fire safety.

Regarding the premises, improvements were seen to the decoration of the premises since the previous inspection and beautiful murals were painted on walls and more furniture was in place in some day rooms. However storage continued to be an issue particularly on Daisy unit which is further detailed under Regulation: 17.

Regulation 10: Communication difficulties

Residents with communication difficulties and special communication requirements had these recorded in their care plans and were observed to be supported to communicate freely. Residents were also supported to access additional supports such as assistive technology to assist with their communication.

Judgment: Compliant

Regulation 12: Personal possessions

The wardrobe space available to residents in the twin and four-bedded multi-occupancy rooms was not in line with a rights-based approach to living in a residential care setting as wardrobe space comprised a single wardrobe which did not provide adequate hanging or storage space for residents living in the centre.

This continued to be a repeat finding over all inspections undertaken in Heather House and has not been addressed and actioned to date.

Judgment: Not compliant

Regulation 17: Premises

There were a number of areas that required action to ensure the premises met the needs of residents:

- there was a lack of storage space for equipment in the centre particularly in relation to comfort chairs, hoists and wheelchairs, which were seen to be inappropriately stored in bedrooms
- the inspectors saw that a number of the outdoor areas were devoid of seating therefore not making it an attractive area to go out and spend time in,
- some of the lounges were not laid out to provide a homely atmosphere; half of one lounge was used to house exercise equipment. These lounges did not appear to be used much by the residents during the inspection,
- the volume of the wanderguard system used to alert staff that some residents were at risk of leaving the centre unaccompanied was heard to be very loud, and as it went off regularly it was disturbing for residents trying to relax.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Action was required to ensure residents were served their meal appropriately:

- the inspectors saw that a number of residents were served the three courses of their lunch together on a tray to residents bedroom. There was a lack of supervision and residents were seen to eat their desert without touching their soup or dinner, and other residents' ice cream had melted by the time they had finished their dinner,
- there was a lack of staff supervising and assisting with the lunch time meal on Daisy unit. There were 15 residents having their lunch with only one staff member to assist. A number of residents required full assistance and the staff member was seen to assist them but had to get up on a number of occasions to direct other residents, and requests deserts etc from the member of catering staff. This was not conducive to a relaxed social dining experience for the residents.

Judgment: Substantially compliant

Regulation 27: Infection control

The centre was seen to be very clean and cleaning staff were found to be knowledgeable about infection control practices. The provider had nominated a nurse to the role of infection prevention and control lead and link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre. There was a cleaning staff member allocated to each unit and appropriate cleaning equipment was available.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety issues were identified in the inspection report in the 06 December 2022 resulting in a restrictive condition being attached to the registration of the centre, for these works to be completed by the 30 September 2023. Although some of the works were completed some were not addressed. Those not completed included the following works identified in the providers' external risk assessment in November 2022:

- upgrading of fire doors and doorsets
- upgrading and or replacing compartment doors to eliminate gaps
- upgrade sub-compartment doors to eliminate gaps and provide glass replacement to achieve correct standards.

Also at the inspection in 2022, a new smoking shelter was planned for the new units to facilitate residents on this side of the building, however, this was not available to residents on the day of the inspection.

During the inspection, inspectors observed some doors were held open by chairs and therefore would not close in the case of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Assessments and care plans were reviewed and showed mixed finding. While there was some personalised information to inform individualised care, others were incomplete and were not sufficiently detailed to direct care. The inspectors also saw

that there was no care plan for a resident with diabetes to direct care for this resident.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to health care including specialist health care services. Residents notes demonstrated that they were regularly reviewed; medications formed part of the review, and residents and staff were consulted with regarding responses to changes in medication to enable best outcomes for residents.

Residents had timely referrals and consults with allied health professionals such as speech and language therapist and occupational therapist, and plans of care were in place along with recommendations to support residents to have a better quality of life. Due to the lack of HSE Occupational therapists and Physiotherapists, private therapists were employed to provide a service to the residents.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff were observed to deliver care appropriately to residents who had responsive behaviours. Residents needs in relation to behavioural and psychological symptoms and signs of dementia were assessed and continuously reviewed; supports were documented in the resident's care plan to address identified needs.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had access to a variety of activities on a daily basis. An external activities company was on site three days a week and a named member of staff was rostered to facilitated activities on the other days. Residents were seen to go out with staff and with family members and told inspectors that this was a regular occurrence.

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 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Heather House Community Nursing Unit OSV-0000714

Inspection ID: MON-0039139

Date of inspection: 31/01/2024

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The directory of the residents is updated with the GP and NOK details in the current book There is also a digital directory of the residents are available in the shared drive.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: ***The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.*** • The outstanding fire and safety works will be expected to complete by April 30th 2024 and an application of vary is submitted for the condition 4. • The smoking shelter in the Lilly courtyard is place and fit for purpose from 17/02/2024. • There have been no resident or family concerns raised to date in relation to the storage space in the four bedrooms in the Daisy unit under any mechanism for service user satisfaction eg Resident meetings, complaints policy etc. However should a concern be raised, a review will be carried out as per the HSE complaint policy. Therefore the service	

is fully in compliance with Regulation 12(c).

• The policies and procedures are in the process of review and update since January 2024 with the Clinical development coordinator for Cork in post.

• Supervision in the meal time of Daisy unit is addressed with the plan of having one nurse must attend the dining room during the meal times with residents and HCAS according to the numbers of residents in the dining area and dependency levels .
In Lilly unit, the dessert will be served in as the last course of the meal for the residents who have their dinner in their bedrooms. To facilitate the same an extra shelving is added in all pantry fridges to store the deserts and ice creams not to melt away.

• There are senior enhanced Nurses on every shift over the weekend and are part of the Governance structure with appropriate escalation pathway to senior management if required as on call.

• The HSE do not respond to anonymous allegations of misconduct so did not submit an NF07. It was later submitted by GM on the direction of HIQA.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaint policy and the complaint notice is updated reflecting the current changes As per the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulation 2022. The updated complaint policy and the algorithm is displayed in all units in the service.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• The policies and procedures are in the process of review and update since January 2024 with the Clinical development coordinator for Cork in post.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

• There have been no resident or family concerns raised to date in relation to the storage space in the four bedrooms in the Daisy unit under any mechanism for patient satisfaction eg Resident meetings, complaints policy etc. However should a concern be raised, a review will be carried out as per the HSE complaint policy. Therefore the service is fully in compliance with Regulation 12(c).

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The volume of the wander guard system is adjusted with reduced volume, different tune and increased the frequency of the alarm system.

• The lounge in Lilly suite is being used by the residents since March 2024 after the smoking shelter was set up in the Lilly courtyard .There are two exercise bikes in the lounge which is being regularly used for exercise by the residents . The same is parked in the corner of the Sun room.

• The service has plans to purchase outdoor seating for the summer and NRE is submitted for approval from the senior management.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• Supervision in the meal time of Daisy unit is addressed with the plan of having one nurse must attend the dining room during the meal times with residents and HCAS according to the numbers of residents in the dining area and dependency levels .
In Lilly unit, the desert will be served in as the last course of the meal for the residents

who have their dinner in their bedrooms. To facilitate the same an extra shelving is added in all pantry fridges to store the deserts and ice creams not to melt away.
• Spot checks and adhoc audits are completed by the CNM of the unit for the same.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The outstanding fire and safety works will be expected to complete by April 30th 2024 and an application of vary is submitted for the condition 4.

• The smoking shelter in the Lilly courtyard is place and fit for purpose from 17/02/2024.

• The installation of the free swing door closures are in progress with the maintenance team.

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:
• All the resident care plans and assessment reviews are completed and audited by the service.
• Documentation audits are completed by the clinical nurse managers and ongoing as required.

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 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Not Compliant	Orange	01/02/2024
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	17/02/2024
Regulation 18(1)(c)(i)	The person in charge shall ensure that each	Substantially Compliant	Yellow	02/02/2024

	resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.			
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	07/02/2024
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	01/02/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/04/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/04/2024
Regulation 28(2)(i)	The registered provider shall make adequate	Not Compliant	Orange	30/04/2024

	arrangements for detecting, containing and extinguishing fires.			
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	30/04/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/05/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared	Substantially Compliant	Yellow	14/02/2024

	under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			