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:	Farranlea Road Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Farranlea Road, Cork
Type of inspection:	Unannounced
Date of inspection:	26 June 2023
Centre ID:	OSV-0000713
Fieldwork ID:	MON-0038220

About the designated centre

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

Farranlea Road Community Nursing Unit is a designated centre located near the suburban setting of Wilton, Cork. It is registered to accommodate a maximum of 89 residents. It is a two-storey facility with stairs and lift access to the first floor. Farranlea Road is set on a large site with enclosed courtyards and gardens for residents to enjoy. Residents' bedroom accommodation is set out in four units, Oak, Sycamore and Willow each are 25-bedded units accommodating older adults; and Cedar is a 14 bedded unit accommodating younger residents. Each unit is self-contained with a dining room, kitchenette, day rooms, a quiet sitting room and comfortable resting areas along corridors. The courtyards have garden furniture seating and tables, raised flower beds and shrubbery and paved walkways. Bedroom accommodation comprised single, twin and multi-occupancy wards, all with wash-hand basins, and en suite shower, toilet and wash-hand basin facilities. There were additional shower and toilets and a bath room in each unit. The Café Corner is located near the entrance to the centre for residents to meet with their visitors; the oratory is located alongside this. There is a well presented library on the ground floor. The atrium is a large communal space located on the first floor between Oak and Sycamore units with comfortable seating, where the group activities are held. Residents have access to facilities such as two activities rooms in Cedar unit, one with a therapeutic kitchen with laundry and cooking facilities to support independent living; physiotherapy gym, and occupational therapy room. There is a family room where people can stay, for example, when their relative is unwell or receiving end of life care. Farranlea Road Community Nursing Unit provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, rehabilitation and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	81

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 26 June 2023	09:00hrs to 17:30hrs	Breeda Desmond	Lead
Tuesday 27 June 2023	08:30hrs to 17:30hrs	Breeda Desmond	Lead
Monday 26 June 2023	09:00hrs to 17:30hrs	Siobhan Bourke	Support

What residents told us and what inspectors observed

Overall, inspectors found that, in general, staff were working to improve the quality of life and promote the rights and choices of residents in the centre. Inspectors met with many residents during the inspection, and spoke with 10 residents and eight visitors in more detail to gain insight into their experience of living there. Generally, feedback was complimentary and people expressed satisfaction about the standard of care provided; residents reported that overall, the service was good and staff were excellent. One relative expressed concern about the lack of safeguarding measures in place in one unit and this was further discussed in the report. Regarding meals and food served, the satisfaction surveys reviewed showed that residents requested more variety at mealtimes, in particular, for their evening meal; one resident wrote that food was exceptionally poor; other feedback stated that the taste of some food was poor and often cold. The weekly coffee morning was requested and that had been re-instated, and residents now enjoyed meeting up with their friends from other units in the coffee doc by the oratory.

Inspectors arrived unannounced to the centre and completed the necessary sign-in process and hand hygiene infection prevention and control measures necessary on entering the designated centre. An opening meeting was held with the person in charge and assistant person in charge (ADON) which was followed by a walk-about the centre.

The centre was a large two storey building set out in four units over the two floors (Cedar and Willow on the ground floor; Sycamore and Oak on the first floor), with lift and stairs access between floors. Administration offices, the main kitchen and laundry were to the right of main reception. There was lovely seating by the main reception for visitors to rest. There was a large screen here welcoming people to 'Farranlea' and display a rolling montage of photographs of residents' activities and outings. Another photographic exhibition was displayed of 'Ascot Day in Farranlea' with residents dressed up in their finery and enjoying the festivities in the garden. Grandfather and fathers day was celebrated and photographs displayed showed family and residents enjoying the party in the garden. There was a varied activities programme displayed on each unit.

The Atrium was an expansive space between Sycamore and Oak where larger group activities were held. Lots of residents attended the quiz there on the first morning of inspection. Staff were available to residents while they were enjoying the activity. On another unit, staff provided 1:1 activation in residents' bedrooms and smaller groups attended sonas in the activities room. The inspectors observed two staff sitting outside with two residents chatting and enjoying the sunshine. Other staff walked around the garden with other residents while more residents walked in the garden independently or with visitors. There was ample seating areas for residents to sit and relax and lots of parasols available to provide shade from the hot sunshine.

On the second day of inspection the activity rooms were prepared for a spa day with diffusers with aromatherapy oils infusing, foot spas and tables were set up for hand massage and manicures. Residents had to book their appointment for these as there was such a demand for the different therapies. The day following the inspection an outing was planned. The centre now had access to a bus that can take a maximum of 8 Residents. This includes 3 wheelchairs and 5 seated residents and four staff. A schedule of outings was planned for the summer with short journeys and places further afield for those residents able for the journey. Activities staff were qualified in massage therapy, podiatry, mindfulness, sonas, imagination gym, creative therapies, doll therapy and palliative care which enabled a diverse range of activities for residents to enjoy. A music therapist attended the centre once a week; an art therapist was on site alternate Wednesdays. The previous pet therapy dog had retired and the new dog Ollie was a regular visitor to the centre from the volunteer organisation, the 'Irish Therapy Dogs'.

One resident with whom the inspector spoke, gave very positive feedback about the ADON and how she facilitated his studies with additional electronic aids and readjustment of their environment to enable them to study comfortably. The resident explained that they wished to increase their mobility and had been practicing to increase their muscle strength. While a meeting was held with the multi-disciplinary team (MDT) (including the CNM from the ward) to discuss the resident's request six weeks previously, no one had reverted back to the resident to keep them informed of the decision made regarding his future. In addition, the meeting was held without the resident's involvement in the decision-making process. The ADON went to the resident after this was highlighted and updated the resident on the positive outcome of the meeting. Additional controls were put in place immediately whereby someone would be assigned at the end of the MDT meeting to inform residents of outcomes of discussions, when residents were unable to attend these meetings.

The family room was by reception and was available to families whose relative was receiving end-of-life care. Recliner chairs, tea and coffee making facilities and a microwave were available here. 'Your Service, Your Say' complaints process, information on the complaints officer and suggestion box were displayed at reception. The oratory was located behind main reception. Tea and coffee making facilities and seating with coffee tables were available in front of the oratory. The patio door here opened to the secure garden and new push-button devices were installed both inside and outside the garden to enable residents to freely access the garden and return indoors independently. Many of the bedrooms of Cedar and Willow had their own patio access to the garden. One resident had decorated her patio with an abundance of artwork, potted flowers and hedging and looked gorgeous. Other residents had patio table and chair sets outside their bedrooms. The hairdressers room was located on the corridor leading to Willow and this room remained undecorated.

All units were self-contained with dining room, sitting room, day room, quiet room, and pantry. The smaller quiet sitting rooms on each unit had been temporarily taken over by staff as part of their pandemic precautions and continued to be used by

staff on each unit even though the restrictions related to COVID and pandemic arrangements had ceased some time ago.

Willow, Sycamore and Oak Units each accommodated 25 residents. Bedroom accommodation on these units comprised one four bedded multi-occupancy bedroom, two twin bedrooms and 17 single bedrooms, all with full en suite facilities. Some bedrooms were decorated with soft furnishings, colourful murals, fairy lights and mementos, however, twin and multi-occupancy bedrooms remained clinical. Privacy curtains in twin and multi-occupancy bedrooms were cumbersome and difficult to use and could not be used independently by residents due to their structure and the requirement to release at least 10 breaks to activate them. Some wardrobes only allowed for shirts or blouses to be hung appropriately, anything longer would have been creased and damaged.

Cedar provided accommodation for up to 14 younger adults with complex neurological care needs and all bedroom accommodation comprised single occupancy with full en suite facilities. The occupancy there was maintained at 10 residents. The activity co-ordinators' rooms were within Cedar and these included the sensory room, activity room and occupational therapy room which had a therapeutic kitchen with laundry and cooking facilities. There was a schedule displayed here where people scheduled their time to use the room, for example, those residents who made their own breakfast, baking time, and other activities such as doing their own laundry and using the computer. All of which were supported by occupational therapy. These rooms had patio access to the outdoors or the enclosed garden.

There was a beautiful enclosed garden within Cedar which was maintained by one of the resident's in Cedar. There was an array of flowering plants, herbs and shrubs creating colour and texture throughout the space. Garden furniture and props were painted different colours and looked really well in the garden.

There were seating areas along corridors on each unit with colourful seating cushions; some had lovely delicate painted murals with words of inspiration and encouragement, others had art work displayed. Views of the enclosed gardens could be seen from many of the seating as the corridors had full-length glass windows. Large ornate clocks were hanging in communal areas to enable residents to easily see the time, day and date. Advisory signage was displayed at junctions throughout the centre directing residents to rooms such as the dining room, day rooms, bedrooms nurses station and reception.

On the first floor a roofed terraced garden off Sycamore unit had wall murals, raised flower beds, tables and chairs. These outdoor spaces were easily accessed by residents and their visitors. A number of residents were actively involved in the maintenance and painting of the gardens. Inspectors were informed that there was a multidisciplinary approach to gardening activities in the centre with the physiotherapist and occupational therapist along with the activities co-ordinators enabling residents to remain active. All balconies had transparent storm-glass protection to ensure the safety of residents and relatives. There was a smoking balcony upstairs and inspectors were told that residents had their own fire retardant

aprons. There was no fire blanket on the smoking unit on Oak ward. Laundry trolleys were stored on the corridor of Willow and partially obstructed an emergency escape routs.

Inspectors observed that some dining rooms were pleasantly decorated while others were functional. The menu with choice was displayed on two units, while there was minimal information displayed on two other units. One unit in particular the menu information was beef/ham for their main meal, and sandwich/salad for their tea. On this particular menu board there were detailed instructions for staff regarding their duties around meal times. Tables were not set prior to residents coming to these dining room; while posies of flowers decorated the dining tables on two units, the other two units were devoid of adornment or condiments.

There were assisted bathrooms on each unit with specialist baths. These rooms were seen to be used as store rooms for large equipment such as hoists and could not be accessed by residents.

The laundry was located on the administration corridor; residents' personal clothing and bed linen was laundered off site; kitchen and cleaning mop-heads and such were laundered in-house. There were lots of items stored on top of washing and dryers such as mop cloths, sheets, bags and a pair of runners, even though there was adequate shelving alongside the machines. Some staff were observed to wear watches and rings with stones; and wore long-sleeved garments.

In the cleaners' room there was no handwash sink for staff to use. In addition, mops were stored on the floor as there was no holders to enable mop handles to be stored off the floor.

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

Capacity and capability

Overall, while there was a commitment to provide quality care to support and promote residents' independence, there was a deficit in specialised clinical services to support the 16 younger residents in the centre.

Farranlea Road Community Nursing Unit was a residential care setting operated by the Health Services Executive (HSE). The general manager was the person nominated to represent the registered provider. The person in charge held the post of director of nursing (DON); she was supported on-site by the assistant director of nursing (ADON), clinical nurse managers (CNMs) on each unit, CNM3 on night duty, senior nurses, care staff and administration. Nonetheless, the management structure in place (ADON and CNMs) continued to comprise five acting posts.

In general, inspectors found that while most feedback from residents and relatives was very positive, there was lack of safeguarding oversight of vulnerable residents in the centre. Previous action plans put in place to safeguard residents such as alarms to bedrooms were not consistently activated to enable safeguarding and prevent unauthorised entry into residents' bedrooms; resident safety checks were not routinely completed during the day to be assured that residents were safe and that their needs were met.

This unannounced inspection was part of on-going regulatory monitoring of the service along with receipt of an application to re-register Farranlea Community Nursing Unit. Actions from the previous inspection were followed up and actions completed included temporary absence transfer information was maintained on site and aspects of infection control; some units demonstrated improvement in assessment and care planning process to enable individualised care of residents.

Issues that remained outstanding from the last inspection included:

- governance and management due to the ongoing number of acting management posts
- Schedule 5 written policies and procedures
- inadequate general storage in the centre
- residents' personal storage space in twin and multi-occupancy bedrooms as residents only had access to a single wardrobe which was inadequate in a long-stay residential care setting
- training records remained difficult to establish training completed or outstanding training
- lack of specialised clinical support to enable better outcomes for younger residents; this was further exacerbated with the attrition of psychiatric services including consultant and clinical nurse specialist that were no longer available to the service.

Additional areas for improvement identified on this inspection included governance and management and safeguarding and protection of residents, aspects of fire safety, wound care and residents rights.

The statement of purpose and residents' guide were updated at the time of inspection to ensure compliance with the regulations. The directory of residents had the required information as specified in the regulations. While most Schedule 5 policies and procedures were available, some were not available or out of date. The management team were aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. The person in charge assured that documentation relating to Schedule 2 of the regulations pertaining to staff was in place including vetting in accordance with the National Vetting Bureau (Children and Vulnerable Adults) Act 2012.

The service was a pension agent for six residents and accounts were appropriately maintained to safeguard residents with a local resident account. This included one resident that had died. Records showed that the service liaised with the solicitor for the resident's estate to ensure monies were appropriately returned to their estate.

Monthly meetings were facilitated by the general manager with the other directors of nursing (DONs) in the HSE CH04 area to discuss and share ideas and learning from incidents and other critical events. Quality and Patient Safety meetings were convened quarterly with set agenda items including infection prevention and control. Key performance indicators were maintained to provide oversight of quality of care delivered. These were fed back directly to each unit to provide oversight of clinical care, as well as informing monthly clinical meetings. A variety of clinical audits were scheduled via the Viclarity audit programme and completed on a monthly basis and these results informed the monthly quality meetings. While associated quality improvement plans were developed to facilitate better service for residents, many of the issues highlighted in this report had not been identified as part of the audit process.

Surveillance of healthcare associated infection (HCAI) and colonisation was routinely undertaken and recorded. Monthly monitoring of a minimum data set of HCAI, antimicrobial resistance (AMR) and antimicrobial consumption was undertaken through CHO4. This initiative provided ongoing assurance to management in relation to the burden of HCAI and AMR in the centre. While infection prevention and control audits covered a range of topics including waste and linen management and environmental and equipment hygiene, recent audits had identified issues with environmental hygiene and record keeping. This was an ongoing concern and the person in charge had discussions with the external cleaning provider to remedy the concerns.

A review of staff levels was required as there was a deficit of twilight care hours to ensure appropriate medication rounds, personal care delivery and supervision.

While there were records maintained of staff training, they were unable to provide assurances that all staff training, including mandatory training was up-to-date. Inspectors were able to determine that fire safety training was up to date for all staff, however, other training was not assured.

Regulation 14: Persons in charge

The person in charge was full time and had the necessary experience and qualifications as required in the regulations. She facilitated the inspection in an open manner and demonstrated excellent knowledge regarding her role and responsibility, and was articulate regarding governance and management of the service, resident care and well-being and quality improvement initiatives required to enhance the service.

Judgment: Compliant

Regulation 15: Staffing

The allocation of care hours required review; although inspectors were satisfied there were adequate staff employed, a re-allocation of hours was required to ensure adequate staffing cover in the evenings.

A review of the number and skill mix of nursing and care staff on Cedar unit (10 residents) was requested. Staff levels for this unit were as follows:

CNM2 – 07:45 – 6pm

CNM1 – 8am – 8:15pm

Nurse 8am – 7pm

Mondays and Thursdays an additional nurse was on duty to facilitate doctors rounds.

HCAs – 8am – 8pm x 2

8am – 6:30pm x 1

Night duty – 1 nurse and 2 HCAs

There was a disproportionately high staffing levels during the day and just three staff from 8pm. Cognisant that most of the 10 residents required either one or two staff to provide assistance with their personal care needs, three staff on night duty would be inadequate to ensure appropriate assistance and supervision. In addition, for example, on the days of inspection, six of the 10 residents were off site from mid-morning either at day service or with their personal assistant, leaving six staff to care for three residents; one resident required additional supervision and an additional staff was in place to facilitate this.

The other three units (25 residents each) also had three staff on duty from 8pm to 8am. Cognisant that many residents were high to maximum dependency requiring two staff to provide care, a review of this staffing level was requested to ensure medication rounds and appropriate care could be facilitated.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The training matrix was reviewed by inspectors and it was difficult to determine whether all training was up-to-date. Some staff did not have any dates entered into their records to determine whether they had complete specific training. This was a repeat finding.

Outstanding training included:

- safeguarding x 35 staff which is further outlined under Regulation 8 Protection
- medication management x 2 nurses
- responsive behaviours x 19 staff.

Due to the rostering schedule as detailed in Regulation 15, Staffing, staff could not be appropriately supervised during twilight hours as the nurse on duty was responsible for medication rounds, and several residents were high to maximum dependency requiring two staff to undertake comfort rounds resulting in no staff available to supervise day rooms or answer call bells.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents was maintained in line with the requirements of records established under Regulation 19, Schedule 3.

Judgment: Compliant

Regulation 21: Records

The professional registrations were available for 61 nurses and were up to date.

Judgment: Compliant

Regulation 23: Governance and management

Some of the management systems in place were not sufficiently robust to ensure that the service provided was appropriate, consistent, and effectively monitored as follows:

- the management structure in place continued to have five acting management posts which could not support effective decision making; the condition on the registration of the centre requiring the registered provider to sustain a stable governance and management structure in the centre, remained in place
- concerns relating to fire safety as outlined under Regulation 28
- deficits in the auditing process

- oversight and monitoring of mandatory training
- oversight of safeguarding was not sufficiently robust to provide assurance that residents were appropriately protected, as detailed under Regulation 8, Protection.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was updated at the time of inspection to ensure regulatory compliance. There were smaller quiet sitting rooms on each unit that had been temporarily taken over by staff as part of their pandemic precautions and, at the time of inspection, they continued to be used by staff on each unit even though these precautions had lifted some months previous. These rooms reverted back for residents use following the inspection to ensure the purpose and function correlated with what was specified in their statement of purpose.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge was aware of the regulatory requirement to submit notifications and these were submitted in a timely manner and in accordance with the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

While most Schedule 5 policies were available, a policy relating to handling and disposal of unused or out-of-date medicines was not in place to inform staff on the appropriate measures to take when dealing with such medicines. This was a repeat finding.

The information relating to the overall management of controlled drugs was inadequate to inform practice in line with professional guidelines.

The policy relating to admissions to a designated centre was out of date.

Judgment: Substantially compliant

Quality and safety

Inspectors found that in general, residents were supported to have a good quality of life which was respectful of their wishes and choices. The person in charge was striving to promote a social model of care and to ensure residents were consulted about how the service was run. While there were several examples of this, there were instances where the resident was not consulted or communicated with to enable them to have information about their care, as detailed earlier in the report.

There was ongoing improvement for opportunities for social engagement noted on inspection. The service continued to be part of the 'Wasted Lives' study relating to younger people in residential care as part of the Office of the Ombudsman initiative. The person in charge was continuously engaging with the HSE disabilities services and had opened up many opportunities for additional personal assistant hours, vocational employment and day services for some of the 16 younger adults in the centre. The person in charge facilitated residents access other services such as Headway, Acquired Brain Injury (ABI), Irish Wheelchair association, Links and Cork Independent Living, Enable Ireland, promoting residents' independence and quality of life. The person in charge re-commenced relatives meetings and residents on Cedar asked that they have separate meetings as their needs were different to the rest of the centre; this was facilitated and the first meeting was scheduled for the week of the inspection.

Residents' health care needs were promoted by ongoing on-site access to their GP, and timely referrals and access to allied health professionals such as on-site physiotherapist, speech and language therapist and occupational therapist. Access to a consultant geriatrician was via the Integrated Care Programme for Older People (ICPOP). This was a relatively new initiative by the HSE which facilitated a care pathway for older people to have co-ordinated care planned around their assessed needs and choices. It comprised a multi-disciplinary team that included a consultant geriatrician to support individualised care.

However, timely access to a clinical neuro psychologist was still not available for the younger residents who were living in the centre. Access to this service was via referral by GP, with waiting times of 3yrs. Previously residents had access to a consultant psychiatrist, but this service was no longer available as the consultant redeployed and was not replaced; in addition, the community psychiatric nurse support was also withdrawn.

A sample of care plans were reviewed and these showed mixed findings. Consent was seen to be signed by residents and co-signed by the staff member gaining consent. Validated assessment tools were used to inform care planning. The HSE 'quick screen' falls assessment tool was introduced and was found to be an additional support to assessing residents' care needs. On some units, care planning

and assessments contained personalised information to inform individualised care, but on other units this was not so. There was a lack of oversight of daily care records to ensure residents received care in accordance with their needs. Personal emergency evacuation plans for residents set out the assistance required for the resident during an emergency. Documentation to support a resident when they were temporarily transferred to acute care was evident on inspection.

Monthly multi-disciplinary team meetings regarding restrictive practice were facilitated. Nonetheless, there continued to be a high level of bed-rail restrictive practice in use with 41 of 81 residents with bed-rails in-situ.

Residents meetings were held on a quarterly basis and the person in charge and activities person facilitated these meetings. These were facilitated in each unit and showed good attendances. Minutes of these meetings demonstrated that the person in charge took the time to explain a rights-based approach and issues such as complaints and giving feedback about the service were discussed and encouraged. Following from these meetings, residents gave feedback on many aspects of care including meals and choices. A nutrition meeting was scheduled for later in the week of inspection following feedback from residents surveys. This will be attended by the head chef, catering manager, residents and the person in charge. The residents' survey will be repeated again in August to determine whether the service had improved.

Controlled drugs were maintained in line with professional guidelines. Drug administration records were examined and of the sample seen, these were comprehensively maintained in line with professional guidelines. There was a generic statement on the drug kardex regarding crushing of medications, which is not in line with professional guidelines with best practice.

An independent fire risk assessment was completed and a comprehensive report was provided. The person in charge was working through the associated action plan which was near completion. The main fire alarm panel was located at main reception and this was difficult to access due to the location of the printer. There were local fire panels on each unit; alongside these were legends displaying the location of oxygen outlets. The compartments identified on these did not correlate with fire compartments. As there were no legends relating to fire safety for evacuation purposes, this would be very confusing and had the potential for serious risk. This was remedied at the time of inspection where legends were displayed alongside fire panels to identify compartmentation. Daily fire safety checks were seen to be comprehensively maintained. Quarterly fire alarm servicing records were available, however, other fire servicing records were not on site to enable assessment of fire safety precautions. Other issues identified relating to fire were discussed under Regulation 28 Fire precautions.

An external infection control review was completed and recommendations included the upgrading of the four sluice rooms in the centre. The person in charge explained they were awaiting delivery of new bedpan washers to commence refurbishment of these rooms. Waste and used laundry was segregated in line with best practice guidelines. An internal audit was completed regarding cleaning in the centre and

deficits were identified. The person in charge explained that discussion with the external provider was ongoing to remedy audit findings, however, there continued to be lack of on-site supervision by the cleaning service provider.

Regulation 11: Visits

There were no visiting restrictions in place and current public health guidelines of June 2023 on visiting were being followed. Inspectors met several visitors on both days of inspection. Visitors were seen in different locations both indoors and outdoors visiting residents. Some visitors took their relative out shopping for their upcoming holiday.

Judgment: Compliant

Regulation 12: Personal possessions

Some residents had access to a single wardrobe with some shelving, which was inadequate for people living in long-term residential care. This was a persistent finding over a number of inspection reports. Residents gave feedback in the satisfaction surveys identifying the inadequate wardrobe and personal storage space along with inadequate shelving to display their personal mementos.

Judgment: Substantially compliant

Regulation 17: Premises

There was inadequate storage space to accommodate assistive and other equipment, for example, several specialised chairs, wheelchairs, hoists and laundry bins were stored in the assistive bathrooms and along corridors. This was a repeat finding.

The quiet room on Willow was not available to residents as it was used as a store room.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents' satisfaction surveys reviewed showed that residents requested more variety at mealtimes, in particular, for their evening meal as there was little choice at tea time; one resident wrote that food was exceptionally poor; other feedback stated that the taste of some food was poor and often cold so food was not properly served.

Judgment: Substantially compliant

Regulation 20: Information for residents

The residents' guide was updated during the inspection to ensure compliance with regulatory requirements.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Templates were available regarding transfer of a resident to another care facility which including infection status, previous antibiotic history and multi-drug resistant (MDRO) status. Transfer letters for times when residents were transferred out of the centre to another care facility were maintained on site, and comprehensive information was supplied to the receiving service to enable the resident to be cared for in accordance with their assessed needs, preferences and wishes.

Judgment: Compliant

Regulation 26: Risk management

The risk management policy had the specified risks as detailed in Regulation 28.

Judgment: Compliant

Regulation 27: Infection control

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by:

- a lack of appropriate storage space in the centre. For example equipment was observed in communal bathrooms of all four units
- there were lots of items stored on top of washing and dryers such as mop cloths, sheets, bags and a pair of runners, even though there was adequate shelving alongside the machines
- staff were observed to wear watches and rings with stones; and wore long-sleeved garments; while they had recently completed hand hygiene training, they did not understand 'bare below elbow' concept to enable appropriate hand hygiene
- while there was a weekly schedule for deep cleaning rooms, this schedule was not adhered with to ensure all rooms were adequately cleaned
- there was no handwash sink in the cleaners rooms
- the protective covering of a small number of bed bumpers, bedside chairs and chairs in some communal rooms were worn or torn. These items could not be effectively decontaminated which presented an infection risk.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While some fire safety certificates were available on site, others were not available to inspectors to be assured that fire safety documentation was current. The person in charge had requested this documentation, however, it remained off site. Concerns were identified regarding fire safety as follows:

- fire drills and evacuations records reviewed demonstrated that evacuations of compartments were not undertaken to provide assurances that evacuations could be completed in a safe and timely manner. This was a repeat finding from the previous inspections,
- records of fire drills and evacuations did not provided consistent information regarding the number of staff or residents involved in the drill/evacuation or the evacuation aids used during the practice to be assured that evacuations were completed in a timely manner
- there was no fire safety blanket on the balcony where residents smoked to ensure their safety.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medications requiring to be crushed were not individually prescribed to ensure that only relevant medications were crushed in line with manufacturer's instructions to facilitate appropriate administration to residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While some of the care plans viewed by inspectors were generally comprehensive and personalised, improvements were required in others. For example:

- 'My Health Profile' contained very little information regarding their medical needs to inform assessment and care planning
- the formal evaluation was not comprehensively completed to be assured that the care residents received was evaluated to ensure the care plan remained relevant and effective.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider, having regard to the residents' care plans prepared under Regulation 5, did not provide appropriate medical and health care for residents, in particular, residents under 65yrs, as:

- residents did not have access to specialist services of psychiatry and clinical neuro psychology although there was evidence that it was required
- a high standard of evidence-based nursing care in accordance with professional guidelines was not provided to residents regarding their wound care. Descriptors such as the wound edge, exudate, or wound size were not recorded so it could not be determined whether a wound was improving or not. While there were photographs taken at different times lines, the wound documentation stated that no photographs were taken on these dates,
- one residents was assessed by the tissue viability nurse specialist on 30 March 2023 who recommended that a skin care bundle was commenced on this resident, however, this care documentation did not commence until 20 April 2023. [This care intervention defines and ties best practice together in preventing pressure ulcers and minimises the variation in care practices to enable better outcomes for residents.]
- 2 hourly safety checks were to be completed on one unit to ensure residents were safe. Many of the residents on this unit would be unable to use a call bell or call for assistance due to their significant care needs, however, during the day these 2 hourly checks were not completed consistently to ensure

residents were safe, or that their needs could be addressed in a timely manner
- daily flow charts were in place for staff to record the daily personal care provided to each resident. One chart reviewed at 4:30pm had no record of the care that was given on the day. In addition, the inspector noted that the last time the resident had a shower was on 3 June and the inspection date was 26th June; cognisant that the weather was hot and humid for several weeks, one shower in three weeks was totally inadequate - there was no evidence to suggest that the resident had refused a shower.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

There continued to be a large number of restrictive practice bed rails in use with 41 of 81 residents with bed rails insitu so it could not be assured that restraint was used in accordance with national policy published by the Department of Health.

Judgment: Substantially compliant

Regulation 8: Protection

The inspectors found that the current systems in place in the centre did not ensure that all residents were safeguarded from abuse:

- safeguarding measures including safety checks which had been prescribed were not applied diligently to ensure the safety of vulnerable residents
- safety alarms were not routinely activated as prescribed in safeguarding plans to ensure the safety and wellbeing of residents in accordance with their assessed needs
- the system in place for the supervision of residents was not sufficiently robust
- as outlined under Regulation: 16 Training and staff development, a large number of staff were outstanding safeguarding training.

Judgment: Not compliant

Regulation 9: Residents' rights

Action was required to ensure the rights of residents were upheld:

- multi-occupancy twin and four-bedded rooms were clinical and lacked a homely feeling. They could not accommodate additional personal storage space fitting for people living in a long-stay residential care setting. This was a repeat finding. The results of the recent resident survey completed reflected that their personal storage space was inadequate and the shelving in their bedrooms was either non-existent or minimal to facilitate display of their mementos,
- privacy curtains in twin and multi-occupancy bedrooms were cumbersome and difficult to use and could not be used independently by residents due to their structure and the requirement to release at least 10 breaks to activate them
- some dining rooms were pleasantly decorated while others were functional. The menu with choice was displayed on two on the units, while there was minimal information displayed on two others. One in particular provided sparse information regarding their meals as beef/ham was all that was written for their main meal, and sandwich/salad for their tea. Tables were not set prior to residents coming to these dining room; while posies of flowers decorated the dining tables on two units, the other two units were devoid of adornment or condiments,
- some residents with significant care needs did not have any activation recorded since 25 May 2023 and just four entries for activation in April so it could not be assured that residents were facilitated to engage in meaningful activation.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Farranlea Road Community Nursing Unit OSV-0000713

Inspection ID: MON-0038220

Date of inspection: 27/06/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of Cedar Unit residents' dependency levels and care needs, including social activity schedules and daily schedules, with the external agencies for each resident is being undertaken. There are 10 Residents living in Cedar Unit, each resident has a daily and weekly schedule of social and support service led activities. No two days are the same for the residents in Cedar Unit. While there is a set roster, it needs to be flexible and innovative to consider the residents daily and weekly schedules. The Cedar roster is monitored weekly, with changes and adaptations made as necessary in accordance with the needs of the residents and service demands. On the day of inspection, a number of residents were out of the ward unit on various activities. One resident attends Abode day services Mon – Fri (10am – 15.00hrs). Two residents were out with staff, walking in the rear garden for 30mins approx. Two residents were attending the Spa Day for 1-2 hours that morning. Another resident was out with PA and a resident was also with HEADWAY Support person for 2 hours. The afternoons and evening roster is under review, as this can be a busy time, with residents returning from outings etc. Residents in Cedar, many wish to stay up late, watch tv, chat in day rooms, etc. A Twilight shift from (18.00hrs – Midnight) will be considered as an option for Cedar Unit, going forward. A roster meeting with CNM's from Cedar Unit and ADON to review roster arrangements is planned for 18.07.23.	
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Training & Education including training records, planning, scheduling and staff development, has been assigned to the CNM3 Night Duty. The CNM3 will complete a comprehensive Training Needs Analysis (TNA) across all grades staff in Farranlea CNU, to include mandatory training, and supplementary education and training requirements.
An EXCEL Training Matrix is to be developed for use at ward level in order to provide easy access for CNMs to update training records on a regular monthly basis. The EXCEL will include all Mandatory Training and Supplementary training records for staff per ward.
The Staff Training Records for all staff grades in Farranlea CNU will be held centrally. To support ongoing education and training, a 'virtual education hub' has been created in Farranlea CNU. This facility allows staff to join education sessions on a face to face basis or 'live streamed' from home. This facility enables the MDT on-site, including the Allied Health professionals, Infection and Prevention Control Link Nurse Practitioners, to use this facility, to present and record education sessions and offer the appropriate links to staff on demand.

from August 2023, CNMs will be required to maintain staff training records at ward level to identify staff education and training needs on a monthly Basis. The CNMs at ward level will communicate directly with CNM3 and ADON in providing the staff names, and identifying the training required. CNMs are required to advise Nursing management well in advance of the staff who require the necessary training as it becomes available and this has been confirmed at meetings with the CNMs. The matter will remain as a standing order at meetings with the CNMs.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
the post of Director of Nursing Position in Farranlea CNU has been filled on a permanent basis from January 2023.
Recruitment for a Permanent CNM3 (Night Duty) position is at interview stage (August 2023).
The Outstanding CNM1 Permanent Posts x 3 are also at interview stage, due to be held in August 2023.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Farranlea CNU will review the Medication Policy in relation to the disposal and destruction of regular medications and Controlled drugs in Farranlea CNU.This will be a site specific update.
The Admissions Policy to Farranlea CNU has been reviewed and updated and new version in place.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Provision of adequate storage space for resident's personal belongings and possessions is being reviewed. Existing wardrobes are built in fixtures installed at the time of construction of the unit. Advice has been sought from maintenance Dept. on how to improve space and to create opportunities for storage of non-personal items.
The contracted carpenter (HSE) has been invited on site, to advise on additional shelving that might be considered to wardrobe space – shelves and hanging rails suggested.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A review of items stored on each until will be undertaken by the relevant CNM and furniture and equipment that is required daily will be identified and appropriate storage locations used.
Equipment and furniture that is not currently being used by residents, is to be identified, labelled, and removed to freight container storage facility on site.
overnight storage of large items will be reviewed and incorporated into the nightly cleaning schedules and have equipment and furniture, cleaned and ready for next day.
Decluttering of all areas and spaces is to continue on a weekly (weekend) basis. Nurse management will conduct weekly walkabouts, to ensure the storage of furniture and equipment is not accumulating unnecessarily at ward level.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

With reference to the HSE Better Together, 2022 initiative, we have learned is that meaningful involvement with residents is a continuous two way process and requires closing of the feedback loop. Language is important, moving away from 'representatives' to 'partners'. We must be prepared to recognize lived experiences and share power. Patient /Resident partnership is about building relationships and trust. With this in mind, a Nutrition and Food meeting was held on Thursday 22nd June following HIQA Inspection

Residents were invited and a total of 11 residents attended. The Catering Officer, Chef, Speech and Language Therapist, Asst. Director of Nursing and DON all in attendance. Very good engagement with all in attendance. Minutes available.

Main areas addressed included (i) effective communication between the wards and the main kitchen is crucial to ensure residents' complaints feedback and compliments are communicated (ii) Modified Diets : the balance between risk and enjoyment of food to be considered. Noted that a number of residents, when out with family and friends are having and enjoying normal diet. Level 5 modified diets are now less modified to enhance food presentation.(iii) Improving the dining room experience. Other issues addressed included having (ii) menus on the tables, in Large Font, in all dining room (ii) quality of food Residents were asked as to what choices would they like Those in attendance were satisfied with the meeting content and having their opinions sought. They would like these meetings to continue and the minutes shared. Next meeting to be held in Sept. 2023.

Next Satisfaction Survey will be announced in August 2023.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

Since the inspection, a meeting with maintenance has been convened a number of requests have been submitted , these include:

• Maintenance have been asked to investigate an odour in the quiet room in Willow Unit and provide a report, in relation to its continued use, as a residents' area.

• In accordance with Health Building Note 00-10: Part C – Sanitary assemblies, Janitorial units 2.30 "Janitorial units are a combination of bucket sink and wash-hand basin used by domestic services staff for the disposal of liquid waste. These units are beneficial where space restricts the installation of a separate sink and wash-hand basin"

• Additional shelves and hanging rails for drying cloths – requested.

• Meeting held with Outside Cleaning Contractors on 13.07.23. The findings from the HIQA inspection were discussed.

• Summary on points agreed: Farranlea CNU to include Cleaning staff in the next Hand Hygiene education on site end July.
• Cleaning Contractors to provide Nursing management with a copy of their Uniform Policy and make this available in bullet format to cleaning staff.
• Deep Cleans is to be addressed immediately by Cleaning Company with their managers in attendance. Guarantees were made that this was not acceptable, and that systems were in place to ensure deep clean schedules are adhered to.
• Agreed to have a supervisor on site from next Monday 17th July.
• Next meeting – August 2023.
CNM Meeting on 13.07.23 – CNM's required to check all bed bumpers, furniture for breaks , tears, or signs of age and to remove and replace where necessary.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire Certificates have since been obtained and are on site for the identified outstanding years, 2019, 2020, 2021.
Quarterly Testing equipment documents are available on site.
Fire Maps have been re-designed and have been placed in correct locations.
Fire Trainer to attend Farranlea CNU on 21st July, to provide staff training on correct evacuation drill process. The current Evacuation Drills Templates will be reviewed by the Trainer and a new Template has been requested that will contain all the required information as set out in this report.
Fire Zones Legends have been requested from Fire Prevention Officers on – 11.07.23.
Fire Blanket has been installed and now in place on patio – smoking area Oak Ward.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
CNMs are required to ensure that where medications to be crushed that they are individually prescribed and to ensure that only relevant medications are crushed in line with manufacturer's instructions.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A comprehensive review of care plan documentation is to be undertaken on each Ward. The CNMs are required to (i) ensure a comprehensive audit on care plans is completed by end August. This audit, to include (i) care assessment documentation, (ii) My Health Profile, (iii) transfer documents, and (iv) wound care plans. The findings from this audit will identify areas for improvement, and include action plans with time frames agreed. Workshops for RGNs on the Cork Kerry HealthCare Care plan documentation is planned for September '23.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Following on from the Ombudsman Report: Wasted Lives (May 2021) engagement with Disability Services (HSE) continues. The Disability Services (HSE South) have engaged with referral pathways to access these services as a matter of priority. A comprehensive needs assessment on each of the individual residents under the age of 65years has been completed. Psychiatry and Psychology needs have been included in this assessment of need. The assessments of need have identified the continuing supports and services required to continue with interagency engagement and support in the coming months. In relation to Wound Care, assessments, including descriptions and photographs that are standard wound care practices. CNMs in Farranlea are now required to attend the Wound Care Workshops now available and scheduled to take place on site in Farranlea CNU over the coming 4-6 weeks. CNMs and RGNs in Farranlea CNU will be required to complete identified care modules on www.hseland.ie in coming weeks and months. As indicated, the CNM3 on Night Duty will complete a comprehensive TNA to identify the education and training needs of RGNs and CNMs in Farranlea CNU. Supervison of Health Care Assistants, and recording of care delivered in Point of Care document will be reviewed by CNMs. RGNs are advised to attend Delegation for Nurses in Mercy University Centre of Nurse Education in Autumn 2023. CNMs are required to ensure residents are checked on a regular 2-hourly basis, and this is documented clearly as evidence that the resident has been checked and is safe. CNMs have 2hourly safety checks reminders at safety pause on a daily basis. CNMs will ensure that the point of care document is completed correctly at end of each shift.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
A review of all restrictive practices in Farranlea CNU will be undertaken, in line with the Restrictive Practice Policy and HIQA guidelines on Restrictive Practices and the expected Thematic Inspections on Restrictive Practice due end of this year.
Restrictive Practice Workshops are planned to commence on site with Allied health Professionals and GP's input. The MDT will focus on so far as is reasonably practicable to reduce or eliminate the use of restrictive practices including the number of bedrails in use. The MDT will be advised to use the general principles and guidance documents available to inform and support decision making in relation to use of restraints in Farranlea CNU.
Where restrictive practices are assessed as necessary they will be implemented, where possible, in consultation with the person receiving care and with their informed consent.
Assessments completed will include physical, medical, psychological, emotional, social and environment issues which may contribute to the use of restrictive practices.
An internal audit on the use of restrictive practices, including bedrails has been scheduled for the 1st week in August 2023. The next MDT meeting planned August, will review the current restrictive practices in place.
Each individual restraint risk will be assessed and deemed (i) appropriate (ii) continue or (iii) be removed.
The review of restrictive practices in place will be used as an opportunity to trial alternatives that are less restrictive and or for a shorter period of time.
Each restraint individual to each resident will be documented clearly, consent obtained from resident or representative, and a risk assessment document will be completed in relation to the use of the restraint with a clear review date and made available in resident's care plan.
Access to appropriate training on the use of restrictive practices will be sourced to include prevention and use of alternatives.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Following a recent safeguarding concern, areas of concern have been identified.
The formal safeguarding plans set out in detail the measures in place to protect residents , and to ensure the safety and to prevent risk to all residents on the Unit. The regulator is separately kept advised in relation to specific incidents.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
CNMs have been updated on the requirements for resident involvement and communication on care plans. Suggestions from residents and staff for improvements have been requested. CNMs will ensure that Safeguarding training has been completed by staff assigned to their wards, with records to be maintained at ward level. All care plan documentation is to be audited in coming weeks and months to ensure residents' rights are protected. Referrals to Advocacy services have been requested from CNMs to ensure residents have access to this support. Residents Meetings with DON will continue, and residents will be invited to participate and communicate any concern or issue that relates to their rights as a resident living on long term residential care.
1:1 professional performance achievement discussion are to commence with CNM Grades from August 2023. These performance discussions will include, identifying leadership development programmes available to CNM1, 2, & 3 Grades.
The National Clinical Leadership Centre for Nursing & Midwifery (ONMSD,HSE) have a suitable programme available for Autumn and Winter 2023

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Not Compliant	Orange	30/09/2023
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	31/08/2023

Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/10/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/09/2023
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	30/09/2023
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	30/09/2023
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	30/09/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in	Substantially Compliant	Yellow	30/09/2023

	accordance with the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/10/2023
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.	Substantially Compliant	Yellow	30/09/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/08/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/08/2023
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for	Substantially Compliant	Yellow	30/09/2023

	testing fire equipment.			
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.	Not Compliant	Orange	31/08/2023
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	30/09/2023
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/09/2023
Regulation 04(3)	The registered provider shall review the policies	Substantially Compliant	Yellow	30/09/2023

	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.			
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	31/08/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not 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.	Substantially Compliant	Yellow	30/09/2023

Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	31/10/2023
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	31/10/2023
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.	Substantially Compliant	Yellow	31/10/2023

Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/09/2023
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	30/09/2023
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Substantially Compliant	Yellow	30/09/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	30/09/2023