Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Prague House
Name of provider:	Prague House Care Company Limited By Guarantee
Address of centre:	Chapel Street, Freshford, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	05 April 2022
Centre ID:	OSV-0005447
Fieldwork ID:	MON-0035421

About the designated centre

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

Prague House is located on Chapel Street, Freshford, Co. Kilkenny. The centre is a two-storey building that is registered to accommodate 22 people. The management of Prague House is overseen by a Board of five Directors. The centre caters for men and women from the age of 60 years. The statement of purpose states that the centre does not provide 24-hour nursing care, and provides low-medium dependency care 24 hours a day. The statement of purpose states that care is delivered in a homely, comfortable and hygienic environment. The centre manager is employed to work on a full-time basis. Residents do not require 24-hour nursing care, and care is provided by a team of trained healthcare professionals. According to the centre's statement of purpose, all applicants for admission must be mobile, and mentally competent at the time of admission. Each resident is provided with single bedroom accommodation.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 5 April 2022	09:30hrs to 17:30hrs	Noel Sheehan	Lead
Tuesday 5 April 2022	09:30hrs to 17:30hrs	Bairbre Moynihan	Support

What residents told us and what inspectors observed

On the day of the inspection the inspectors noted that residents were supported to enjoy a good quality of life by staff who were kind and caring. There was a welcoming and homely atmosphere in the centre. The overall feedback from the residents was that they were happy with the care provided by staff. Residents spoken with by the inspectors said they were happy with the care they received in the centre and with their quality of life. There was evidence to show that residents were offered choice in many aspects of their care, such as what meals they would like to eat and their individual choices. Residents could come and go as they pleased but would require the assistance of staff to enter or exit.

On arrival to the centre, the inspectors were met by a staff member who ensured that all necessary infection prevention and control measures, including hand hygiene and temperature check were completed prior to accessing the centre. Alcohol hand gel was available on entry at the front door and at regular points throughout the centre. Hand hygiene sinks were limited throughout the centre and were not available at the point of care for staff to clean their hands. The centre had recently experienced an outbreak of COVID-19, all staff and residents had completed their isolation period, and the outbreak was officially declared over. Normal day-to-day routines had returned to the centre. Following an opening meeting with the person in charge, the inspectors were guided on a tour of the premises.

Prague House Care Centre provides long term care to both male and female residents with low or medium care needs. The centre is situated in the middle of Freshford, Co. Kilkenny. The village is readily accessible to the residents of Prague House. The centre was originally a school and had been adapted over time to accommodate residents. It is a two storey facility with 17 single bedrooms on the ground floor and 5 single bedrooms on the first floor and is registered to accommodated 22 residents. Two of the bedrooms located on the ground floor have en-suite facilities. The remaining bedrooms in the designated centre have wash hand basins in the room and residents in these rooms share access to communal bathrooms. On the day of inspection, only the ground floor bedrooms were occupied.

On the walk about of the centre the inspectors observed a friendly, relaxed and calm atmosphere throughout. The inspectors spoke with a number of residents during the inspection who said that they were happy in the centre and that the staff were always kind and helpful to them. Residents indicated that they felt safe and that they could raise concerns, if they felt the need to do so. Staff reported it to be a very good place to work.

Residents' bedrooms were clean and bright and most had adequate space for residents' personal belongings and to have a comfortable chair at the bedside. Resident accommodation was all single rooms and some had individualised their rooms with furnishings, pictures, ornaments and belongings from home. Communal

areas were comfortably furnished and decorated and there was access to a variety of communal spaces inside and outside for residents as they preferred. Some areas of the centre needed minor repairs and a bedroom upstairs was being renovated at the time of the inspection.

Communal space comprised a large dining room which included a sitting room, an oratory and a smaller sitting room. On the morning of the inspection there was bingo underway in the sitting room and a number of residents were seen to be enjoying the activity. All residents were seen to have their meals in the dining room. As a result, the dining experience had an atmosphere of a social occasion. Residents were very complimentary about the choice and quality of food provided in the centre. Residents nutritional needs were being met and mealtimes were an enjoyable occasion for residents with ample assistance and supervision provided by staff. There was access to drinks and snacks outside of the regular meal times.

The inspectors spoke with several of the residents and the general feedback was that Prague House was a pleasant place to live and that they felt safe and well cared for by staff. Residents stated that staff and management were responsive to their needs and they never waited long for their call bell to be answered. Residents were highly complimentary of all staff in the centre. The inspectors observed a pleasant, relaxed atmosphere throughout the day and saw many examples of kind person-centered interactions. The quality of food was good and residents had a good choice of home cooked meals and snacks.

Visitors were observed in the centre during the day visitors took the time to speak with the inspector. They stated they were assured that their relative was being well cared for and they did not have to worry about them during periods of restriction as they had built up a trusting relationship with staff and management.

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

Capacity and capability

The inspectors found that improvements were required in relation to governance and management of the designated centre, as issues found on the previous inspection had not been satisfactorily addressed. Inspection findings reflected the need for enhanced oversight of the day to day operation of the centre to ensure that issues identified for improvement on this inspection were captured through the centre's own audit process. It was also found that a review was required of medication management, infection prevention and control, and care planning.

Inspectors found that while some of these previous non-compliance's had been addressed, not all of the changes outlined in the previous compliance plan had been sustained or implemented, particularly with regard to governance and oversight

systems within the centre. Furthermore, new non-compliance's were identified on this inspection which did not assure inspectors that the registered provider had taken all necessary actions to ensure the safety and welfare of the residents.

Repeat non-compliance was found with regard to;

- Regulation 23: Governance and management
- Regulation 27: Infection control
- Regulation 05: Individual assessment and care plan

Additionally, new non-compliance was found with regard to;

- Regulation 28: Fire Precautions
- Regulation 29: Medicines and pharmaceutical services

In addition Regulation 17: Premises, Regulation 15: Staffing Regulation 11: Visits and Regulation 09: Residents Rights required action and were found to be substantially compliant.

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

The person in charge (PIC) facilitated the inspection throughout the day. She demonstrated an understanding of her role and responsibilities and was a visible presence in the centre. The person in charge is supported in her role by an Assistant Manager and a team of care staff, housekeeping, catering and maintenance. The Assistant Manager took charge of the centre in the absence of the person in charge. This centre accommodated residents that were low or medium dependency and residents were assessed as not requiring full time nursing care. Nursing expertise was provided by the person in charge only. Residents whose needs changed and increased over time were supported to move to a more appropriate centre. Residents were aware of this prior to admission.

While there was a well established management structure, improvements were required in governance and oversight arrangements. Commitments given in the compliance plan response to the inspection carried out in May 2021 had not been implemented by the date of this inspection. There was a comprehensive schedule of audits that included for example fire, consent and staff files, however, the person in

charge told inspectors that no audits had taken place in 2022 so far.

There was evidence of records of all incidents and near misses that ensured appropriate action was taken and they were followed up on and reviewed. The annual review of the quality and safety of care for 2021 was available.

The human resource policy was centre-specific and included details for the recruitment, selection and vetting of staff. A review of staff records showed that staff were recruited and inducted in accordance with best practice. A sample of staff files was reviewed and those examined were complaint with the Regulations and contained all the items listed in Schedule 2. Garda Síochána (GV) vetting clearance was in place for all staff. Appraisals had been completed for all staff.

The inspectors examined staff training records, which confirmed that the majority of staff had up-to-date training in areas to support them in their respective roles, such as fire safety, manual handling procedures and safeguarding residents from abuse. Staff also had also attended training in areas such as infection prevention and control practices, COVID-19 awareness, and cardiopulmonary resuscitation. However, not all staff had up to date training as required. This is detailed under Regulation 16 Staff Training and Development below.

There was a stable and dedicated team of staff that ensured that residents benefited from good continuity of care from staff who knew them well. Staff turnover was low with many staff working in the centre for a number of years. The service was appropriately resourced with staffing levels in line with that described in the statement of purpose. A sample of rosters were reviewed and staff and residents confirmed that there were adequate staff on duty at all times. The person in charge who also undertook nursing duties worked Monday to Friday during the day. However, similar to the findings of inspection in May 2021, inspectors found that the current staffing arrangements for household and laundry staff required to be strengthened. This is further discussed under Regulation 15: Staffing.

Staff meetings and shift handovers ensured information on residents' changing needs was communicated effectively. There was evidence that staff received training appropriate to their roles and staff reported easy access and encouragement to attend training and to keep their knowledge and skills up to date. However, specific training on cleaning duties within the centre was not provided to staff.

The provider had an up-to-date complaints policy and the complaints procedure was displayed throughout the centre. The inspector reviewed the two complaints received in 2022 and saw that adequate records were not maintained of the investigation conducted in response to the complaint or the satisfaction or otherwise of the complainant.

Regulation 14: Persons in charge

The person in charge is a registered nurse, works full-time in the centre and had the required qualifications, experience and knowledge to fulfill the requirements of the role.

Judgment: Compliant

Regulation 15: Staffing

Similar to the findings of the previous inspection in May 2021 there were no assigned household staff on duty, and the staff assigned for laundry duties worked three days per week from 10.30 to 15.30hrs only. The result of this was that the care staff were responsible for caring for the residents, cleaning the centre and managing the laundry duties and on days when the laundry personnel were on a day off or every day during sickness or annual leave. Given the building's layout and the necessity for an intensified cleaning regimen required to prevent an outbreak of COVID-19 in the centre, it was not possible to clean the centre to the required standard.

Judgment: Substantially compliant

Regulation 16: Training and staff development

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

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents contained all of the information specified in the regulations.

Judgment: Compliant

Regulation 21: Records

Records were stored securely and readily accessible. A review of a sample of personnel records indicated that the requirements of Schedule 2 of the regulations were met.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that many of the issues found on the last inspection in May 2021 had been addressed, however the overall levels of compliance with the regulations remained very poor, and new non-compliance's were identified on this inspection. Inspectors were not assured that the governance and management systems in place were sufficient to ensure that the service provided to residents was safe, effective and consistently monitored. For example, the registered provider did not identify the issues found by inspectors during the inspection regarding clinical and environmental risk. In particular the following areas required immediate attention:

- Risk assessments were generic and were predominantly focused on falls only. Risk assessments that were due to be reviewed in December 2021 did not happen.
- The risk register and accident and incident log involving incidents available in the centre on the day of the inspection did not include all risks and necessary actions to mitigate.
- The system of risk identification in the centre required further oversight to ensure that management were risk-aware and identified any potential and actual risks, both clinical and environmental.
- Audit tools in use were not comprehensive enough to identify poor practices and action plans following audits carried out in 2021 did not demonstrate what improvements had been made or how the audit was promoting and supporting good clinical governance.
- No audits had taken place in the first quarter of 2022.
- Systems of communication were not sufficiently robust as quality and safety meetings, had not taken place since the end of 2021.
- Inspectors identified areas of concern around oversight of the administration and transcribing of medication, infection prevention and control, fire safety, individual assessment and care planning, resident rights. These are each discussed under Quality and Safety below.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Each resident had a written contract of care that detailed the services provided and the fees to be charged, including fees for additional services. However, contracts of care had not been reviewed annually as described in the statement of purpose.

Judgment: Substantially compliant

Regulation 30: Volunteers

All volunteers working in the centre had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 in place. They also had a memorandum of understanding which outlined their roles and responsibilities.

Judgment: Compliant

Regulation 31: Notification of incidents

All incidents and allegations had been reported in writing to the Chief Inspector as required under the regulations within the required time period.

Judgment: Compliant

Regulation 34: Complaints procedure

There were two incidents recorded in the complaints log and had been managed through the complaints process but were more appropriate to being handled by other processes.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Similar to the findings of the previous inspection in May 2021 inspectors found that the policies and procedures had not been updated and reviewed in response to the

COVID-19 pandemic. For example, the Health Protection Surveillance Centre's guidance had not been updated in the admissions and visiting policies.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors identified that the rights of residents were respected and residents were encouraged to live their lives to the best of their capabilities. Prague House is a low support facility and as such residents freely went to the village shops or the church. A small number of residents had additional needs and as such were being assessed as to their suitability for this centre. In addition, improvements were required around fire precautions, infection prevention and control, medication and pharmaceutical services, records, risk management, individual assessment and care planning and premises. While inspectors observed residents taking part in bingo on the day of inspection, improvements were required in the choice and number of group activities available.

Visiting had not resumed in line with the latest HPSC guidance. Residents had access to GP and health and social care providers via the community on a referral basis for example, dietitian.

The corridors were narrow but clutter free with assistive handrails throughout the premises. All rooms were single rooms containing wash hand basin and adequate storage for residents. Two rooms were en-suite, otherwise toilets and showers were available in each area. Residents had two access pathways to the garden, however, one of these required residents to access an area that contained a janitorial sink and mops that were in use. The sitting room was inviting, comfortable and clean. A large dining room including a sitting room was available and inspectors observed the majority of residents attending there for their meals.

Residents needs were assessed on admission using validated assessment tools for example falls risk assessment but these tools were not always updated. Care planning of residents needs was not always person centred or linked to the information provided on admission for example the residents medical needs or their likes and dislikes.

The centre was generally clean, however a number of improvements were required in relation to infection prevention and control practices which will be discussed further under Regulation 27, Infection Prevention and Control. The centre had a recent COVID-19 outbreak which closed in March 2021. A COVID-19 contingency plan was in place, updated in December 2021 and identified the person in charge as the COVID-19 lead for the centre. However, learning from the outbreak was not evident. Renovations on Nuenna were ongoing since the last inspection.

Inspectors identified areas of concern around the administration and transcribing of

medication, This is discussed under Regualation 29, Medicines and Pharmaceutical Services.

Fire drills were completed that included night time simulated drills to reflect night time conditions. Records documented the scenarios created and how staff responded. Staff and residents spoken with were clear on what action to take in the event of the fire alarm being activated. Each resident had a completed personal emergency evacuation plan in place to guide staff. Annual fire training had taken place in 2021 and was attended by all staff. Newly recruited staff had been inducted in fire safety procedures. Fire escape routes were noted to be unobstructed by chairs, trolleys and boxes etc. Fire doors were noted to be of sound construction and were fitted with self closing devices. However, records related to fire safety management systems were not available for inspection and detailed in Regulation 28, Fire Precautions, below.

Regulation 11: Visits

The COVID-19 contingency folder contained Health Protection and Surveillance Centre (HPSC) guidance from December 2021 which was not the most current guidance. Furthermore, the visiting policy referenced guidance from July 2021. This was also the findings on the day of inspection. Inspectors were informed that resident's visitors were require to phone ahead prior to visiting. In addition, visitors were required to provide vaccination certificates and have temperature checks. This was not in line with the current Health Protection and Surveillance Centre (HPSC) guidance on visits to long term residential care facilities. If the centre operates outside of current guidelines, a risk assessment to underpin this decision by the management team should be completed.

Judgment: Substantially compliant

Regulation 17: Premises

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

- Areas of the first floor (Nuenna Area) were in disrepair; for example, exposed pipes, plaster exposed and watermarks on walls. The inspector observed that some bedrooms were being painted.
- The 'janitorial sink' for cleaners was situated in the hall residents used as a thoroughfare to access the garden. This was outlined during the inspections in 2019 and 2021, and had not been addressed to date.
- Three cleaning trolleys were stored in the store room upstairs, which was also

used to store the incontinence wear and cleaning supplies. The walls in the store room were damaged with holes. The floor finishing also did not support effective cleaning.
- There was no sink available in the treatment room.

Judgment: Substantially compliant

Regulation 26: Risk management

There was an up to date risk management policy.

Judgment: Compliant

Regulation 27: Infection control

Overall, the centre was clean on the day of inspection, however, inspector's identified a number of areas requiring improvement in order to ensure that the centre was compliant with procedures, consistent with the National Standards for Infection prevention and control in community services (2018) For example:

- The centre had a recent outbreak of COVID-19 in February/March 2022. An outbreak report was not available for inspectors to view. In addition, there was no evidence from speaking to staff that there was any learning from the outbreak.
- Healthcare assistants were assigned to both cleaning and caring duties. Staff had not received training in relation to their cleaning duties.
- A number of staff were routinely wearing gloves while carrying out duties such as delivery of medications to residents and assisting residents at mealtimes. Routine use of gloves for all clinical contact with people cared for is not appropriate and not in line with national guidelines.
- Staff were not wearing respirator masks while carrying out resident care activity in line with HPSC guidance.
- Staff did not have access to dedicated hand hygiene sinks. Inspectors identified two dedicated hand hygiene sinks in the centre; one in the hall residents used as a thoroughfare to access the garden and one in the kitchen. These sinks did not comply with recommended specifications for clinical hand wash sinks.
- Inspectors were informed that a chlorine based bleach was not used to decontaminate resident areas during the recent COVID-19 outbreak. Overall review of the cleaning products and methods used for routine cleaning and cleaning during an outbreak was required to ensure compliance with national guidelines.
- Partially used toiletries were observed in the bathrooms and shower rooms.

The use of communal toiletries is not advised.

- Nuenna was being repainted at the time of inspection and was unoccupied. The registered provider needs to ensure that systems are in place to mitigate the risk of legionella in line with national guidance. Taps, showers and toilets were not being routinely flushed and no records were available.
- While the COVID-19 contingency plan was in place and reviewed in December 2021, actions identified were from March 2020.
- The hall residents used as a thoroughfare to access the garden did not have a cleaning schedule in place and the floor was visibly unclean. In addition, mops used to clean the kitchen were stored in this room. The use of this room and the thoroughfare need to be reviewed to ensure that infection prevention and control risks are mitigated to residents.

In addition issues identified on the inspection in May 2021 had not been addressed or partially addressed. For example:

- Cleaning schedules were put in place for the empty rooms in Nuenna, the schedule indicated that they had not been cleaned since October 2021.
- A cleaning schedule had been put in place for medical equipment belonging to a resident, the schedule indicated it had not been cleaned since October 2021.
- It was identified on the last inspection that a sharps box was inappropriately stored in bathrooms and the temporary closure mechanism was not engaged. This was again the finding on this inspection in one bathroom in Cascade.

Judgment: Not compliant

Regulation 28: Fire precautions

Records were not available on site on the day of inspection and as a consequence inspectors could not be assured that fire safety systems in place were sufficient to protect residents. The following documentation was not available on the day of inspection:

- The servicing and maintenance records (carried out every three months) for the fire detection and alarm system for the past 12 months in the format prescribed by the Irish Standard for fire detection and alarm systems for buildings, I.S. 3218:2013+A1:2019
- Confirmation that the fire detection and alarm system in the designated centre is an L1 system (or LDI system, including a fire alarm control switch for testing the system, in a community dwelling), that there is full coverage throughout the designated centre and that the system is fully addressable
- The servicing and maintenance records (carried out every three months) for the emergency lighting system for the past 12 months in the format prescribed by the Irish Standard for emergency lighting, I.S 3217:2013+A1:2017

- Confirmation of the satisfactory standard and fire integrity of compartment doors, walls, ceilings and floors
- A current fire safety risk assessment and the control measures in place
- Copies of any correspondence between the provider and the local fire authority relating to fire safety
- Current installation and servicing certification confirming that the fire extinguisher installation is in accordance with Irish Standard I.S. 291:2015
- A periodic inspection report for the electrical installation in the form described in the latest version of the National Rules for Electrical Installations.
- Records of fire safety checks undertaken on a daily or weekly basis.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Healthcare assistants who had received training from the local pharmacy were administering medications, checking controlled drugs at every shift change and administering the drugs as prescribed. However, while the centre had a Medication Management policy in place which was updated in 2021, it did not outline the role of the healthcare assistant in medication management. Furthermore, the policy stated that only nurses on the register can administer drugs in the home. Inspectors were not assured that the medication management systems in place were safe and effectively monitored. For example:

- A sedative, prescribed three times daily, was administered twice daily. Furthermore, an as required (PRN) dose of half a tablet was administered on occasion. This was not prescribed. An inspector was informed that this was a verbal direction from the resident's specialist medical team.
- Inspectors were informed that medications were only transcribed on occasion. The medication policy covered the practice of transcribing medication. It stated that it must be completed by a registered nurse and checked by another registered nurse. This was not the finding on inspection. For example; one medication, a sedative was transcribed by a healthcare assistant but not transcribed correctly. The medication was prescribed for four weeks but this was not transcribed onto the medication record which potentially could result in a resident receiving the drug indefinitely.
- Similar to findings from inspection in 2019, the process of transcribing was not subject to audit in line with the centre's own policy.
- The allergy section on the medication records was not completed for any resident.
- Inspectors were informed that staff were encouraged to report medication errors, however, inspectors were informed that staff were not reporting them.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of residents' individual assessment and care plans. While care plans had been completed on the sample reviewed, inspectors identified a number of areas that required improvement. These included:

- The majority of the care plans viewed had not been updated since May 2021. The regulations require that the care plan is based on the assessment and that care plans are formally reviewed at intervals not exceeding four months or sooner if the residents condition changes. This lack of updated assessments and care plans needs to be addressed to adequately inform and guide staff in the care given.
- A falls risk assessment had not been updated since a resident was admitted in 2018.
- Care plans were not in place to support the care of diabetic residents.
- One care plan had two different dates of birth on the documentation and some of the documentation in the same record was not dated.
- Inspectors were informed that vital signs and resident's weights were completed at monthly intervals. However, of the files viewed these were not completed in February. Furthermore, weight loss of a resident was not identified and actioned. However, on the day of inspection the resident was reweighed and the recorded weight was identified as an documentation error by staff.
- Inspectors were informed that a small number of residents may require higher support and were awaiting assessment. This is of concern where a registered general nurse is not on duty at all times.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to the local GP or a GP of their choice. The person in charge stated that residents had access to a range of health and social care providers through the community if required such as dietitian, speech and language therapy, physiotherapy and occupational therapy. Advice on tissue viability was available through local general practice. Psychiatry of old age attended on-site to review residents.

Judgment: Compliant

Regulation 8: Protection

Residents reported that they felt safe in the centre with many residents citing the need for security as a reason for moving to this service. The centre acted as a pension agent for four residents and appropriate measures were in place to protect resident finances. Staff had attended training in the prevention of elder abuse and safeguarding of vulnerable older people. Staff were knowledgeable of what constituted abuse and what to do if they had suspicions of abuse or had abuse reported to them. There had been no allegations of abuse. There were no restraints in use in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors noted that bingo was being played while on-site but following conversations with residents and staff it was identified that activities were limited. Inspectors were informed that bingo and hangman were the only activities identified as taking place. The person in charge informed inspectors that residents were not interested in activities and that music had been in place prior to COVID-19 but had not been sought by the residents since. In addition the activities provided were not in line with the centre's Statement of Purpose.

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 24: Contract for the provision of services	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Prague House OSV-0005447

Inspection ID: MON-0035421

Date of inspection: 05/04/2022

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The registered provider has informed the BOM of the need to increase staffing hours in the Laundry to cover 5/7 day period and to cover sick leave and annual leave. Staffing issues in relation to a designated cleaner will be resolved by assigning one staff each morning to the role of cleaning only and the remaining staff to provide care. This will be indicated in advance on the staff roster.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has requested further support from the Pharmacist to update training for all staff in relation to medications. This training has been requested to include all aspects of medication management. The PIC is also seeking support from the Practice Nurse in the local GP practice to come to the Center and hold information sessions for staff in relation to all relevant aspects of medication applicable to the Center Support has been sought from the HSE and Infection Control in relation to formal training for cleaning duties. The PIC has also contacted local contract cleaners to seek advice regarding training Staff have been requested to complete the following HSE Land training before the end of May 2022. Cleaning and Disinfecting the Healthcare Environment and Patient Equipment Basics of infection, Prevention and Control and Clostridioides Difficile Infection.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC has developed a schedule of delegation of duties and responsibility for same to all HCAs in various areas. Training and support will be given to each staff to ensure they can carry out the task to an acceptable standard. This will ensure that all documents are updated as required and will be done with the support of key workers to ensure a full picture is captured to ensure best outcome.
Care Plans and the risk register will be updated and reviewed quarterly. The PIC will work closely with designated staff in each area.
Audit for 2022 have commenced and are being followed by the quality and safety meeting leading to the action plan as per findings. This will also include a corrective action/preventative action/and improvement request being completed with audits and being used to correct issues

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
All Contracts of Care are being reviewed to ensure they are in line with present practices. This will be completed by the PIC with the support of the Chairperson of the BOM and then forwarded to the Company solicitor for review and rectification where necessary. All Contracts of Care will be reviewed annually or more frequently if required to reflect the situation for each individual

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The PIC will discuss, separating issues from concerns in a reporting format with the providers of the policies each Wednesday and discuss with staff how each situation

should be reported and followed up on.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
All policies have been updated in the file to reflect the 2021 versions. All policies and procedures relating to the Centre will be reviewed by the PIC with the support of the Policy service to reflect present day practices and to ensure all aspects relating to Covid 19 are covered. Any policy found that is no longer reflective of the practices at present will be amended.

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
The guidelines have been updated to reflect the latest version. All restrictions except mask wearing have stopped. Visitors no longer need to fill in Covid related questionnaires show vaccination certs, pre book visits, etc. Signs to reflect these new practices have been placed at strategic points in the Home visible to resident's visitors and staff.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The janitorial sink is to be removed and area left free of exposed pipe work, etc. A press will be provided and attached to the wall to store mops and buckets. The area has been deep cleaned and a sign off sheet has been put in place. The staff assigned to cleaning will take responsibility for this area each day.
The cleaning trollies are being stored in a separate area from the supplies. The maintenance staff have been requested to fill all holes and plaster over the defective area. Flooring to be replaced
All treatments for residents are carried out in their bedrooms. As there are no shared bedrooms in the Center, this allows for privacy.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
One staff will be identified cleaning staff each day on the Rota. Staff no longer wear gloves for general duties. Respirator masks are worn when in direct contact with residents. Supply of hand washing sinks is presently being reviewed and suitable locations for installation being identified. Chlorine based beach has been sourced and is stored in the event of any outbreak. All families/NOK will be asked to supply the resident with an appropriate wash bag which can be brought to and from the bathroom ensuring the use of personal products. A cleaning schedule for the upstairs area has been put in place to ensure the frequent running of water in all sinks, showers and toilets. Staff have again been made aware of the necessity to fill in all documentation at the time of cleaning. The cleaning of medical equipment is once again being documented daily. The sharps box is now located in a locked press in the medicines room.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Works have commenced to ensure all areas are fully compliant. In addition to this a representative from Siemens attended the Centre last week and updated staff on using and understanding the fire panel. All smoke sensors and associated control systems have been inspected and operating satisfactorily.
Fire Doors checks carried out and defective sealing system being replaced and closing systems adjusted to comply with regulations.
Emergency lighting and exit lighting systems have been checked and defects identified. All defective batteries are being replaced.
PAT Tests being carried out and facilities on site will be checked and certified.
Gas system checked by qualified fitted and gas leak sensors are all satisfactory.
Underground sections of the gas mains are in Galvanized mild steel and an order has been issued for replacement of same by HDPE mains, most of which will now be wall mounted overground.
Hot water system temperature checks completed, and system is satisfactory.
Fire extinguishers and fire blankets have been serviced and confirmed as being fully compliant with regulations.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The medication policy will be reviewed with the PIC and the Policy company Wed 10.05.22. It has been agreed that all medications will be prescribed after consultation with the attending Psychiatric nurses by the GP who will forward the prescription to the Pharmacy. The residents Kardex will be amended by the GP and the MARS sheet will be supplied by the pharmacist to reflect exactly how the medication is to be given. There will no longer be any instructions taken over the phone. Transcribing is not to be carried out in the Home except by the registered nurse. All entries on both the Kardex and MARS sheets will be checked to ensure they are correct The Pharmacist will be asked to reflect any allergies on the recording sheets. The reporting of medication errors was highlighted at a recent staff meeting and the reasons for same explained to staff as best practice

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All care Plans are presently under R/V. Two staff have been assigned to implementing and updating care plans as required with the support of the resident, PIC and relevant key workers. (See attached list of assigned duties)
The PIC will support staff with training in this area. Staff are enthusiastic to be involved in this area of care. Care Plans will be implemented in all relevant areas for each individual and attention paid to ensure correct data is entered.
All fall risk assessments, Mini mental tests and Bartels will be reviewed as per the plan outlined on the delegation list and any changes reported to the PIC/ delegate immediately.
As per plan a member of staff is now assigned to ensure the weights BMIs vital signs are taken and recorded monthly and again any changes to be reported and followed up on.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A member of staff has been assigned the responsibility of the role of activities co-

ordinator. She will be responsible for putting a schedule together each week to offer activities daily to the residents. She will meet with the residents who are interested to devise this each week. This will ensure that the activities offered are of the kind that reflect the resident's interests. These activities will then be carried out by the staff on duty each day. Recordings of the success rate of each activity will be kept and reviewed monthly Care will be taken that the activities are in line with the Center's Statement of Purpose

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 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Substantially Compliant	Yellow	17/05/2022
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	30/05/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	18/05/2022

	have access to appropriate training.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/11/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	25/05/2022
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	25/05/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Not Compliant	Orange	30/06/2022

	consistent and effectively monitored.			
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	20/06/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/05/2022
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	30/11/2022
Regulation	The registered	Not Compliant	Orange	30/06/2022

28(1)(c)(iii)	provider shall make adequate arrangements for testing fire equipment.			
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.	Not Compliant	Orange	30/06/2022
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/05/2022
Regulation 04(3)	The registered provider shall review the policies and procedures	Not Compliant	Orange	30/06/2022

	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(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/06/2022
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.	Not Compliant	Orange	30/06/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and	Substantially Compliant	Yellow	30/06/2022

	capacities.			