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:	Killarney Community Hospitals
Name of provider:	Health Service Executive
Address of centre:	St Margaret's Road, Killarney, Kerry
Type of inspection:	Announced
Date of inspection:	24 October 2023
Centre ID:	OSV-0000568
Fieldwork ID:	MON-0033208

About the designated centre

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

Killarney Community Hospitals is located on the outskirts of Killarney town. There is a strong association between this healthcare setting and the local community of Killarney and the wider population of County Kerry. The centre is registered to provide care for 66 residents of various dependencies. The centre is divided into three wards: Fuschia, Hawthorn and Heather. Fuschia is a unit for residents diagnosed with dementia and can accommodate 18 residents and caters for all ranges of dementia and residents who need extra support and supervision.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	61

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
Tuesday 24 October 2023	09:10hrs to 17:20hrs	Ella Ferriter	Lead
Wednesday 25 October 2023	08:30hrs to 15:45hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

Residents living in Killarney Community hospital gave positive feedback about the care they received in the centre. Residents were extremely complimentary of the staff, who they described as always helpful, caring and friendly. Residents told the inspector that they were familiar with the staff who supported them daily and this made them feel safe living in the centre.

This was an announced inspection carried out over two days. On arrival to the centre the inspector met with the management team for an opening meeting, to discuss the centre, the current residents and to outline the plan for the inspection. Following this meeting the inspector was guided on a tour of the premises with the person in charge.

Killarney Community Hospital provides long term care for both male and female adults with a range of dependencies and needs. The centre is situated in the town of Killarney, County Kerry and is part of a large campus of buildings, which also accommodates some community and social services. It is registered to provide care for 66 residents, and there were 61 residents living in the centre on the day of this inspection.

Residents accommodation in the centre is divided into three distinct units, all named after flowers. The Fuchsia unit (dementia specific) is situated off the main entrance of the centre, on the ground floor of a two story building. The remainder of this building comprises of staff offices, a training room, laundry services and a staff canteen. Hawthorn (male occupancy) and Heather (female occupancy) are adjoined units and are situated in a separate single story building, with a separate entrance. The inspector saw that the centre was exceptionally clean throughout and there was adequate cleaning staff employed, on each of the three units. Overall, the centre was well maintained and there was full time maintenance staff employed. However, a few bedroom walls and door frames were observed to require painting as paint was chipped, which is actioned under regulation 17.

The majority of residents living in Killarney Community Hospital are accommodated in four bedded rooms (78%). The remainder of bedroom accommodation comprises of three twin rooms and eight single bedrooms. Bathroom and shower facilities for all residents living in the centre are situated on the corridors. Residents in single bedrooms that spoke with the inspector expressed satisfaction with the privacy they were afforded. Two of these residents told the inspector that had previously lived in shared bedrooms and they were delighted to now have their own space and comfort. Three residents living in four bedded rooms told the inspector they would love to have their own bedroom and described how it was sometimes difficult to live in a bedroom with three other people. Some other residents told the inspector they didn't mind sharing and they knew the other residents in their room well.

The inspector began the walk around on day one of the inspection on the Fuchsia

Unit, which was home to 18 residents. All the residents living in the Fuchsia Unit were living with a cognitive impairment and were unable to detail and discuss their experience of the service. They were observed by the inspector to be content and relaxed in their environment and in the company of staff. The inspector had the opportunity to speak with two visitors on Fuchsia on day two of this inspection. They both spoke extremely positive about the care that their family member received, particularly about the kindness of the staff working there and the very personalised care they received.

All residents living on the Fuchsia unit were sharing bedrooms, with the exception of one. The inspector saw that some residents did not have adequate space for their clothes in some of these bedrooms. As a result some residents clothes were stored in boxes in the linen press, situated on the corridor. This is actioned under regulation 17.

Communal space for residents in this unit comprised of a dining room and two sitting rooms. The inspector observed that eight of the residents living in this unit were allocated electronic bracelets. The inspector saw that these bracelets when in use, restricted access to the larger communal spaces for residents, as the doors on the corridors locked when a resident approached wearing a bracelet. This practice was seen as overly restrictive and institutionalised. Access to the garden was also seen to be restricted on this unit as the door remained locked. These findings are further detailed under regulation 7.

The first day of this inspection took place on a sunny October day. On the walk around of Fuchsia the inspector observed that rooms were very warm and some windows could not be open, to allow areas to be ventilated. Discussions with staff indicated that this was an ongoing issue and there was not a method in place to monitor the environmental temperature, which is actioned under regulation 17. The inspector saw over the two days that staff working on Fuchsia were very kind to residents and were observed to be interacting in a positive and meaningful way. Residents were observed enjoying music sessions on both days, a movie evening, one to ones with staff and mass on television.

The inspector spent time over this two day inspection observing care practices and meeting with residents and staff on the Hawthorn and Heather unit. Residents living on these units were observed to have their individual style and appearance respected. Residents told the inspector that staff always spent time with them in the morning, supporting them to select their clothing and ensuring that they had everything they needed. It was evident that staff knew residents well and all interactions by staff with residents were seen to be respectful. Residents stated that staff were quick at answering their call bells and they were always respectful in their interactions.

The inspector saw that the walls of Hawthorn were painted blue and it was home to 22 male residents. The Heather unit was painted a bright pink and home to 23 residents. Communal space for the two units consisted of a large dining room and a sitting room, overlooking the car parking facilities. The inspector saw there were some benches to the front of the building, and a few visitors were observed to bring

their family member outside on day one, as the weather permitted. Residents did not have access to or use of a garden.

The inspector observed that with the exception of mealtimes, when the majority of residents came to the dining room, the sitting room was only accessible for use by the male residents. Female residents remained in the dining room or in their bedroom for the day. Activities were seen to take place separately in these rooms, by two members of staff and television was only available in one of these rooms. Therefore, residents were not afforded a choice of alternative communal space, a more varied activities programme and opportunities to converse with residents living in the adjacent unit, which is actioned under regulation 9.

As part of this announced inspection process, residents and visitors were provided with questionnaires to complete, prior to this inspection. The aim of this was to obtain their feedback on the services provided and the care they received. The inspector reviewed these questionnaires as part of this inspection process. In total, nine family members and nineteen residents completed the questionnaires. All residents conveyed that they received excellent care from the team of staff. Some residents described it as a family, praised the individual care they got and acknowledged the time they were always given. Other residents gave suggestions of things that could improve their life such as more walks outside, a garden and one resident requested more fish options and variety on the menu. Residents wrote that they were happy living in the centre, however, some stated they would prefer not to be living in shared bedrooms and they would like more room for their belongings. Family members that completed the questionnaires expressed satisfaction with the care and services being delivered in the centre. One family member stated they felt very reassured that their loved one, who had a cognitive impairment, was being so well cared for by the team of staff.

The inspector spent time observing the dining experience for residents in the three units, over both days. On all of the units mealtimes were seen to be a social experience for residents. Tables were nicely set with coloured table clothes, condiments, cutlery and drinks. The inspector saw that there were adequate amounts of staff available to assist residents. Residents were provided with a choice of meals from a menu that was updated daily and displayed for residents to view. Residents confirmed that they could request other meals such as salads or sandwiches, if they preferred something that was not on the menu. Staff were also observed attending to residents in their bedrooms, to provide support during mealtimes. The inspector saw that the storage of trolleys and equipment made the dining room for residents in Hawthorn and Heather cluttered, which is actioned under regulation 17.

Throughout the two days, residents were observed to be engaged in various activities including music, bingo and games that encouraged light exercise. The inspector observed that activities, designed to be enjoyed by residents who had communication difficulties or who were unable to participate in general group activities, were taking place. Residents told the inspector that they enjoyed a variety of activities. The centre had recently been gifted a three wheeled bicycle. Volunteers attended the centre on a weekly basis and took residents around Killarney National

Park, which they reported they enjoyed. Some residents told the inspector they were facilitated to go home for weekends or out on day trips with family. At residents request they had had some trips out of the centre during the summer to a local beach and to Muckross house.

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

Capacity and capability

This was a two day announced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older people) Regulations 2013. Overall, the inspection found that residents living in the centre received a high standard of healthcare and there was a defined management structure in place. However, action was required to comply with the regulations in relation to training and staff development, personal possessions, the premises, management of responsive behavior and residents rights. These will be detailed under the relevant regulations of this report.

The registered provider of this centre is the Health Service Executive (HSE). There was a clearly defined management structure in place. The person in charge worked full-time in the centre and was supported by an assistant director of nursing, three clinical nurse managers and a team of nursing, health care, household, catering, activity and maintenance staff. The person in charge reported to a Director of Nursing, who also has responsibility for a 34 bedded district hospital, adjacent to the registered centre.

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

The centre was very well resourced in terms of staffing. The inspector found that the levels and skill mix of staff, at the time of inspection, were sufficient to meet the care needs of the residents living in the centre. Clinical nurse managers provided clinical supervision and support to staff on each unit. There was management cover in the centre at the weekends, which was rotated between the management team.

There was a schedule of clinical audits in place in the centre to monitor the quality and safety of care provided to residents. Arrangements were in place to provide supervision and support to staff through senior management presence, induction processes and formal performance appraisals. However, training records viewed by the inspector confirmed that there was a large proportion of staffs mandatory

training expired, which is actioned under regulation 16.

All requested documents were readily available to the inspector throughout the days of inspection. Staff files reviewed contained all the requirements under Schedule 2 of the regulations. Garda vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available in the designated centre, for each member of staff.

Regular management meetings were taking place to discuss key operational issues at the centre. Staff were seen to be knowledgeable about residents' care requirements and regular staff meetings took place. However, there was limited evidence of consultation with residents in the planning and running of the centre, to help inform ongoing improvements and required changes in the centre, which is actioned under regulation 9.

There were systems in place to manage clinical incidents and risk in the centre. Accidents and incidents in the centre were recorded, appropriate action was taken, and they were followed up and reviewed. Incidents, as detailed under Schedule 4 of the regulations, were notified to the Chief Inspector of Social Services within the required time-frame. Written policies and procedure as set out in Schedule 5 of the regulations were in place and available to staff. Each resident had a contract of care that outlined the services that would be provided within the centre, as per regulatory requirements.

Regulation 15: Staffing

From an examination of the staff duty rota and communication with residents and staff it was the found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of the residents living in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Training records reviewed on the day of the inspection did not provide evidence that all staff had received mandatory training. In particular;

- 58% of registered nurses had not completed cardiopulmonary resuscitation training, as per the centres policy.
- 25% of staff were due safeguarding vulnerable adults training.
- over 50% of staff were due management of responsive behavior training.

This was an area also identified as requiring action on the previous inspection of

December 2022.

Judgment: Not compliant

Regulation 21: Records

All records as set out in schedules 2, 3 & 4 were made available to the inspector. Retention periods were in line with the centres' policy and records were stored in a safe and accessible manner. A sample of four staff files were reviewed by the inspector and they complied with Schedule 2.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place to monitor the quality of the service required further action to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. For example:

- the system in place for oversight of the use of of restraint in the centre was not always in line with national policy and did not ensure that the least restrictive option was always used. This is further outlined under regulation 7.
- the oversight of staff training to ensure staff have access to appropriate training as detailed under regulation 16.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A review of a sample of contracts of care indicated that they detailed the services and facilities available in the centre. The contract outlined the fees to be charged and room to be occupied.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose as per regulatory

requirements and it contained the information required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies and procedures as set out in Schedule 5 were in place and available to all staff in the centre. These were reviewed at intervals not exceeding three years, as per regulatory requirements.

Judgment: Compliant

Quality and safety

The inspector found that residents living in the centre received a high standard of medical and nursing care and support that was of an good standard. Residents reported they felt safe in the centre. However, action was required in relation to the use of restraint, personal possessions and ensuring that residents' rights were upheld. These areas will be further detailed under the relevant regulations.

A sample of residents' assessments and care plan records were reviewed. Residents physical, psychological and social care needs were comprehensively assessed on admission to the centre using validated assessment tools. The outcome of the assessments informed the development of care plans that provided guidance to staff on delivery of care to residents.

Arrangements were in place for the service to provide compassionate end-of-life care to residents in accordance with resident's preferences and wishes. There was a dedicated palliate care rooms, in the centre to provide residents with privacy during their end of life. Staff had access to specialise palliative care services for additional

support and guidance, to ensure residents end-of-life care needs could be met.

Residents had access to health and social care professionals such as general practitioners, dietitians, speech and language therapists, physiotherapy. A review of residents records evidenced regular general practitioner reviews and physiotherapy availability. However, there was not availability of occupational therapy services, within the HSE at the time of the inspection. Staff had ensured access to this service via a private provider in response to this deficit.

Risk management systems were underpinned by the centre risk management policy. The policy detailed the systems in place to identify, record and manage risks that may impact on the safety and welfare of the residents. As part of the risk management systems, a risk register was maintained to record and categorise risks according to their level of risk, and priority. Where risks to residents were identified, controls were put in place to minimise the risk impacting on residents.

Significant improvement was required in the reduction of restraint within the centre to ensure it was in line with national policy. This related to the use of wander bracelets and the high use of bedrails, which was a repeat finding. These and other findings will be actioned under regulation 7. A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Any safeguarding issues identified were reported, investigated and appropriate action taken to protect the resident.

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

Residents were supported to continue to practice their religious faiths and had access to newspapers, radios and televisions. However, the inspector found that residents were not always free to exercise choice in how to spend their day. This particularly related to access to communal space, which is actioned under regulation 9.

Residents' nutritional and hydration needs were assessed and closely monitored in the centre. There was good evidence of regular review of residents' by a dietitian and timely intervention from speech and language therapy when required. Systems were in place to ensure that residents received correct meals as recommended by speech and language therapists and dietitians. Information on residents' requirements regarding special diets and correct food consistencies were communicated to the catering staff.

Regulation 10: Communication difficulties

The registered provider had arrangements in place to ensure residents who

experienced communications difficulties were appropriately assessed and supported, to enable residents to make informed choices and decisions. Staff demonstrated an appropriate knowledge of each residents communications needs. Aids and appliances, such as electronic devices, required by some residents to support their needs were provided. Communication requirements were recorded in the resident's care plan, prepared under Regulation 5.

Judgment: Compliant

Regulation 13: End of life

Residents' care preferences for their end of life were discussed with them and recorded in their care plan and there was evidence of general practitioner involvement. Residents spiritual preferences were recorded and residents received spiritual care from the local priest. The provider had ensured there was access to two single bedrooms in the centre, to ensure privacy and dignity at end of life.

Judgment: Compliant

Regulation 17: Premises

Areas to be addressed pertaining to the premises to ensure it complied with Schedule 6 of the regulations included the following:

- there was not a system in place in the Fuchsia Unit to monitor the environmental temperature and some windows in the unit could not be opened, to allow for adequate ventilation of the rooms. This unit was found to be particularly warm on day one of this inspection. Discussions with staff and management inferred that this was an ongoing issue.
- there was limited outdoor space for residents living in Hawthorn and Heather units. Residents feedback in the questionnaires indicated residents living in these units would like additional seating outdoors. This had also been a finding on the previous inspection of the centre. However, it had not been actioned by the registered provider.
- there was not suitable storage facilities for residents personal possessions. In particular, the inspector saw that some residents did not have sufficient space for storing their clothes on the Fuchsia Unit. Therefore, these residents clothes were being stored in the centres linen presses, which did not ensure residents had control over their clothing and it was not person-centred. Feedback submitted from family and residents to questionnaires also referenced the lack of storage for clothing on some units.
- the storage of kitchen trolleys and equipment in communal rooms impacted on space afforded to residents.

- some walls and door frames were observed to require painting.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were offered a varied nutritious diet. The quality and presentation of the meals was good and residents spoke positively about the food. Some residents required special diets or modified consistency diets and these needs were met. Residents spoken with were complimentary regarding the quality and choice of food. Residents weights were being monitored monthly or more frequently if required.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

On review of documentation the inspector was assured that where a resident was temporarily absent form a designated centre, for treatment in hospital, all relevant information about the resident was provided. This information is required to ensure consistency in care delivery.

Judgment: Compliant

Regulation 26: Risk management

The registered provider had a risk management policy in place that met the requirements of the regulation. There was an emergency plan in place to respond to major incidents. The risk register was maintained and updated to manage the risks in the centre. There was an up-to-date risk management policy and associated risk register that identified risks and control measures in place to manage those risks. The risk management policy contained all of the requirements set out under regulation 26(1).

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plans reviewed on the day of inspection were personalised and updated regularly and following a change in residents assessed care needs. Care plans detailed the interventions in place to support residents and manage identified risks such as the risk of malnutrition, impaired skin integrity and falls. There was sufficient information to guide staff in the provision of health and social care to residents based on their individual needs and preferences.

Judgment: Compliant

Regulation 6: Health care

Residents living in the centre received a high standard of evidence of nursing and medical care. Residents had access to general practitioners (GP), weekly and an out of hours service. Physiotherapy is provided on a weekly basis. Services such as speech and language therapy and dietetics were available when required. The inspector found that the recommendations of health and social care professionals were acted upon, which resulted in good outcomes for residents.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Significant action was required to comply with this regulation evidenced by:

- the inspector found that the use of restraint was not in line with national policy and it was high within the centre. For example: the use of wander bracelets for 50% of residents on one unit restricted their access to communal space and their right to mobilise freely.
- where bed rails were in use there the inspector saw there was an appropriate and consent and assessment in place, however, the use of them remained high within the centre at 27%. This was an area identified for improvement of previous inspections.
- a review of a care plan for a resident with a history of responsive behavior did not outline de-escalation techniques, and ways to effectively respond to their behaviours. This residents behaviours were also not being assessed, monitored and documented as per the centres policy.
- from discussion with staff some did not have an appropriate awareness of national guidelines with regard to promoting a restraint free environment and what constitutes a restrictive practice. As actioned under regulation 16, training in this area was due for a large proportion of staff.

Judgment: Not compliant

Regulation 8: Protection

Procedures were in place for the management of residents' monies and locked storage was provided for residents' valuables. The provider supported a number of resident in the centre to manage their pension and welfare payments and the process as described to the inspector was in line with the Department of Social Protection guidelines. Management of residents' finances and invoicing for care was managed robustly in accordance with HSE standard operating procedures.

Judgment: Compliant

Regulation 9: Residents' rights

The following was required to be addressed to ensure residents' rights were promoted and upheld:

- access to the communal space for all residents on the Hawthorn and Heather Unit, to ensure they were offered a choice and had variety in where they spent their day.
- the frequency of residents meeting required review to ensure that residents were consulted in regard to the running of the centre. Records of residents meeting showed that meetings took place on each unit in 2023. However, these were at intervals of up to five months. This was contrary to information in the centres statement of purpose, which stated residents would be consulted with every three months. Some of these meetings also did not evidence consultation with residents.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Killarney Community Hospitals OSV-0000568

Inspection ID: MON-0033208

Date of inspection: 25/10/2023

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: · A new traffic light Excel training matrix has been developed to alert management when staff training is due to expire. · We currently have 2 in house moving and handling instructors and have a third waiting to be trained. All staff will have their refresher manual handling training completed by 31st March 2024 · We also now have four Basic Life Support in house trainers who will be certified to train alone by January 31st 2023. All staff will have their refresher BLS training completed by 31st March 2024 · The two Assistant Directors of Nursing are delivering the responsive behavior education. All staff will have their responsive behavior training completed by 31st March 2024 · Staff who are rostered for, but do not complete mandatory training on time will be subject to a disciplinary procedure as per the new HSE Mandatory Training Policy.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: · Following discussions with the Quality and Patient Safety Team, the Safeguarding Officer and residents' family members, in the interest of safety, considering the human rights of our residents, and to ensure that their will and preference is respected, residents who are at risk of absconding will continue to wear bracelets unless they refuse	

to do so. The bracelet does not restrict the resident from movement within the unit but it activates the entrance/exit door to lock as they approach it.
· The alarm on the middle door in the corridor is being deactivated during the day to facilitate resident's access to communal areas independently.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
· Maintenance have advised that they will have all required painting completed by February 2024.
· As single rooms become available they are offered to the residents who would like a single room.
· Additional storage has been obtained for residents clothes.
· Thermometers have been ordered for each room.
· Additional outdoor seating will be ordered for Spring 2024.
· The layout of the dining room has been changed so the trollies now have an allocated space and the dining room is clutter free.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
· The two Assistant Directors of Nursing are delivering the responsive behaviour education.
· All staff members will receive the training so that they are equipped to deal with any resident presenting with responsive behaviour.
· Regular audits of ABC charts are undertaken.
· All staff will be reminded to familiarize themselves and keep up to date with restraint policy and HIQA restrictive practices guidance.

Regulation 9: Residents' rights	Substantially Compliant

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

· Residents are consulted in regard to the running of the centre at a residents meeting. This will be strictly every 3 months going forward.
· There is a large communal sitting room, and dining room. Each room can be used by residents as they so wish.
· Both activity therapists will now work together with a special emphasis on residents who like to go outdoors.
· Outdoor trips have been increased. The next outing involves the residents' visiting Muckross House for afternoon tea and a drive through Killarney town to view the Christmas lights.
· The availability of a fish option for lunch remains in place. Residents will be reminded of that option.
· Currently there 12 security bracelets and 12 bed rails in place for 63 residents. Each resident has a risk assessment completed before a security bracelet or bed rail is put in place, and they are used for safety measures and protection of residents only.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/03/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	28/02/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/11/2023
Regulation 7(2)	Where a resident behaves in a manner that is	Not Compliant	Orange	31/03/2024

	challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	30/11/2023
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	30/11/2023
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	30/11/2023