Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	St. Anthony's Unit
Name of provider:	Health Service Executive
Address of centre:	Glenconnor Road, Clonmel, Tipperary
Type of inspection:	Unannounced
Date of inspection:	24 August 2022
Centre ID:	OSV-0007836
Fieldwork ID:	MON-0037155

About the designated centre

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

St. Anthony's unit is owned and operated by the HSE and is registered to provide care to 18 residents. It is located on the outskirts of the town of Clonmel on an elevated site with beautiful views of the mountains and local area. The centre is a single storey facility and bedroom accommodation is provided in four single rooms, a twin room and three four-bedded rooms. There is a very large communal room at one end of the building that provides lounge, dining room and activities facilities. The service caters for the health and social care needs of residents both female and male, aged 18 years and over. St Anthony's unit provides long term care, dementia care, respite care, convalescent care and general care in the range of dependencies low / medium / high and maximum. The service provides 24-hour nursing care. Two designated palliative care beds are a recent addition to the care provided in the unit.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 24 August 2022	09:15hrs to 17:45hrs	Catherine Furey	Lead

What residents told us and what inspectors observed

As part of the inspection process, the inspector observed staff practices and interactions with residents, and where possible spoke with residents and their families to gain an insight into the overall experience of living in St. Anthony's Unit. From these observations, and from what the inspector was told, it was clear that there was a high standard of nursing care provided in this centre. Feedback from residents and families were positive about their experiences.

This was an unannounced inspection to monitor the centre's compliance with the regulations and standards and to follow up on the actions outlined in the centre's compliance plan, following the previous inspection in March 2021. On arrival in the morning, the person in charge met with the inspector, and following a brief screening for signs and symptoms of COVID-19, welcomed the inspector into the premises. From walking through the centre in the morning, it was clear that the centre was well-staffed and residents were being attended to promptly on request. The person in charge outlined that of the 16 residents accommodated in the centre on the day, a large majority had some level of cognitive impairment. Fourteen of the residents were assessed as maximum dependency level and were partially or fully immobile and requiring a high level of support.

Many of the resident were unable to voice their opinions to the inspector, however from observation throughout the day, these residents were seen to appear content and comfortable in their surroundings, seated in appropriate comfortable support chairs, and appearing well-dressed and groomed. Residents who could voice their opinions, were unanimous in the staff describing them as "the best" and describing them as excellent. Residents reported feeling safe in the centre. Interactions between staff and residents were friendly, yet respectful, and there was an unhurried and calm atmosphere in the centre. Staff knew the residents well, and residents were happy in their company.

The centre is laid out on the ground floor, with easy access to the main communal area from each bedroom. A very small number of residents could mobilise independently, and the inspector observed staff providing encouragement with this, offering assistance and maximising independence where possible. The main communal area is bright and airy with beautiful views and residents spent a lot of time here during the day. There was photographs of recent outings to Mount Mellary, Cahir Castle and a local garden centre on display. One resident said the outings were great days out for all. This room serves a dual purpose, being both a dining and a sitting room. A new large screen television had been purchased where residents could watch news and popular programmes, and could access streaming Internet services. Tables were laid prior to mealtimes and residents enjoyed a satisfactory dining experience. Some residents remained in their rooms for meals, and the inspector was informed that this was at their request, or due to the level of assistance they required at mealtimes. These details were not observed in the residents care plans therefore the inspector could not validate that these were the

residents' wishes. Food was delivered prior to each meal from an external facility in the local acute hospital and served to residents warm from a heated bain marie. This food was seen to be nutritious and wholesome and was presented in a satisfactory manner.

Residents bedroom accommodation was contained in four single, one twin, and three four-bedded rooms. These rooms exceeded the minimum floor space criteria, however, as identified on the previous inspection, the inspector observed that these rooms were more typical of an acute setting, and required more work to ensure a personalised and homely ambiance for all residents. One single room was devoid of any additional display shelving or furniture, and contained only the minimum required furniture and bed. There was no paintings, decorations or personal items on display. Additionally, storage space, particularly in the four-bedded rooms was minimal. Additional plastic storage drawers were in use for some residents however these appeared as a temporary solution and they were not suitable as permanent bedroom furniture. There had been noted improvements in overall storage of equipment in the centre, and there was good organisation and dedication of spaces for linen, personal care items and supportive equipment. Areas requiring decorative upkeep in the centre had been well-maintained since the previous inspection and every are of the centre was exceptionally clean.

Dedicated activity hours had increased, and on the day of inspection a dedicated activity coordinator led activities in small groups, including exercise and ball games designed to aid hand-eye coordination, and individual dementia-specific therapies in residents rooms. One activity noted on the weekly schedule was listed as "walks outside". The lack of sufficient accessible garden space meant that generally, spending time outdoors was a scheduled activity, and not something that could be enjoyed by residents at their leisure. A small area to the front of the centre was dedicated for resident use. Efforts had been made to decorate this area with plant pots and a small table and chairs. Portable partitions were available to section off the are from oncoming cars. Despite the beautiful views of the mountains, this area was insufficient and unsafe.

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

The overall governance and management of the service required further strengthening to ensure a consistently safe and effective service was provided to residents. The inspector followed up on the compliance plan submitted following the last inspection in March 2021, and found that a number of the actions outlined in the plan had not been implemented. Similar findings of non-compliance were found in relation to;

- Regulation 17: Premises
- Regulation 23: Governance and Management

Additionally, a lack of action to implement the outlined compliance plans, and further issues identified on inspection found that the following areas had increased from substantially compliant to non-compliant;

- Regulation 28: Fire precautions
- Regulation 9: Residents' rights

Other areas for improvement identified during the inspection included staff training, management and oversight of staff files, access to health care professionals, person-centred care planning and the management of behaviours that challenge. These are discussed further throughout the report, under the relevant regulations.

Historically, St. Anthony's Unit was registered with HIQA as part of the larger St. Patrick's Hospital in Cashel. As part of a restructure of services in the area, St. Anthony's Unit was registered as a separate designated centre in August 2020. The registered provider is the Health Service Executive (HSE). The senior management team shares responsibility for St. Anthony's Unit and the residential services based in Cashel. There has been recent changes to the senior management of the centre and to the management team within the centre on a daily basis. A new person in charge was appointed in February 2022. This was the third change of person in charge since the first registration of the centre. The person in charge is a clinical nurse manager and reports directly to the director of nursing based over the two services. The director of nursing was appointed in March 2022. Regular management meetings had taken place during the changes in the governance of the centre and the director of nursing is available to visit the service, to provide support. On a daily basis the person in charge is supported by a team of experienced nursing staff, health care assistants, activity coordinators and domestic and catering staff teams. The arrangements for the management of the centre in the absence of the person in charge required review, as discussed under Regulation 23. No annual review of the quality and safety of care had been completed for 2021. As the centre was registered in late 2020, there had been no review completed for that year, as outlined in the previous inspection report. This meant that there has been no documented quality improvement plan outlined for the service since first registration.

St. Anthony's Unit is a small centre which is registered to accommodate 18 residents, including two dedicated palliative care beds. The management team liaises directly with the palliative care consultants in South Tipperary General Hospital to admit residents, largely from the local area, for active palliative care services. There were 16 residents residing in the centre on the day of the inspection. The inspector acknowledged the dedication of the staff in successfully keeping the centre free from an outbreak of COVID-19 during the global pandemic. There was a contingency plan in place, ready for implementation should this occur. This was kept up-to-date by management with changing national guidance. Protocols remained in place for the regular testing and surveillance of staff and residents. The HSE infection control nurse for the area was assisting the centre's staff to sustain the

high levels of good practice and preventative measures in place to minimise the spread of infection.

Overall, there had been improvements in relation to the provision of training for staff. The training matrix supplied to the inspector showed that the majority of staff had completed mandatory, appropriate training modules. Nonetheless, there was gaps in the training records for fire safety and the management of behaviours that challenge, which are required by the regulations. The centre was implementing some quality improvement initiatives, and maintained a record of key clinical areas that were monitored weekly, for example, falls, incidents and wounds. However, there were elements of the service that were not being captured during routine auditing, for example audits of care plans did not identify the issues seen on inspection. Owing to the low numbers of residents in the service, and the good staff to resident ratio, there was a very low number of incidents and accidents occurring in the centre. Records showed that those that did occur were well-managed, with appropriate notification to HIQA as required. The person in charge outlined that there had been no recent complaints made, and that any minor issues that may come to the attention of staff from residents or their families, were dealt with promptly, thus not reaching the level of a complaint.

Regulation 14: Persons in charge

The person in charge of the centre had commenced the role in February 2022. She held the necessary qualifications and experience to fulfil the requirements of the role. Nonetheless, the person in charge was not currently working in a full-time capacity in the centre. This is discussed further under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 15: Staffing

Having regard for the design and layout of the centre, and based on the residents' current dependency levels, the inspector found that there was a sufficient and appropriately-skilled level of staff rostered daily to meet the assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Improvements were required to ensure all staff had training appropriate to their role. For example;

- Not all staff had completed training in the management of behaviours that challenge, as required by Regulation 7
- Not all long-term agency staff had completed centre-specific training in fire safety, including participation in evacuation drills.

Judgment: Substantially compliant

Regulation 21: Records

Staff records required under Schedule 2 of the regulations were maintained securely in an off-site facility. Requested records were made available to the inspector during the inspection. In the sample of four files reviewed, one file did not contain the required vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were long-standing governance and management systems in the centre which did not provide assurances of adequate oversight of the service. This was a repeat finding from the previous inspection in March 2021. Issues in relation to the governance and management of the centre included:

- The person in charge did not currently work in a full-time capacity in the centre. There were no other assigned management personnel working in the centre. There were no contingency arrangements for a staff member in the centre to act as person in charge during planned or unplanned absences.
- The person documented as deputising for the person in charge was the director of nursing. However, she had oversight of another designated centre, and could not dedicate herself solely to the services in St. Anthony's Unit for extended periods of time
- There was continued lack of oversight of key areas including fire safety, staff training and care planning, as seen on the previous inspection also.
- There was no annual review of the quality of care delivered in 2021 completed. Therefore, the centre had no documented action plan to improve service provision in 2022. Residents and their families had not completed feedback on the service, which is used to inform the annual review.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of the centre's incident and accident reports found that all events requiring notification to HIQA had been made in accordance with regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The centre had had no formal documented complaints logged since the previous inspection. The policy and procedure on complaints was clearly documented, with nominated individuals designated to oversee the complaints process and details of a comprehensive appeals process. The complaints procedure was clearly displayed in the main entrance, and throughout the centre for residents' and relatives' attention.

Judgment: Compliant

Quality and safety

Overall, residents in the centre were treated with kindness and respect by dedicated staff who provided high-quality nursing care. The inspector identified that the challenges associated with the lack of safe outdoor space impacted negatively upon the rights of the residents. Improvements were required to ensure that all residents had equal opportunities to access the outdoors, and to ensure that privacy and dignity was promoted and maintained in shared bedrooms. This is discussed further under Regulation 9: Residents' rights.

Overall, the centre was maintained to a very high level of cleanliness throughout. Cleaning schedules were in place and there were two cleaning staff on duty each day. Staff were knowledgeable about the specific products, equipment and methods required to ensure the centre was adequately cleaned and decontaminated. All staff were observed to be wearing personal protective equipment (PPE) such as surgical face masks correctly. Hand hygiene sinks and alcohol hand gel dispensers were available for staff at convenient locations throughout the centre. These sinks were of a high specification and met best-practice criteria for clinical handwashing. Hand hygiene and other important infection control notices were displayed throughout the centre.

The centre was well laid out and there were wide corridors with assistive handrails and orientation signage. The communal areas were bright and spacious. The décor in the centre was well-kept and there was minimal wear and tear to furniture and fixings. Nevertheless, there were a number of improvements that were required to ensure that the premises was appropriate to the needs of the residents and in accordance with the centres statement of purpose. These issues had prevailed since first registration of the centre, and are outlined under Regulation 17: Premises.

Good access to medical services were provided, with regular visits from the local medical centre's general practitioner. Regular reviews of medication and changing health needs were recorded and updated in residents individual care plans. There was continued liaison with the local acute services and residents were facilitated to attend outpatient clinics and appointments as necessary. While access to some health and social care professionals such as speech and language therapy and dietetics were good, and residents were reviewed in a timely manner, access to physiotherapy and occupational therapy services was subject to long community waiting times. Following the last inspection, the registered provider had given assurances that access to physiotherapy would be provided on a regular basis. This had not been completed, and was only currently in the process of being addressed. This is discussed further under Regulation 6: Healthcare.

Evidence-based assessment tools were used to assess for various risks, including risk of malnutrition and falls. These were updated on a monthly basis and were seen to be updated sooner if there was a change in a resident's condition. Residents' care plans continued to require review to ensure a person-centred approach to care delivery. Detail and personalisation of care plans varied greatly. Some care plans were formatted from a historical template used in the acute services which did not support individualised care planning. There was a centre-specific restraint policy which promoted a restraint-free environment and included a direction for staff to consider all other options prior to its use. Despite this, the bedrail risk assessment tool in use did not include the trialling of less-restrictive alternatives such as low-profiling beds and alarm mats were in use. These alternatives were available, and were seen in use on the day, however the consistently high bedrail use, coupled with an ineffective assessment tool, did not provide assurance that the centre was committed to promoting a restraint-free environment.

Some aspects of fire safety in the centre were well-managed. There was fire evacuation maps throughout, and a log of daily and weekly checks of means of escape and fire fighting equipment was maintained. Each resident had a personal emergency evacuation plan and these were updated regularly, detailing the method of evacuation and the level of assistance required. Nonetheless, fire safety risks remained, and these are detailed under Regulation 28: Fire precautions.

There was a schedule of varied activities on offer throughout the week. This was led by dedicated activity staff six days, and on Sundays the nursing and healthcare staff ensured residents enjoyed a suitable activity. The activity programme included art and crafts, dementia-friendly Sonas therapies, and chair based exercises.

Improvements were required to ensure all residents had a social activity assessment in place, as detailed under Regulation 5: Individual care plan and assessment.

Regulation 11: Visits

Visits to the centre were occurring on the day of inspection, and the current visiting procedures were not posing unnecessary restrictions on residents.

Judgment: Compliant

Regulation 17: Premises

The external grounds of the centre did not contain outdoor space that was suitable for, and safe for use by, residents. The main door opened directly onto a road, and other external doors opened into car parking areas and loading bays. While efforts had been made to dedicate an area at the main entrance for resident use, the inspector observed that this area was not safe, and additionally, staff reported that not all residents, particularly those using high-support wheelchairs could easily access this area.

Residents' storage spaces for clothing and personal items were insufficient, as only one narrow wardrobe and a locker were provided at a residents' bedside. This was a repeat finding, and the provider had outlined in their previous compliance plan that this was due to be completed by May 2021. The person in charge outlined that work had commenced on measuring spaces for additional wardrobes, but there was no time-bound plan for their completion.

The design of the centre was not in keeping with the centre's Statement of Purpose which outlines that care will be provided in a homely setting. Some areas of the centre had an institutionalised and clinical environment, which was more in keeping with a hospital ward, and not conducive to a residential care setting. For example;

- Residents' daily documentation records were held on clipboards and stored on the handrails on the corridor outside each room
- One area of the centre contained inappropriate medical equipment which was not in use, and detracted from the homely environment
- Some residents' rooms were devoid of personalisation and were clinical in appearance, with no spaces or shelving to display objects, pictures or photographs.

Judgment: Not compliant

Regulation 27: Infection control

The designated centre was cleaned to a high standard, with well organised cleaning schedules and routines. A staff nurse was assigned as the infection control link nurse, and was afforded protected time each month to complete infection control audits including observational audits and audits of practice. There was evidence that practice improved on re-audit. The link nurse liaised with the local area HSE infection control nurse, to support staff to implement infection control measures in line with the standards for the prevention and control of healthcare associated infections published by HIQA.

Judgment: Compliant

Regulation 28: Fire precautions

At the time of the inspection, the registered provider had not taken adequate precautions to ensure that residents could be safely evacuated in the event of a fire, as evidenced by the following:

- The 2022 quarterly servicing records of the emergency lighting system in the centre had been completed, and records indicated that on each occasion, a recommendation was made that extra coverage was required. This had not been addressed. The most recent quarterly servicing report stated that a the system required a full upgrade.
- While oxygen storage within the centre had been improved since the last inspection, the storage of an excessive amount of oxygen cylinders externally had not been addressed. These were stored outside, directly adjacent to open windows, opening into the centre's largest fire compartment. Additionally, while only two oxygen cylinders were stored inside the centre, these were stored on the corridor in the largest compartment, further increasing the risk in this area.
- Fire drills in the centre were being conducted, however, these had failed to address the high-risk fire compartment containing 10 residents. An evacuation drill was conducted in this area following the inspection and the evacuation time did not provide assurances that the area could be safely evacuated in a timely fashion. Further, regular fire drills of this nature are required to ensure all staff are competent to carry out an evacuation in this area.

The person in charge outlined that a recent fire safety risk assessment had been completed by a fire safety professional and the report of this was awaited.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Based on the review of a sample of resident's care plans and assessments, a number of issues were identified, which were the same findings as the previous inspection:

- Care plans were not always person-centred in nature, with many referring to "the patient" and "the client" as opposed to the resident's individual name
- Care plans were not personalised with enough detail to fully direct staff to provide appropriate care
- There was no detailed social assessment in use which addressed residents social and activation needs. As such, there was no clearly individualised plans for occupation and recreation in place.

Judgment: Substantially compliant

Regulation 6: Health care

Despite community-based physiotherapy and occupational therapy services being outlined as freely accessible in the centre's statement of purpose, the person in charge outlined that there had been extreme delays in accessing these services for residents in the centre. This had been an ongoing issue prior to the person in charge commencing in February 2022. Staff stated that the delays had resulted in residents not receiving the recommended physiotherapy plans, and being unable to access suitable supportive seating.

The registered provider had recently taken some steps taken to reduce the impact to residents, for example, a private physiotherapist had been recruited and was due to commence in the next month. Discussion were ongoing in relation to procuring private occupational therapy services. This was important as the majority of residents were maximum dependency and required specialist input in relation to seating and support.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Similarly to the previous inspection, there was high instances of bedrail usage in the centre, with ten of the 16 current residents using full length bedrails. A review of the risk assessment process before applying bedrails identified that these were not consistently used in accordance with national policy as published by the Department

of Health. For example, records showed that alternatives to bedrails were not always trialled, the risks involved with using the bedrail were not documented, and the specific circumstances under which the bedrail was being applied were not detailed.

A care plan was being developed for a resident displaying behaviours that challenge associated with a diagnosis of dementia. As described under Regulation 5: Individual care plan and assessment, the care plan in place was generic in detail and did not sufficiently detail the antecedents to the behaviour, and the known techniques to manage the behaviour in a non-restrictive way. Nursing and healthcare staff records detailed good documentation of these behaviours in Antecedent - Behaviour-Consequence (ABC) charts, however there was no clear process in place to evidence that person-centred interventions were trialled before PRN (as required) antipsychotic medication was administered as a means to control the behaviour.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider did not provide sufficient facilities for occupation and recreation as follows; ?

- There continued to be no safe, enclosed outdoor garden space for residents' use. While some residents were assisted to go for walks nearby with staff, other residents had limited access to the outdoors. This is also discussed under Regulation 17: Premises

The inspector found that residents were not consistently consulted with about the organisation of the service as follows; ?

- A large number of residents with a cognitive impairment did not have a formal mechanism to voice their feedback, for example through regular family surveys or questionnaires
- As discussed under Regulation 23: Governance and management, feedback had not been sought and used to develop an annual review of the service provided to residents

Residents who were accommodated in the centre's four-bedded rooms could not always undertake personal activities in private;

- The configuration of some of these bedrooms required review, for example; only one television was provided in these bedrooms, and this was not easily seen from each bedspace, as it was partially obscured by the screening curtain rail.?

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St. Anthony's Unit OSV-0007836

Inspection ID: MON-0037155

Date of inspection: 24/08/2022

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff Training on Behaviors that challenge and Fire training for long term agency staff will be completed by the 17th November 2022.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The File that did not contain vetting disclosure has now got that disclosure since August 24th 2022.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Approval sought for post of C.N.M1 for St Anthony's to Manage when Person in charge is absent or leave by November 18th 2022. Designated Person in charge works full time capacity and will be identified on Roster. Residents and their families had completed feedback survey on early August 2022 and	

next feedback survey will conduct on November 17th 2022.
Annual Review will be completed for year 2022 to 2023 in December 17th 2022.

Consultation will take place with families who have Residents with a cognitive impairement through use of surveys/questionnaires with results/findings completed by 0ctober 31st 2022.

Review will take place in relation to configuration of the four bedded rooms in relation to placement of Television by October 24thth 2022.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A meeting with Estates, Technical Services personnel and QPS Manager has been scheldues to examine provision of an appropriate external recreational area with exit from the current Day Room. Meeting arranged for week beginning 17th of October 2022 with a proposed completion before year end 2022.

Installation of Personal Wardrobes/ Shelving for Residents to be completed by October 30th.

Medical Equipment i.e. Resus trolley & oxygen cylinders were removed with immediate effect on August 24th 2022 and new seating arrangement in place instead of that for residents to relax.

Resident's daily documentation records were moved from corridor to nurse's station with immediate effect on August 24th 2022.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Patient Evacuation: Training completed September the 1st by provider Maurice Johnson Partners with specific attention to Compartment evacuation.
The Compartment containing 10 residents in 3 ward rooms. This has been noted as "high risk". With the removal of the portable oxygen from the corridor, this may no longer be considered so in the view of the HSE Fire Officer. Reason: Each of the 3 ward rooms within the compartment are built within 1 hour rated walls/partitions and each protected by doors FD30s with closers linked to FDAS.
Room 1 has its own external exit within the room as well as a compartment exit within

10m.
Room 2 has a compartment exit within 5metres and an external exit within 1.5metres.
Room 3 has a compartment exit within 2 metres.
During the recent drill training the largest room of 4 residents has been bed evacuated to adjacent compartment within 2 minutes. The other 2 rooms were unaffected due to fire doors but were evacuated out of the compartment in a controlled fashion.
Regular evacuation drills based on this training are been conducted to ensure all staff are competent to carry out the task. Staff and management in consultation with the Fire Officer are continuing to improve patient evacuation outcomes. Additionally a Pre Fire Planning document is being completed of St Anthony's for Clonmel Fire Service. A familiarization visit has also been offered.

Portable Oxygen Storage: Internally- the two portable oxygen cylinders stored inside the center on the corridor were removed with immediate effect and reduced the risk.
Piped Oxygen: Externally - An assessment of Oxygen requirements is ongoing and storage of any excessive amount of oxygen cylinders externally will be removed by 30th October 2022.
Currently the fixed line piping system is being adequately maintained by BOC. Staff are aware of the location of the emergency shut off device at the staff base. Storage of Oxygen cylinders is within the manufactures guidance, well ventilated, away from all other combustible materials, aerosols or electrical switch gear. This will be reviewed by the HSE Fire Officer post Oct 30th 2022.
Emergency Lighting: The current system is providing the appropriate cover based on its installation under IS3217:2008. It is being maintained and serviced under the most up to date code of IS3217:2013+A1:2017. It is in this context that additional lighting would be required if the unit was to be installed today. The Service Engineers recommendations noted had been fed into the Technical Services team. An upgrade has been agreed by the Fire Officer. An application for funding to upgrade the EL system has been included in the 2023 Fire Capital Programme.

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:
Currently another unit St Claire's in Our Lady's campus is the pilot site for introduction of a more comprehensive assessment and person centered care plans. Due to time needed for planning and education the aim is to have these care plans introduced permanently in St Anthony's by April 19th 2023.

Activity sheet and care plan addressing the resident's social and activity levels now introduced 22/09/2022 and will be completed for all residents by October 30th 2022.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: Private Occupational Therapist and Physiotherapist services are in place for the Residents in St Anthony's from 1st September 2022. Physiotherapy service commenced one day (Thursdays) per week since 1st September 2022. Occupational therapy assessments were completed for the residents who required suitable supportive seating on 14th & 15th September 2022 and future OT service are available without any delay as required for the residents.

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: New documentation including bed rail risk assessment tool to be introduced for Restrictive practice by November 19th 2022. Staff education and training will be given in relation to restrictive practice. A detailed person centered care plan were completed for the resident who are displaying behavior's that challenge September 29th 2022. A clear process in place now to follow the person centered interventions before administering the PRN antipsychotic medications and staff are completing a detailed ABC charts.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Residents and their families had completed a feedback survey on month of July- August 2022. Consultation will take place again with residents and families who have Residents with a

cognitive impairment through use of surveys/questionnaires on November 7th 2022.

Annual Review will be completed in December for year end 2022 to2023.

Review will take place in relation to configuration of the four bedded rooms in relation to Placement of Television by October 24th 2022.

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.	Substantially Compliant	Yellow	17/11/2022
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	17/10/2022
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	17/10/2022

Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	24/08/2022
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	18/11/2022
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	17/11/2022
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with	Not Compliant	Orange	17/12/2022

	relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	01/11/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	01/09/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	01/09/2022
Regulation 5(1)	The registered provider shall, in so far as is	Substantially Compliant	Yellow	19/04/2022

	reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).			
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	15/09/2022
Regulation 7(2)	Where a resident behaves in a manner that is 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.	Not Compliant	Orange	29/09/2022
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	Not Compliant	Orange	19/11/2022

	Health from time to time.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	17/10/2022
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	24/10/2022
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	07/11/2022