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:	St Phelim's Nursing Home
Name of provider:	Flanagan's Nursing Home Limited
Address of centre:	Dromahair, Leitrim
Type of inspection:	Unannounced
Date of inspection:	02 June 2021
Centre ID:	OSV-0000395
Fieldwork ID:	MON-0031386

About the designated centre

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

St Phelim's Nursing Home is a purpose-built centre which opened in 1996. The centre is located in a rural area approximately 1km outside the town of Dromahair in County Leitrim. It is currently registered for 85 residents. Most of the residents have lived in the surrounding area prior to their admission to the centre. The centre provides care and support for female and male adult residents mainly from 65 years of age. Respite and convalescent care may be provided to both under and over 65 years. Day care services are also provided to residents from the local community. The building has two floors with all residents accommodated on the ground floor. Bedroom accommodation comprises a mix of single, double and multiple occupancy rooms, in four units: Lough Gill, Railway View, Railway Court and Inisfree. A secure courtyard garden is available. Nursing and care staff are available 24 hours per day and the management team are all based in the centre to oversee care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	76

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 2 June 2021	09:30hrs to 20:30hrs	Catherine Sweeney	Lead
Wednesday 2 June 2021	09:30hrs to 20:30hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Inspectors walked the premises accompanied by the management team and met most of the residents. It was not possible to speak with residents in private as the management team or another staff member were present at all times. The seven residents who spoke with inspectors were complimentary about the care they received. Residents reported that staff were kind to them and inspectors observed staff interaction to be kind and respectful.

The centre was observed to be bright and well maintained on the day of the inspection. New flooring and furnishings had been added to the older parts of the centre. New wardrobes had been installed into some of the multiple occupancy rooms. The centre was fitted with clear directional signage that facilitated residents to mobilise freely around the centre. Inspectors observed some residents moving independently around the centre and the internal gardens.

Some residents bedrooms, particularly the single occupancy rooms, were observed to be spacious and well decorated. Rooms were decorated in a person-centred way using personal photos and items from home. Some improvement was required to the layout of the multiple occupancy rooms to ensure that residents' privacy could be respected.

The centre was located in a small community where most of the residents would be familiar with each other and with the staff working in the centre. Inspectors observed comfortable and positive social engagement between staff and residents and between fellow residents. On the day of the inspection, activities were facilitated by an activities coordinator and a care assistant who had been reallocated from care duties. Country music was playing in the day room and residents spoken with confirmed that they enjoyed this type of music. Some residents were participating in arts and crafts, while others chatted with each other. A music session with singing was scheduled in the day room for the afternoon. Inspectors observed that a number of residents spent their day in their bedrooms. The person in charge explained that many residents choose to spend their day in their bedrooms. These residents were not observed participating in any group activities on the day of the inspection. It was not evident how the social care needs of these residents were met.

Residents reported that they enjoyed the return of the live mass in the centre. Hairdressing services had not yet recommenced, however, management confirmed that arrangements were in place for the service to recommence the week following the inspection. Residents had been facilitated to have their hair done by staff who held the appropriate qualifications.

Residents reported that they enjoyed the food in the centre. They explained that they were offered choice at each mealtime and that they could also have an alternative dish if they wished. Menus were available on each table in the dining

room. Meals at both lunch and tea-time appeared appetising and nutritious. There was water and juice station available to the residents throughout the day.

Visiting was observed to be in line with the Health Protection Surveillance Centre (HPSC) national guidelines for visiting. Inspectors spoke with a number of relatives, selected by the provider representative, who were complimentary about the service. Inspectors spoke with one resident who was being facilitated to visit their family overseas. The resident explained how pleased they were that this could be arranged as they had not seen their family for an extended period of time due to the COVID-19 pandemic.

Inspectors observed multiple closed circuit television cameras (CCTV) throughout the centre, including communal areas and areas where residents and families would have an expectation of privacy such as the day room, the dining room and the visitors room.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place, and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This inspection found that while some improvements had been made since the last inspection, repeated non-compliance in the areas of staffing, governance and management and residents' rights continues to impact on the quality of life of residents in the centre.

This was an unannounced risk inspection by inspectors of social services to follow up on the compliance plan actions submitted following an inspection in November 2019. While action had been taken to address the governance and management and staffing issues found on the last inspection, further improvement was required. Governance and management systems including complaints management, risk management, auditing systems and policy reviews had been introduced. However, oversight of these management systems was poor and not properly implemented, resulting in overall compliance not been achieved.

The inspectors also followed-up on unsolicited and solicited information received by the Chief Inspector in relation to a serious incident and a complaint. Inspectors found that the provider's investigation of these incidents required review so that learning could be identified and a quality improvement plan could be developed.

The provider of this centre is Flanagan's Nursing Home limited. The provider representative had a strong presence in the centre and was present on the day of the inspection. The provider had submitted an application to renew the registration of the centre. Inspectors reviewed the detail of this application during the

inspection.

The organisational structure and the roles and responsibilities of the management team was not clear. There was a new person in charge appointed to the centre in June 2020. The daily presence of the person in charge was not clearly evident. Residents and relatives spoken with referred to the provider representative as being the person in charge. It was unclear who was in charge or if the person in charge worked full-time in the centre. A review of the staff sign-in sheets for the month of May 2021 found that the person in charge's attendance was not consistently recorded.

The provider had introduced an environmental and clinical auditing system which was effective in identifying areas of improvement and developing a quality improvement plan. The results of these audits were communicated to staff through staff meetings and actions were allocated to staff for review at follow-up meetings. Governance meetings were held monthly.

A review of the complaints register found significant improvement in the management of complaints. A revised documentation system was in place with all complaints and concerns being documented and managed in line with the centre policies.

A review of the risk management systems was required to ensure that health and safety issues identified from incidents and complaints were documented and an appropriate action plan developed. From an incident and a complaint reviewed, the providers response to the issues was poor and did not adequately address the risks identified within the investigation reports. For example, an incident that had resulted in a serious injury to a resident was not included in the risk register.

The rosters reviewed did not reflect the staff in the centre on the day of the inspection. The provider confirmed that they were in the process of recruiting health care assistants. The provision of activities was supported by health care assistant staff. Supervision arrangements for weekends and night duty were not clearly documented on the rosters reviewed. While staffing numbers were adequate on the day of inspection, a review of staffing levels and skill mix was required to ensure staffing reflected the staffing numbers identified in the centre's daily roster and the statement of purpose.

A review of the training records found that staff had received training including safeguarding, fire safety, and infection control. However, a training gap was found in the provision of basic life support training for nurses. This meant that the nurses on duty did not have up-to-date training to deliver care to residents who required advanced life supports as identified in their care plans.

In summary, the staffing and governance and management systems in the centre required strengthening to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Registration Regulation 4: Application for registration or renewal of registration

Inspectors reviewed the application to renew the registration of the centre. Some changes were required to ensure the accuracy of the floor plans.

Inspectors found that a review of a number of the twin and multiple occupancy rooms was required to ensure that each resident accommodated in the centre would have their right to privacy and dignity upheld, and that each room had adequate light and ventilation, in line with the requirements under Schedule 6 of the regulations.

The provider submitted revised floor plans following the inspection.

Judgment: Substantially compliant

Regulation 15: Staffing

It was difficult to review staffing on the day of the inspection as the staffing in the centre did not reflect the staffing on the roster. For example, a rostered health care assistant was reallocated to facilitate activities, a care assistant and a clinical nurse manager were on site but not reflected in the roster.

The provider had on-going recruitment for four care assistants. Due to recent recruitment of staff nurses, carer duties were being completed by nurses. Notwithstanding that some of the staff assigned to care duties assisted the activity personnel, there was insufficient staffing for the provision of meaningful activities. There were two staff rostered to provide activities on the day of inspection. Inspectors observed that this resulted in one of these allocated staff providing activities to 28 residents in one of the three sitting rooms. The roster confirmed that for week of 31 May 2021 to 6 June 2021 there were four days when there was one activity personnel rostered.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A review of the training matrix found that no qualified nurse had received up-to-date training in cardio-pulmonary resuscitation. Care plans reviewed identified that this formed part of their plan. The provider confirmed that training was scheduled for the week after the inspection.

The centre had four clinical nurse managers rostered in a supervisory capacity.

However, the level of supervision was inconsistent. For example, on the week of the inspection four clinical nurse managers were on duty on Monday, reducing to one on Saturday, who was rostered for six hours and one on Sunday, rostered for 12 hours. The nurse in charge at weekends or on night duty was not identified on the roster.

The training matrix was difficult to review and did not facilitate oversight into staff training needs. This issue is addressed under regulation 21, Records.

Judgment: Substantially compliant

Regulation 21: Records

A review of records in the centre was required to ensure compliance with regulation 21. This is evidenced by:

- rosters reviewed did not accurately reflect the staff on duty on the day of the inspection.
- the role of individual staff member was not identified on the training record making it difficult to assess if all staff had training commensurate to their role.
- the documentation of a serious incident in the centre was incomplete. The record did not document the name of the person supervising the resident or the person in charge of the centre at the time, the result of the investigation and the action taken, as required under Schedule 3 (4)(j) of the regulations.
- pension agent records were incomplete and required review. When inspectors reviewed the financial records for seven residents for whom the provider was a pension agent, there were no records available for one resident.

Judgment: Not compliant

Regulation 23: Governance and management

The organisational structure in the centre was clearly described in the statement of purpose however, the role of the person in charge within the centre required clarity. Inspectors found that residents and their families were not clear about who was in charge of the centre. The provider representative and the person in charge gave assurance that the roles and responsibilities in the centre were clear.

The provider had an on-going programme of recruitment in place, however, a review of the numbers of care and activity staff was required to ensure that adequate resources were available to meet the assessed needs of all residents.

Improvement was required to the management systems to ensured that the service provided was safe and effectively monitored. This included the providers' response

to adverse incidents and risk management. For example, a serious incident investigation report and a complaint investigation report were reviewed on this inspection. These reviews did not encompass all of the factors that could have contributed to the incidents, therefore the analysis, conclusion and recommendations were not robust. These reviews would not support improved quality outcome for residents. This issue was discussed with management at the feedback meeting and, following the inspection, further assurance was sought by the Office of Chief Inspector.

In relation to risk management, some risks had not been identified in line with the centre's risk management policy. For example,

- recommendations from incident reviews were not included in the risk register
- a number of bedroom doors required review as they had domestic style handles which may not perform well in in the event of a fire.
- the doors into the smoking room and into a sitting area did not close properly and would not prevent the spread of smoke or fire.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaints policy and procedure in the centre found that the system was much improved since the last inspection. A review of the complaints log found that complaints and concerns were managed in line with the centre's new policy and with the requirements under regulation 34. Complaints management is included in the audit schedule for the centre.

This is a completed action from the last inspection.

Judgment: Compliant

Quality and safety

This inspection took place during the COVID-19 pandemic. The centre had remained free from COVID-19. The provider had infection prevention and control systems in place to address the risks associated with COVID-19. COVID-19 protocols were observed to be in line with the Health Protection Surveillance Centre Interim Public Health, Infection Prevention and Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities.

The provider had completed a number of improvements to the centre since the last inspection. A bathroom had been renovated and was now an accessible shower

room. A number of bedrooms had been renovated with new flooring and appropriate furnishings.

In recent years, the centre has been extended with the addition of 20 single, en-suite bedrooms. These rooms are modern, spacious and meet the needs of the residents accommodated in them. The original part of the centre consists of nine multiple occupancy rooms, 11 twin and 12 single rooms. Previous inspections identified issues relating to the privacy and dignity of residents accommodated in some of these rooms. The provider had a plan to commence a building programme which was due for completion in December 2021. The building plan sought to address the privacy and dignity issues relating to the multiple occupancy bedrooms, however, due to the national COVID-19 restrictions the building works had not commenced. In light of this delay, the provider committed to reducing the occupancy of a number of the multiple occupancy rooms and this commitment was reflected in the recent application to renew the registration of the centre.

While the provider had reduced the capacity of a number of the multiple occupancy rooms, the layout of some rooms continued to impinge on the privacy and dignity and personal choice of the residents. A review of two multiple occupancy bedrooms found that there was insufficient light and ventilation for the number of residents accommodated in the room. Furthermore, the layout of a number of twin rooms meant that one resident would have to enter the bed space of another resident to access their own bed.

A revised system of risk management was in place and reviewed regularly. However, recommendations for an incident investigation, directly related to risk assessment, had not been completed and documented in the risk register.

A review of assessments and care plans was required to ensure that care plans are developed using appropriate assessment tools and person-centred information so that an appropriate care plan can be used to inform and direct high-quality nursing care. While all residents had a care plan in place, the quality of the care plans was inconsistent. While the residents' social care plans were person-centred and detailed, other care plans reviewed such as dementia and end of life care plans were generic and did not guide staff to deliver care in a person-centred way.

Residents were found to be well supported by local general practitioners and a team of allied health care professionals such as physiotherapists, occupational therapists and dietitians.

The activity schedule on display in the centre did not provide assurance that opportunities for occupation and recreation had been developed to meet the needs of all the residents in the centre. A review of the provision of activities and the availability of staff to facilitate activities in the centre was required to ensure that all residents had the opportunity to participate in activities in accordance with their interests and capacities.

Inspectors noted multiple Closed Circuit Television Cameras (CCTV) around the centre. Cameras were located along corridors and in the communal areas of the centre including the dining and day rooms. This impeded the ability of residents

undertaking personal activities in private. While CCTV use was referred to in a data protection policy, the content did not identify the measures taken to protect the privacy of the resident.

Regulation 17: Premises

Two multiple occupancy bedrooms reviewed did not have adequate ventilation and lighting suitable for all residents accommodated in these rooms. Each room had one small window available to one resident only. When privacy screens were in position around the bed next to the window, the other bed spaces in the room had no natural light. Residents who wished to look out or open the window of their bedroom would need to enter another residents bed space to do so.

The layout of a number of bedrooms required review to ensure they met the assessed needs of the residents. One twin bedroom reviewed did not have floor space to provide adequate personal storage and a chair for each resident accommodated within the room.

Judgment: Substantially compliant

Regulation 26: Risk management

The risk management policy in the centre contained all the information required under regulation 26. A risk register was in place. The register had a COVID-19 section which was updated with national public health guidance. However, a review of the risk register found that risks specifically identified in the recommendations following the investigations of a serious incident investigation report and a complaint investigation report had not been addressed within the risk register. Therefore, no action had been taken to mitigate these risks and ensure resident safety.

Judgment: Substantially compliant

Regulation 27: Infection control

The centre had remained free from COVID-19 during the pandemic.

The centre was visibly clean on the day of the inspection. An appropriate number of cleaning staff were available and a cleaning schedule was in place. Cleaning staff spoken with had a good knowledge of cleaning systems and confirmed that infection control and cleaning training had been received.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Resident dependencies were assessed using the Barthel score, however this assessment did not take account of residents' cognitive needs. There were 42 residents with a diagnosis of dementia and or cognitive impairment. One resident with complex health and social care needs, who required a high level of staff support had been assessed as having a low dependency. The dependency assessment is used to calculate care hours and staffing levels. Inaccurate dependency assessment can result in inadequate staffing provision.

All residents had a care plan in place. Care plans for activities of daily living were presented in different formats and were inconsistent in quality. A review of the social assessments and care plans for residents found that they were detailed and person-centred. However, a review of care plans for dementia or end of life found that the detail was generic and not person-centred.

Judgment: Not compliant

Regulation 6: Health care

A review of the residents files found that residents had unrestricted access to their local doctors throughout the period of the pandemic. Residents were also supported by allied health care such as physiotherapy, occupational therapy, chiropody and psychiatry of later life.

Judgment: Compliant

Regulation 9: Residents' rights

The use of CCTV in the communal rooms is not supported by a policy identifying and managing the risk to residents' rights to privacy and dignity. This meant that residents and visitors using the communal areas of the centre including the day rooms, dining rooms and visitors room had the ability to undertake personal activities such as receiving visitors, in private.

In addition to the privacy issues in shared bedrooms discussed under regulation 17, there was a single bedroom, located near the main entrance that required the resident to pass through the reception area to access bathroom and toilet facilities.

This is a risk to the protection of the resident's privacy and dignity.

A review of the allocation of staffing to social care and activities was required to ensure that all residents had equal access to opportunities for social engagement, including residents who chose to spend their day in their bedrooms.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Substantially compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Phelim's Nursing Home OSV-0000395

Inspection ID: MON-0031386

Date of inspection: 02/06/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 4: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 4: Application for registration or renewal of registration: St. Phelims Nursing Home have submitted revised floor plans to HIQA following the inspection. A review of the twin and multiple occupancy rooms has been completed. The room reviewed by HIQA inspectors will be modified to ensure adequate light and ventilation. As of 1st of Janruary 2022 the twin and multioccupancy rooms will meet the requirements of amendements of schedule 6 to the principle regulations. Status: Timeframe: As of 1st of Janruary 2022 Responsibility: Registered Provider	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing Rota: The Barthel dependency assessment tool is used in St. Phelims Nursing Home to access resident dependency levels. The nursing home has now adjusted the assessment tool used to document the additional needs of residents when determining skill set, supervision and staffing ratio. An actual and planned Rota will be maintained and revised where there are any changes to staffing. Activities Coordinator: Three activities coordinator are scheduled to ensure that all residents have equal access to opportunities for social engagement, including residents who chose to spend their day	

in their bedrooms where this is their preference.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The planned training for provision of basic life support training for nurses was completed on 09.06.2021. Training is scheduled every three years as required and delivered as soon as possible to expiry date.

The rota has been ammended to reflect the following:

• Shifts for all staff including the Registered Provider representative and Person In Charge.
• Identify the nominated senior person for staff supervision for all shifts.
The training matrix has now been revised to include the role/disclipine on the top of each page to indicate the category of staff.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The first floor of St. Phelims Nursing Home is part of the designated centre. This is evidenced by St. Phelims Nursing Home home registration and statement of purpose and function. The floor is utiised for administrative duties, meetings and training.

Schedule 2,3,4 records are retained for a period of not less than seven years. The records are safe and accessible.

As discussed in Regulation 15 of this report, an actual Rota will be maintained to reflect any changes to the planned Rota for example, where staff are absent or sick the actual Rota will be adjusted to reflect the amendments to personnel.

The role of all individual staff members is now included on the training matrix.

The documentation regarding the serious incident has been reviewed. The summary report did not contain the required information as per schedule 3, the requirements however were detailed within the minutes/records of investigations. All summary reports for investigations will now include appendixes of information reviewed as part of the

investigation process and minutes of meetings in line with data protection and best practice. The record discussed during the inspection of the incident reviewed by the HIQA Inspectors has now been ammended to inlcude:

• Name of the person supervising the resident or the person in charge of the centre at the time,
• The result of the investigation and the action taken, as required under Schedule 3 (4)(j) of the regulations.

The pension agent application form was forwarded to the resident's GP for signing and authorisation. The GP subsequently posted the application to the Department of Social Welfare. A copy of the form has now been sought and placed into the residents record.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
During the Inspection process the Management Team of St. Phelims outlined to HIQA that the roles and responsibilities for the registered provider representative and person in charge were very clear, documented in their individual Job descriptions and in line with the roles and responsibilities outlined in the Regulation S.I. 415 of 2013 Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People), relevant standards, and guidance documents.

Additional training has been completed by the Person In charge. The training included documentation requirements to support robust reports that evidence the interventions implemented to enhance residents quality of life. All risks identified following complaints, incidents, audits and Gap Analysis will be added to the risk register and Quality Improvement Plan.

All fire risks are in the process of being addressed specifically:
• domestic style handles on doors
• replacement of the doors into the smoking room and into a sitting area

The risk register has been revised to reflect the corrective actions.

Status:
Timeframe: 30th August 2021.
Responsibility: Registered Provider

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The room indentified during the inspection will be modified to ensure adequate light and ventilation through the provision of a skylight.
Status:
Timeframe: 30th October, 2021
Responsibility: Registered Provider

As of 1st of Januuary 2022 the twin and multioccupancy rooms will meet the requirements of amendements of schedule 6 to the principle regulations including adequate personal storage and a chair for each resident.
Status:
Timeframe: As of 1st of January 2022
Responsibility: Registered Provider

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
A review of all incidents, complaints and audit reports are in the process of being completed by the Person In Charge, where there are any gaps identified the current controls, risks and learnings shall be added to the risk register. As part of the monthly mangement team meetings the Registered Provider and Person In Charge will verify that the Risk Register has been updated where indicated. All risks will continue to be discussed during team meetings.
Status:
Timeframe: 30th August, 2021
Responsibility: Registered Provider

Regulation 5: Individual assessment	Not Compliant

and care plan	
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: All residents care plans will be reviewed to ensure they are consistent in format, person centered and inform staff regarding the care requiements for each resident. Status: Timeframe: 30th August, 2021 Responsibility: Person In Charge.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The number and location of cameras in St. Phelim's Nursing Home is currently being reviewed to ensure that their use does not intrude on residents' privacy. Status: Timeframe: 30th August, 2021 Responsibility: Person in Charge. The single bedroom, located near the main entrance is used for the provision of end of life care to afford residents a single room, this room is not used where residents require access to a bathroom and toilet facilities. Allocation of staffing to social care and activities has been disussed within Regulation 15 Staffing of this report.	

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
Registration Regulation 4 (1)	A person seeking to register or renew the registration of a designated centre for older people, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Substantially Compliant	Yellow	01/01/2022
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	20/07/2021
Regulation 16(1)(a)	The person in charge shall	Substantially Compliant	Yellow	20/07/2021

	ensure that staff have access to appropriate training.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	20/07/2021
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	21/01/2022
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.	Not Compliant	Orange	20/07/2021
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	20/07/2021
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for	Not Compliant	Orange	30/07/2021

	all areas of care provision.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/07/2021
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	30/07/2021
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	30/07/2021
Regulation 5(3)	The person in charge shall	Not Compliant	Orange	30/07/2021

	prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/07/2021
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	30/07/2021