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
Name of provider:	Prague House Care Company Limited By Guarantee
Address of centre:	Chapel Street, Freshford, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	07 May 2021
Centre ID:	OSV-0005447
Fieldwork ID:	MON-0032299

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 22 people. The management of Prague House is overseen by a Board of five 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. One nurse was employed by Prague House to work a total of five hours per week. A day care service is provided in the centre one day a week on Wednesdays, and this activity is supported by volunteers. 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 24hour nursing care, and care is provided by a team of trained healthcare professionals with one nurse employed for five hours per week. 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:	14

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
Friday 7 May 2021	09:45hrs to 16:00hrs	Helena Grigova	Lead

What residents told us and what inspectors observed

Overall, residents were observed to be well cared for and were seen to be content and settled in their surroundings and their interactions with staff. Staff spoke to residents kindly and with respect. The inspector received a warm welcome from the person in charge, staff and residents throughout the inspection. The person in charge completed the temperature and symptom check for the inspector on entering the designated centre. During the inspection the inspector met with residents and staff and spoke in more detail with six residents.

The atmosphere in the centre was relaxed and unhurried. The environment was warm and comfortable and provided homely surroundings for the residents. The centre is located in the middle of the Freshford community, surrounded by the village park and mature trees. The local church is just opposite the centre, and in normal times residents and their visitors could attend mass. The centre was divided into three areas as follows Achadh Ur, Cascade and Nuenna. Residents were observed mobilising independently around the centre and had unrestricted access to two outdoor garden areas.

The entrance foyer is an open space that is filled with natural light. Residents were observed to sit there and enjoy people-watching on the street or wait for their loved ones to accompany them for their appointment. The inspector saw a large communal area with a dining room tastefully decorated with modern furniture creating a cosy and homely atmosphere. Residents were seen enjoying watching TV or chatting with each other. The inspector observed that residents looked well cared for, and they were generally well-groomed and nicely dressed. A planned activities programme was displayed in the communal area. Discussion with staff and a review of the activity programme showed that arrangements were in place to meet residents' social, spiritual and recreational needs. The centre kept chickens on site, and residents continued to visit them when weather permitted. A small oratory with a collection of devotional materials was available for residents, staff or visitors' use. While religious services were temporarily suspended, these were delivered remotely by TV and radio. Daily newspapers were available to residents.

The majority of residents' bedrooms, especially in the Achadh and Cascade areas, were found to be personalised with items of memorabilia and special interests, and this was to the preference of the individual. Walkways throughout the home were kept clear and free from obstruction. There had been several improvements to the environment, including redecoration, new flooring and furnishings. These gave a homely appearance to the environment. However, further improvements were needed in the Nuenna area on the first floor to complete the refurbishment programme for five bedrooms and related ancillary areas.

Residents spoken with gave positive feedback regarding the food provided to them. Measures had been put in place to maintain physical distancing for residents where possible. Seating in the communal and dining room had been arranged in such a

way as to allow adequate physical distancing. Dining tables were appropriately set with place mats, and a range of condiments. Residents were offered a choice of fluids to accompany their meal. The daily menu was displayed; the inspector observed that the food provided was well presented and smelled appetising. Staff were helpful, attentive, and demonstrated their knowledge of residents' dietary preferences.

The person in charge discussed the visiting procedures in the centre, and advised visiting was being facilitated by booking a time slot. Visiting took place in designated visiting rooms or the garden area of the centre. The person in charge told the inspector that they recognised the importance of maintaining good communication with families whilst visiting had been suspended to some extent during the COVID-19 pandemic. The care staff assisted residents in making phone or video calls with their families to reassure relatives.

Residents spoken with indicated that they were well looked after by the staff and felt safe and happy living in Prague house. Residents also expressed their confidence in raising concerns with the centre's staff and management. Residents expressed high satisfaction with their life in the centre. One resident commented, "I get good attention. They always ask you how you're doing. The staff are excellent. I'm very lucky to be here.' Another resident said, 'Everyone is very sociable. They are very nice to us. They are like our own family.'

A review of residents' meetings carried out by the person in charge indicated that the residents were involved and updated with current events, training and changes in the centre. Some improvements to the service had been identified as a result of this review. The person in charge was keen to put these changes into practice in future, such as the residents' satisfaction survey and discussion on the designated centres' annual review.

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

Capacity and capability

Overall, the care provided to residents was to a good standard, and there was evidence of commitment providing a quality and person-centred service for residents. This was a one-day unannounced inspection to monitor compliance with the regulations. The last inspection of this centre had been in June 2019. The previous inspection found multiple sub-compliance's and two non-compliance's related to systems of governance and management, premises, fire precautions and infection control in the centre. This inspection found that while some progress had been made to address the non-compliance from the previous inspection, significant further action was required.

Prague House is managed by Prague House Limited by Guarantee, and was established for the supported care of older people from the local and surrounding areas. Funding for the service is granted under a service level agreement with the Health Service Executive (HSE) under section 39 of the Health Act, 2004, voluntary fund raising, and residents' own contributions. The centre provides long-term and respite-care for a maximum of 22 residents who require minimal assistance only. The governance structure of the centre includes a board of management, one of whom is the registered provider representative. A new person in charge has been appointed in January 2021. The person in charge told the inspector that she felt well supported in her role and that good working relationship was maintained in the centre. The person in charge attends the monthly board meetings and presents a report to them of all aspects of residents care, staffing requirements and management of the centre.

An Audit schedule was in place to monitor the quality of the service provided. The inspector examined a sample of governance audits, including those focused on infection prevention and control, smoking audit, staff files, safeguarding, falls prevention and accidents, and care records. The inspector reviewed the process for the auditing, and although the audits were completed the deficits found at inspection had not been identified. This is further outlined under Regulation 23: Governance and management in this report.

The inspector acknowledges that there had been no known outbreak of COVID-19 infection at the centre since the start of the COVID-19 pandemic. The COVID-19 contingency plan was updated by the new person in charge, and included sequential delegation of responsibility for the centre; information on the infection prevention, control expertise available in the CH05 area, and accommodation arrangements for residents if they became acutely ill as 24 hour nursing oversight was unavailable in the centre. However, the inspector reviewed a 'COVID-19' folder and found that it did not include up-to-date information from the Health Protection and Surveillance Centre (HPSC). There were various guidance documents in the folder that were not updated regularly and dated back to May 2020. The most recent guidance on the prevention and management of COVID-19 was missing. Policies and procedures that were impacted by the pandemic were also not updated.

The inspector found that the levels and skill mix of staff at the time of inspection were sufficient to meet the low dependency needs of the residents. However, the inspector concluded that the current staffing arrangements for household and laundry staff required to be strengthened and was not assured that to prevent the COVID-19 outbreak in the centre, the contingency arrangements in place would be adequate. This is further discussed under Regulation 15: Staffing.

Training records indicated that staff had access to appropriate mandatory training as manual handling, safeguarding vulnerable adults, infection control, medication management and fire safety. All staff working in the centre had attended training in infection prevention and control and included practical demonstrations on donning and doffing PPE, hand hygiene and breaking chain of infection. However, some training fell behind schedule, and not all staff had attended up-to-date, relevant

training. This is stated in Regulation 16: Training and Staff development.

The person in charge assured the inspector that Garda Síochána (GV) vetting clearance was in place for all staff. A sample of staff files was seen to be in compliance with Schedule 2 of the relevant regulations.

The new person in charge implemented procedures to ensure that any complaints received would be managed in accordance with regulation and the centre's policies and procedures. The complaint log for past years was unavailable at the time of the inspection.

Regulation 14: Persons in charge

The person in charge had been appointed to the position in January 2021. The person in charge was a registered nurse with the required managerial and nursing experience specified in the regulations. The person in charge demonstrated good clinical knowledge and knew the individual needs of each resident.

Judgment: Compliant

Regulation 15: Staffing

The inspector had reviewed the roster and found that there was not assigned a household staff on duty, and the staff assigned for laundry duties worked three days per week from 10.30 till 15.30hrs only. This resulted that the care staff were responsible for cleaning the centre and managing the laundry duties on days when the laundry personnel was missing or every day during sickness or annual leave. Given the building's layout and the necessity for an intensified cleaning regimen required to prevent an outbreak of COVID-19 in the centre, it was not possible to clean the centre to the required standard. As a result, the opportunities for improvement were identified under Regulation 27: Infection Control.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The staff training matrix indicated high levels of staff compliance with mandatory training requirements except for safeguarding and medication management training.

Judgment: Substantially compliant

Regulation 21: Records

On the day of inspection, the inspector found examples of poor record-keeping including:

- The inspector was informed that there was no Risk register available on the inspection day, including the COVID-19 Risk assessment.
- An Annual review was not completed for 2019 or 2020.
- An Incident and Accident log was also unavailable.
- The complaint's log for complaints recorded in 2020 and previous years was also missing.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector found that governance arrangements at the centre could be strengthened to ensure that accurate information is produced through local monitoring and data to identify potential risks and opportunities for improvement. By way of example, Infection Control and COVID-19 audits were completed; however, the audits did not identify areas of improvement. The root cause is that the infrastructural and staff resource limitations impacted on staff's ability to adhere to correct infection prevention and control procedures. For instance, the audit findings stated that all related policies were updated to COVID-19 where required. The cleaning matrix/ schedule identified the method, frequency of environmental cleaning, or the smoking shelter was appropriately risk assessed with fire fighting equipment. The inspector observed that none of the mentioned sources was in place. Consequently, the audits did not identify the overall level of risk this posed and the urgency required to mitigate this risk until the refurbishment plan on the first floor was implemented. Furthermore, how this data was used did not inform the improvement action plans.

The interim arrangements required to provide safe care and services are further detailed under Regulation 15: Staffing, Regulation 27: Infection Control, Regulation 26: Risk management and Regulation 17: Premises.

Systems to manage critical accidents and incidents in the centre were also missing. An immediate improvement was necessary to record all incidents and near misses and ensure that appropriate action was taken and they were followed up on and reviewed.

The annual review of the quality and safety of care delivered to the residents was

not completed for 2019 or 2020. Additionally, there was no evidence that the feedback regarding the residents' experiences and the operation and support delivered by the designated centre was sought.

Judgment: Not compliant

Regulation 34: Complaints procedure

The procedure and policy reviewed reflected the legislative requirements. An accessible complaints procedure was displayed in the centre. However, the complaint log for previous years was missing, and this was actioned under Regulation 21 Records. The current person in charge created a new Complaint log for 2021. A suggestion box was also available.

Judgment: Compliant

Regulation 4: Written policies and procedures

The inspector found that the policies and procedures had not been updated and reviewed in response to the COVID-19 pandemic. For example, on the admissions and visiting practices to ensure adherence with HPSC guidance.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

As there was no record in place of the review of accident and incidents recorded in the centre, the inspector was not assured that all notifiable events were investigated and reported to the Office of the Chief Inspector or other relevant bodies appropriately. The inspector followed up on the NF03 notification received in December 2020 but found no record of the resident's fall leading to serious injury in the resident's file.

Judgment: Substantially compliant

Quality and safety

Residents' lives had been significantly impacted by the COVID-19 restrictions. However, they all reported that they felt the care and support they had received was of good quality.

The inspector observed that staff used PPE according to the current guidance. The staff had identified changing facilities where they could put on their uniform and the recommended PPE (personal protective equipment). PPE was readily available, and PPE stations were well stocked. Dispensers containing hand sanitiser were observed to be full and in good working order. The person in charge advised that all staff had a temperature and symptom check on arrival to work and at the end of their shift and that all residents in the centre had their temperature checked twice daily.

All new admissions had a comprehensive pre-assessment completed, and when admitted into the centre, were cared for in single rooms with limited staff for 14 days. Clinical risks such as malnutrition fall and pressure sores were assessed; however, the inspector found that some care plans were not reflecting residents' personal and medical needs.

During the lock-down period, residents continued to visit GP in the local medical practice accompanied by staff or family members. Access to allied health was evidenced by regular reviews by the occupational therapist, podiatry, tissue viability, dietician, speech and language, as required. The pharmacist attended the centre regularly to provide expertise, review prescriptions, and stock in the centre.

The inspector followed up on an action from the previous regulatory inspection concerning fire precautions and found that the centre had addressed the automatic closing devices on all bedrooms doors and the oratory, and emergency lighting was regularly serviced on a quarterly basis. Appropriate certification was evidenced for maintaining fire safety equipment. Fire safety checks were undertaken in accordance with legislation.

The centre had a health and safety statement and a risk management policy in place. However, the procedures for risk management did not reflect good practice; for example, the risks associated with the centre, and the COVID-19 pandemic were not identified, and the procedure of fire drills management required improvement to include the regular evacuation of a complete compartment with night time staffing levels to ensure staff could achieve this in a timely way.

The inspector found that some deficits were noted concerning the cleanliness of the environment, cleanings schedule and facilities, staffing resources, and inappropriate storage space. This is discussed under Regulation 27: Infection Control and Regulation 17: Premises.

Regulation 11: Visits

In line with the national guidance, visiting had recommenced and was taking place on an appointment basis. Visitors were permitted to visit their loved ones, and the

inspector observed families accompany residents for their appointments. Staff were committed to ensuring residents and their families remained in contact by means of regular window visits, telephone and video calls.

Judgment: Compliant

Regulation 17: Premises

While efforts had been made to address a number of maintenance issues, the physical environment in the centre had not been managed and maintained in compliance with Schedule 6 of regulation. For example:

- The renovation plan for upstairs accommodation in the Nuenna area mentioned in the previous inspection in 2019 was not completed and required completion date. Areas of the first floor were in disrepair; for example, exposed pipes, plaster exposed and watermarks on walls. The inspector observed that some bedrooms were being painted.
- There weren't enough storage facilities in the centre' for example, some bedrooms were observed to be cluttered and used to store various items such as wheelchairs, boxes with sterile dressings, excess furniture, or boxes PPE.
- There was no sluice room with the sluice machine in the centre. The 'low sink' for cleaners use was situated in the hall residents used as a thoroughfare to access the garden. This was outlined during the inspection in 2019, and had not been addressed to date.
- Three cleaning trolleys were stored in the store room upstairs, which was also used to store the incontinence wear and cleaning supplies. The walls in the store room were damaged with holes. The floor finishing also did not support efficient cleaning.
- A toilet upstairs was without a seat and required to be replaced immediately.
- There was no sink available in the treatment room.
- The inspector observed that an oxygen concentrator was stored inappropriately and was not easily accessible in emergency situations. Assurance was required in relation to the appropriate storage of oxygen concentrators with a proper risk assessment. Also, there was no cautionary signage to alert people of the fire risks associated with oxygen cylinders or concentrators.

Judgment: Not compliant

Regulation 26: Risk management

There was an up to date risk management policy; however, the risk register and accident and incident log involving incidents were not available in the centre on the

day of the inspection. The new person in charge stated that these documents were not in place since she commenced her position. Risks associated with the COVID-19 pandemic were also not identified.

Judgment: Not compliant

Regulation 27: Infection control

The findings of this inspection were that residents were at risk of infection as a result of the provider failing to ensure that procedures consistent with the standards for infection prevention and control were implemented by staff. In particular, the provider did not demonstrate adherence to and compliance with the Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units, a guideline issued by the Health Protection (HPSC) to safeguard and protect residents from infection. For example:

- The cleaning matrix/schedule for deep cleaning, routine cleaning, shared space cleaning, and terminal cleaning directed at the centre's audit was not in place. Furthermore, the general cleaning checklists were in place for occupied bedrooms only and did not include the empty bedrooms. There was no system in place to ensure that frequently touched areas were cleaned regularly over the 24 hours in addition to the regular cleaning schedule. The inspector identified gaps in the cleaning dates. Additionally, the cleaning checklist in shared communal areas was not regularly recorded. An immediate cleaning schedule was also required for the whole first floor.
- The carpet on the stairs was visibly dirty, and the cleaning plan needed to be addressed.
- Two empty bedrooms and bathrooms identified for residents who required isolation on the first floor required an immediate deep cleaning; for example, used towels were left on the bed, and the floors were visible stained and dusty in all mentioned areas.
- Cleaning and decontamination of residents' medical equipment required to be improved upon; for example, the inspector observed that an unused oxygen concentrator had still a bottle with used water and tubes connected to the device. A checklist for nebulisers, oxygen mask, and other medical equipment used in the centre was also not in place.
- The sharps box was not signed when opened, or the temporary closure mechanism engaged when they were not used. Additionally, the sharp box was stored inappropriately in the bathroom.
- Inappropriate open-top waste storage bins were observed to be in use in several areas of the centre.
- There was no sluice machine in the centre to deep clean urinals or basins used for residents.
- The inspector observed clutter and untidiness in the linen room on the first

floor. The management of this room required review.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspector identified a number of fire safety issues that needed to be addressed, and remained outstanding from the previous inspection:

- There was a smoking shelter for the residents with no fire-fighting equipment available, such as fire extinguisher, fire apron, and a call bell for residents.
- There was one fire drill simulated in February 2020. The records did not indicate the time of the drill, the number of staff involved in the procedure, and the actions taken or the lessons learned. There were no recent fire drills to provide assurances that residents accommodated in the larger fire compartments could be evacuated safely with the current night time staffing levels. This was discussed with the person in charge who undertook to carry out, and submit fire drill records simulating a night time scenario. A full compartment evacuation was undertaken following the inspection with night time staffing levels, which provided the necessary assurances. Ongoing fire drills of compartments are required to improve times and efficiency of evacuations.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Some improvements were required in care planning to ensure that the care plans were easily assessable and sufficiently detailed to direct all aspects of care for the resident. The inspector reviewed a number of care plans with the person in charge and found that not all care plans were in place for all records reviewed. For example:

- Two residents with respiratory treatment, such as oxygen and nebuliser therapy, did not have a supportive care plan supporting their treatment process.
- Personal care plans outlining personal needs support for residents were missing.
- Catheter and stoma - elimination and stoma care plans were not available.
- Regular reviews of care plans, including discussion with the residents about their needs, also required improvements.

Judgment: Not compliant

Regulation 6: Health care

Residents in the centre were facilitated to attend local medical practice. Access to physiotherapy, occupational therapy, tissue viability nurses, dietitian, and speech and language therapy was available through community services. Residents also had access to services as geriatrician, optician and dentist. Residents who were suitable to and met the criteria for the National Screening Programmes were supported to attend.

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	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
Regulation 4: Written policies and procedures	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant

Compliance Plan for Prague House OSV-0005447

Inspection ID: MON-0032299

Date of inspection: 07/05/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: One staff each day will be assigned to cleaning duties only and will not be involved in the personal care of the residents. Staffing of the laundry is on the agenda for the next Board of Management meeting and the PIC will outline the issues to the Board. Staffing levels will be increased in line with the % Occupancy of the Care Home, which at the moment is 64% mainly due to high level of Covid restrictions	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1) Safeguarding Training. The PIC contacted the safeguarding team in the HSE seeking support around training in this area. They advised that staff again complete the training modules on HSEland as well as the HIQA module available there. They also advised that as restrictions ease that a member of their team will attend Prague House to complete a training session with the staff. They assured the PIC that they are available for advise at all times. As the HSEland system is still not available due to the recent cyber attack staff have been requested by the PIC to complete this training as soon as the system is available. The PIC will then set a time for staff to meet to discuss the learnings from the training. 2) Medication training The PIC liaised with the Pharmacy who supply all the medications	

to the center and requested support with training. This was agreed and one of the Pharmacists attended the center on May 26th and completed training with all staff who are trained in medication administration. She also met with the PIC and checked through the systems in place in Prague House which was found to be satisfactory.

3) Infection Control training. The PIC has had conversations with the ADON for Infection Prevention Control for CHO5 and spoke of the concerns raised at the inspection. She advised that staff continue to update themselves with all available course online and when the restrictions ease, she will arrange for either herself or a member of her team to attend the Centre to do training.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1) The risk register was located May 10th and updated to reflect risks in relation to Covid 19.
Risk assessments have been completed for all residents reflecting the situation both pre and post vaccination in relation to Covid 19. Completed May 2021

2) The Incident /Accident logbook was located in the staff office following the inspection and I sincerely apologize for this. Any incident that has occurred had been logged and followed up on. Completed May 2021

3) A complaints log has been compiled and will reflect any complaints, concerns as well as compliments. Staff have been informed of the necessity to document any of the above. Forms to reflect any of the above are available in the hallway for peoples use.

4) Annual reviews for the missing years have been completed by the Deputy Manager who was here during those periods.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider of all the policies and procedures for the center, Hennessy & Associates, have been contacted and requested to update the policies starting with the ones most relevant to Covid 19. They have agreed to do this in a timely manner.

The PIC has put a system in place where there are regular meetings between herself and the Deputy Manager to discuss any issue that arises and to work together to complete Audits. This will give a broader view of audits as the deputy always works frontline.

The incident/accident log has been located and all incidents have been logged and followed up on.

The smoking area has been clearly defined with the addition of a call bell, smoking jacket and a fire blanket to hand. These are kept in a box clearly marked re the contents. The one resident who does smoke has been clearly advised of the need to avail of these supports. Staff have been advised to constantly remind the resident.

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 PIC has contacted the company who provide all the policies and SOPs for the center and they have agreed to update all, starting with policies such as Infection Control which reflect Covid 19. They have agreed to send on policies each week. The PIC will then replace the old ones with the newer versions. Commencing June 2021

The PIC will then begin to introduce a Policy of the Week for staff to familiarize themselves with and a sign off sheet for each one will be provided. Commencing June 2021

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The incident /accident logbook was located in the staff office following the inspection. Again, my apologies for this on the day.
All incidents have been logged and followed up on.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A schedule has been devised for upgrade works in the upstairs of the center.

All unnecessary items have been removed and either discarded or stored appropriately. The area has been thoroughly cleaned.

Maintenance staff have been given a schedule of works in relation to filling holes, boxing in exposed pipes, replacement of broken or missing items, etc.

Tenders to paint the entire upstairs are being sought and prices for replacement of defective floor coverings are also being sought.

The low sink situated in the hallway will be addressed as part of the maintenance staff work plan. Works to be completed by end of July 2021

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
The risk register which could not be located on the day of the inspection was found wedged behind a pillar on the bookshelf in the office the following day.

All risk assessments relevant to Covid reflecting pre and post vaccination have been completed.

All other risks relevant to the residents have been completed and filed.

Risk Assessment policy in the process of being updated to reflect Covid 19 in process.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Cleaning schedule has been updated to reflect Covid 19 and schedules are present in all designated areas.

A schedule of works to improve the upstairs premises has been put in place.

Tenders have been requested for full painting of the area and process sought to replace floor coverings as necessary.

Maintenance staff have been given a list of tasks such as filling holes in walls and fixing all fixtures and fittings.

All old/worn items from the linen room have been removed and itemized and will be replaced as required. Remaining linen has been returned to the press replaced in an orderly way.

All areas upstairs have been cleared of all unnecessary items and areas have been cleaned.

All medical equipment not in use has been cleaned and stored in the store room. Checklists for nebulizers and oxygen have been put in place and are available to staff in the designated areas.

The sharps box has been removed from the bathroom and is now stored in the treatment room in a press with clear instruction to date when opened.

Storage bins will be replaced with pedal operated lid covers in each area.

A Sluice Machine was installed and operational up to 2019 in Prague House but was not being used. Following discussions with HIQA representatives it was decided to take this out of commission and stored away. Unit can be reinstated residents needs demand it.

All residents in the Home have been individually assessed as to their needs in intimate care such as the area of continence
A cleaning regime is being put in place for all equipment used by individual residents and a sign sheet made available to staff for signing after each time the equipment is cleaned. A clear timeframe is identified on each sheet for times of cleaning equipment

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The smoking area has been adapted to meet the requirements with the inclusion of a call bell and smoking jacket for the resident who smokes. Both a fire blanket and extinguisher are in the conservatory beside the smoking area.

A fire drill simulating nighttime was carried out in the days following the inspection. Nighttime evacuation procedures in place were found to be satisfactory.

All staff have completed fire training and the trainers have agreed to complete an evacuation with all residents and staff by the end of July 2021

A schedule of fire drills has been put in place.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All Care Plans as outlined in the report have been updated to reflect the need of the residents.

Care Plans for people with catheters or stomas have been completed and filed for the relevant people.

Care Plans for all residents in relation to personal needs have been completed.

Care Plans for people using any respiratory treatments have also been completed and filed.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	01/07/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	01/07/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/2021
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Not Compliant	Yellow	25/10/2021

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
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.	Not Compliant	Yellow	31/07/2021
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	Yellow	03/06/2021
Regulation 21(3)	Records kept in accordance with this section and set out in Schedule 3 shall be retained for a period of not less than 7 years after the resident has ceased to reside in the designated centre concerned.	Not Compliant	Yellow	10/05/2021
Regulation 21(4)	Records kept in accordance with this section and set out in paragraphs (6), (9), (10), (11) and (12) of Schedule 4, shall	Substantially Compliant	Yellow	10/05/2021

	be retained for a period of not less than 4 years from the date of their making.			
Regulation 21(5)	Records kept in accordance with this section and set out in paragraphs (7) and (8) of Schedule 4, shall be retained for a period of not less than 7 years from the date of their making.	Substantially Compliant	Yellow	01/06/2021
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	25/10/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Yellow	08/06/2021
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre	Not Compliant	Yellow	10/05/2021

	to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.			
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Yellow	03/06/2021
Regulation 23(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the Chief Inspector.	Not Compliant	Yellow	04/06/2021
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Yellow	10/05/2021
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the	Not Compliant	Yellow	10/05/2021

	measures and actions in place to control the risks identified.			
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Not Compliant	Yellow	31/05/2021
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Not Compliant	Yellow	10/05/2021
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Not Compliant	Yellow	10/05/2021
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression	Not Compliant	Yellow	23/07/2021

	and violence.			
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Not Compliant	Yellow	23/07/2021
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.	Not Compliant	Yellow	23/07/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Yellow	23/07/2021
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting	Substantially Compliant	Yellow	03/06/2021

	equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/07/2021
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Substantially Compliant	Yellow	08/06/2021
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	08/06/2021
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	Substantially Compliant	Yellow	08/06/2021

	notice in writing of the incident within 3 working days of its occurrence.			
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	08/06/2021
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	08/06/2021
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Yellow	03/06/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not	Not Compliant	Yellow	08/06/2021

	exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 5(5)	A care plan, or a revised care plan, prepared under this Regulation shall be available to the resident concerned and may, with the consent of that resident or where the person-in-charge considers it appropriate, be made available to his or her family.	Not Compliant	Yellow	08/06/2021