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:	Ospideal Pobal Chorca Dhuibhne (West Kerry Community Hospital)
Name of provider:	Health Service Executive
Address of centre:	Mail Road, Dingle, Kerry
Type of inspection:	Unannounced
Date of inspection:	10 July 2024
Centre ID:	OSV-0000569
Fieldwork ID:	MON-0043230

About the designated centre

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

Ospidéal Pobail Chorca Dhuibhne (West Kerry Community Hospital) is a designated centre which is located on the outskirts of the coastal town of Dingle, Co. Kerry. It is a single storey facility that also accommodates the primary care public health service and community care day centre. It is registered to accommodate a maximum of 46 residents. The entrance to the centre is called the Croí (heart) and this is an expansive space with seating areas for residents and visitors to gather. The main dining room, oratory, quiet room and activities room are located here. The designated centre is set out in two wings: Ionad Bhreannainn with 22 beds and Ionad Eibhlis with 24 beds. Bedroom accommodation comprises single, twin and multi-occupancy four-bedded rooms, all with hand-wash basins; some bedrooms have en-suite facilities of shower, toilet and hand-wash basin while others share shower and toilet facilities. Each unit has a dining area, two day rooms and occasional seating areas by the nurses' station and along corridors. Residents have access a sensory room, and to paved enclosed courtyards with seating and garden furniture. Ospidéal Pobail Chorca Dhuibhne provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, respite, convalescence and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43

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 10 July 2024	16:30hrs to 20:30hrs	Breeda Desmond	Lead
Thursday 11 July 2024	09:00hrs to 14:00hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

This unannounced inspection took place over two days in Ospidéal Pobail Chorca Dhuibhne (West Kerry Community Hospital). The inspector met with many residents during the inspection, and spoke with two visitors. The inspector spoke with eight residents in more detail to gain insight into their experience of living there. Residents gave positive feedback about the centre and were complimentary about the staff and the care provided, and said that the food was excellent.

On arrival for this unannounced inspection, the inspector completed the centre's risk management procedures, which included a signing in process and hand hygiene. The inspector arrived in the centre at 16:30hrs on the first evening of inspection and visited both units. The inspector found that in one unit, two residents were in each dining area having their evening tea, the remaining 18 residents were either in bed or in their bedroom having their evening meal. Staff were seen to provide social interaction and actively engage with residents; some staff spoke in Irish to residents in accordance with the resident's preference. Two residents were out with their families and upon returning, they were served their meal in their bedrooms. At 6:30pm there was one resident in the day room; the inspector heard staff ask whether they wanted to go to bed or their bedroom. On the second day of inspection, the inspector met with the person in charge and outlined the rationale for this unannounced inspection.

The centre was a large single-storey building which also accommodated the mental health day service and community public health. Orientation signage was displayed to guide residents and visitors to the two units of Ionad Bhreannan and Ionad Eibhlis to allay confusion and disorientation. The main entrance was wheelchair accessible. The central space beyond main reception had comfortable seating areas to relax. An Croí (The Heart) was a large room on the left and was used for larger groups activities such as bingo, arts and crafts and music events. Access to the mental health day services was to the left. The main kitchen, laundry and other offices were located beyond An Croí. The oratory was located on the right of the corridor leading to the units. This was a beautiful room with hand-crafted wood altar and tabernacle; the priest was on site every Wednesday to say mass for residents. The main dining room was immediately in front of An Croí; this room was being upgraded at the time of inspection. Both Ionad Bhreannan and Eibhlis were located to the right of the dining room. One unit was secure with key-code access and the second unit was freely accessible. Both had butterfly images with the key-code displayed to enable independent access. Residents were seen using this code to independently exit and enter the unit.

Both units were similarly set out and were self-contained regarding facilities which included the nurses station, clinical rooms, sluice rooms, dining areas and day rooms. Both units had access to enclosed outdoor gardens; one garden was well

maintained and had beautiful murals of scenes of local places painted, raised flower beds and garden furniture seating.

Residents accommodation was set out as follows: Ionad Bhréannainn, 22 residents (single, twin and four bedded multi-occupancy rooms); Ionad Eibhlís, 24 residents (single, twin and four bedded multi-occupancy rooms). Some single bedrooms were personalised in accordance with residents' wishes and preferences; most twin and multi-occupancy four-bedded rooms were clinical and devoid of personalisation and did not reflect a homely residential care setting. While residents had accessible bedside lockers, most residents had very limited personal storage space comprising a single wardrobe for their clothing.

Overall, the premises was bright and easily accessible and the atmosphere was calm and relaxed. In general, staff were seen to actively engage with residents, and socially engage when providing assistance. Some residents were seen to mobilised independently around the centre and explained they had a route planned and were getting in their daily step count.

During the morning, afternoon and evening walkabouts, many residents were seen to remain in their bedrooms, with a maximum of five residents in the day room at any time. There were large white boards with the daily activities displayed; the information was very limited with 'group' activities but it did not inform the reader of what that might be, such as hand massage and manicures for example. There was no group activity observed on the first evening of inspection or in the morning of the second day; bingo was facilitated by a volunteer in the afternoon of the second day of inspection. The activities programme indicated that tea/coffee in the morning was a social occasion to meet-up with friends and chat, however, there were no residents in communal spaces, all residents remained in their bedrooms and beverages were served to residents in their bedrooms.

Another volunteer facilitated pet therapy and brought Milo, the cute King Charles dog to the centre on a weekly basis; Milo was an unexpected visitor during the morning of inspection. Residents enjoyed Milo's visit with the games and entertainment he provided. Visitors were seen calling to the centre and some residents were taken out by their families; visitors were seen to routinely sign when taking their relative off-site and sign-in again upon return.

There were two small dining areas on both units; these comprised two tables in open spaces which led to the outdoor gardens. One of the staff painted a large beautiful mural on the wall of one dining area to enhance the setting; however, in general, these spaces were not suggestive of dining rooms or set out or furbished to enhance a dining experience for residents. In all, the inspector saw six residents in each unit having their main meal in the dining area, the remainder had their meal in their bedrooms. Residents had choice regarding their meals, and complimented the quality of food served. Medications were administered after the main meal to ensure residents could enjoy their meal undisturbed.

Observation on inspection showed that most staff had good insight into responding to communication needs and provided support to residents in a respectful and

friendly manner, however, other staff did not have this understanding and found it difficult to actively engage with residents.

The physiotherapist was on site during the inspection providing individualised care to residents, mobilising them in accordance with their assessed needs and providing support and guidance to enable better outcomes for them.

The inspector observed that doors to clinical rooms such as clean utility and treatment rooms were secured to prevent unauthorised access to equipment such as needles and medication.

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 provided.

Capacity and capability

This unannounced risk inspection was undertaken to monitor ongoing compliance with the regulations, to follow up on previous inspection findings, and following receipt of unsolicited information relating to residents' rights regarding accessibility to a meaningful activities programme and residents' choice, and these concerns were partially verified on inspection.

The findings of this inspection were similar to the last inspection in that there was very limited personal storage space for residents, the dining experience for residents required improvement as the main dining room remained inaccessible. Improvement was noted regarding qualifications of the person in charge, records maintained in the centre, end of life care plans, medication management, and aspects of fire safety precautions. On this inspection, action was required to comply with the regulations in relation to food and nutrition, the premises, infection control, care planning and institutional practices relating to residents' rights. These will be further discussed under the relevant regulations in this report.

Ospidéal Pobail Chorca Dhuibhne (West Kerry Community Hospital) is a residential care setting operated by the Health Services Executive (HSE). The management structure identified lines of accountability and responsibility for the service. The governance structure comprised the interim general manager for the CH04 area of the HSE, who was the person appointed to represent the registered provider. The person in charge reported into the general manager. Off site, the service was supported by the clinical development co-ordinator, quality and safety adviser, infection control link nurse specialist and human resources. On site, the person in charge was supported by the clinical nurse manager (CNM) who deputised on occasions when the person in charge was absent.

Policies and procedures were viewed and all the policies specified in Schedule 5 were in place and available to staff. The fire safety policy was updated to reflect the

fire safety works demonstrating the sub-compartments installed and the associated bedrooms and number of residents per compartment. Areas for improvement relating to Schedule 5 policies and procedures are further detailed under Regulation 4, Written policies and procedures.

The person in charge discussed the quality improvement initiatives following the findings of the last inspection. Regarding the premises: new double wardrobes were designed and ordered and awaiting delivery by mid august. Once these are installed, a review of the rooms will determine if additional chest of drawers can be accommodated. New colour schemes of duvets covers and paint work will follow this. Work had just commenced in the main dining room with the installation of a new kitchen. This room will be designed to enable residents and visitors to make a cup of tea or coffee, have access to fresh baking daily throughout the day. At designated meal times, residents will be served their meal here. Large black boards were displayed to show the daily menu choice. It is envisaged that coffee mornings will be held here after weekly mass and other occasions such as celebratory evening meals and parties. Upon completion of these projects, the person in charge outlined that communal rooms will be upgraded then. All these improvements are welcomed as they will enhance the quality of life of residents.

While staffing levels were adequate to the size and layout of the centre, institutional staff practices were identified, for example, most residents being either in bed or in their bedrooms at 6:30pm on a summer's evening. While there was some improvement regarding activities, most residents remained in their bedrooms following morning care as described heretofore. These issues are further discussed under Regulation 9, Residents' rights.

Regulation 14: Persons in charge

The person in charge met the requirements of the regulations; she was full-time in post and was involved in the governance, operational management and administration of a designated centre. Observation showed that she was familiar with residents and their care needs.

Judgment: Compliant

Regulation 15: Staffing

The staff roster showed that the number and skill mix of staff was appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the centre. Issues relating to oversight of meaningful activation and work practices are further discussed under Regulation 9, Residents' rights.

Judgment: Compliant

Regulation 16: Training and staff development

Training needs analysis formed part of staff annual performance reviews and additional training was facilitated. Mentoring was provided for staff new to the Irish healthcare system including additional support regarding language and communication. Quarterly probation checks were undertaken by the person in charge to ensure staff had the necessary supports to help them in the transition to the Irish healthcare system. Additional on site safeguarding, wound care and palliative care training was provided.

Judgment: Compliant

Regulation 23: Governance and management

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

- lack of meaningful activation for residents on a daily basis
- institutional practices (as detailed under Regulation 9, Residents' rights).

Regarding risk:

- all rooms with oxygen in use or in storage did not have the necessary advisory signage as part of their risk management.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints procedure display was updated on inspection to ensure it was accessible to residents, as part of the procedure was displayed at the entrance to the unit and the other part was by the nurses' station. Combining the two documents together made it accessible and easier to follow for people reading this. Obsolete information relating to the complaints procedure referencing the directors of nursing for the CH04 area was removed to allay confusion.

Judgment: Compliant

Regulation 4: Written policies and procedures

Action was necessary to ensure policies were in compliance with specified regulatory requirements of Schedule 5, as follows:

- the centre-specific policy relating to the complaints procedure devolved all the responsibility to the person in charge, however, the responsibility is that of the registered provider
- the policy relating to the creation of, access to, retention of, maintenance of and destruction of records advised that records may be transferred with a residents should they be discharged to another similar facility which is in conflict with the regulation itself, stating that records set out in Schedule 3 (Records to be Kept in a Designated Centre in Respect of Each Resident), are available for inspection, and retained for a period of not less than 7 years after the resident has ceased to reside in the designated centre concerned,
- floor plans associated with the fire safety policy required updating to ensure they were legible and important information could be extrapolated from it, such as the fire zones, compartments and location of fire fighting equipment
- the admissions' policy required updating to reflect the criteria and time-lines relating to short and long-stay residents regarding appropriate care planning documentation.

Judgment: Substantially compliant

Quality and safety

In general, the atmosphere was relaxed and staff actively engaged with residents in a friendly and respectful manner and visitors to the centre were made feel welcome.

Oversight of residents' health care needs was good. Residents' health care needs were promoted by daily on-site access to their GP, health and social care professionals such as to speech and language and dietitian services when required, and other specialist care such as psychiatry of old age and palliative care.

Observation on inspection showed that staff had good insight into responding to residents' medical care needs. Care and support given to residents was respectful and relaxed. A sample of care planning documentation was examined and these showed mixed findings. The daily narrative reviewed showed good monitoring of care needs as well as monitoring residents' responses to interventions. Some care plans contained valuable individualised information to inform personalised care. The assessment and care planning documentation was different for short and long-stay

residents and short stay residents were not afforded the more comprehensive care planning documentation. This and other issues are further discussed under Regulation 5, Individual assessment and care plan.

A daily safety pause was facilitated to remind staff of issues such as residents at risk of falls, skin integrity, absconsion, those on treatments other than routine medications such as eye drops and antibiotics.

The pharmacist attended the centre on a weekly basis. Notes in residents' medication management documentation showed comprehensive information from the pharmacist alerting staff to effects of some medications, maximum dosages regarding 'as required' medications for example. An antibiotic log formed part of the medication administration record as well as blood sugars records as part of safe management of residents with a diagnosis of diabetes. Medications requiring crushing were individually prescribed. Controlled drugs were appropriately maintained and records kept in accordance with professional guidelines.

A residents' survey was undertaken and several residents reported that they were really looking forward to the new dining room; there were lots of suggestions regarding menu choice and the menu was changed to include pasta dishes as suggested. This was further reviewed after two months to gain residents' feedback, and the menu choice was further expanded. Some residents suggested that they would like fresh fruit and this has been added to the breakfast menu choice. While residents gave positive feedback about the quality of food served, there were issues identified relating to the dining experience for residents and these are further expanded upon under Regulation 17, Premises.

As previously described, there was limited social activation for residents. Most staff actively engaged with residents in a social manner, however, a social model of care was not evident as most residents had their meals by their bedsides, and most residents were in their bedrooms by 6:30pm which is reflective of an acute care model and not a residential social care model.

A relatives forum was facilitated by the person in charge and the next meeting was scheduled for later in July; the agenda for this meeting included information on the quality improvement projects proposed and initiated, to share the vision regarding promoting and improving the quality of life for residents in the centre and encouraging community involvement.

Fire safety records showed that appropriate fire certification was in place for alarm tests, emergency lighting and fire safety equipment. Daily fire safety checks were comprehensively completed. Fire safety training was up to date for all staff. Personal emergency evacuation plans were available for all residents and these showed residents' evacuation aids for day and night duty. Many fire safety doors were upgraded since the last inspection and new sub-compartment fire doors were in place on corridors to reduce compartment sizes. Nonetheless, fire safety issues were identified on inspection and these were discussed under Regulation 28, Fire safety.

Regulation 11: Visits

Visitors were welcomed to the centre by staff who were familiar with the routine of visitors regarding taking their relative off site. Visitors signed they were taking the resident out and chatted with staff regarding the plan for the outing. Visitors met with their relatives in day rooms and bedrooms and staff actively engaged with them during their visit.

Judgment: Compliant

Regulation 12: Personal possessions

The person in charge explained that new double wardrobes were being made at the time of inspection and were due to be delivered by mid August. This was to be welcomed but on the day of the inspection residents in twin and multi-occupancy bedrooms did not have access to appropriate personal storage space as the wardrobe space available comprised a single wardrobe only, which was a repeat finding over all inspections.

Judgment: Substantially compliant

Regulation 17: Premises

The following were repeat findings and action was required to ensure compliance with Schedule 6 of the regulations:

- the residents' main dining room continued to be inaccessible to residents for their meals resulting in limited dining space for residents
- the decoration and layout of dining areas on each unit were not suggestive of a dining room; they did not have adequate dining tables to facilitate residents have their meals there, this was a repeat finding
- most communal spaces were not decorated in line with a residential care setting or inviting places to go to socialise; this was a repeat finding.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents gave positive feedback about the quality of food served and explained that they always had choice and if they did not fancy what was on the menu they could have whatever they liked. Surveys were undertaken to gain residents feedback regarding menus and menu choices were changed in line with residents' suggestions, for example, pasta dishes and fresh fruit were added to the choice.

Judgment: Compliant

Regulation 27: Infection control

The following issues were identified regarding infection prevention and control and required action:

- many of the protective surfaces of furniture, doors, and hand rails on corridors were worn so effective cleaning could not be assured
- paintwork though out the building was chipped
- some clinical handwash sinks were not compliant with current guidelines
- one twin bedroom did not have any bedside tables; as residents were in bed, bedside tables were brought from another area to the bedrooms increasing the risk of cross contamination
- clean trolleys were seen to be stored in sluice rooms
- some staff were seen to wear wrist watches and rings with gems, which is contraindicated in 'bare below the elbow' best practice hand hygiene technique.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required to ensure appropriate fire safety precautions as follows:

- full compartment evacuations had not been completed; cognisant that there were some new staff, assurance were not provided regarding compartment evacuation, in particular evacuation of the largest compartment of 10 beds,
- there was one emergency floor plan displayed in each nurses station. While there was a legend detailing the zones, the location of the zones were not included. This would assist the many new staff in orientation as part of a review of fire safety precautions,
- some fire doors were seen to be held open with door wedges which would impeded the closure mechanism and prevent the fire door closing should the fire alarm be activated
- fire doors to the main dining room did not have the free-swing mechanism and as they were heavy it will be difficult for residents to use these

independently, in particular residents using mobility aids such as wheelchairs and rollators.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Following the findings of the last inspection, all nurses had completed medication management training. In addition, additional training was scheduled in July whereby the palliative care nurse specialist was coming on site to provide training on anticipatory palliative care medications and this will include controlled drug medications.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The following required action regarding residents' assessment and care planning to ensure compliance with regulatory requirements:

- assessments were not comprehensively completed, for example, where a residents was deemed as requiring communication aids but the specific aids were not detailed to support the resident in accordance with their individual needs; it was not indicated whether the resident was at risk of absconsion for example,
- while a resident's assessment regarding their mood and behaviour was normal, their mood and behaviour care plan indicated that a behavioural chart was necessary to identify unknown triggers for their mood disturbance,
- some care plans indicated that residents were re-assessed in August 2023 and again in April 2024 which is outside the minimum regulatory requirement of assessment every four months,
- one residents care plan reviewed showed that the care planning documentation was not sufficiently detailed to direct care and provide for the resident's care needs.

Judgment: Substantially compliant

Regulation 6: Health care

The GP was on site on a daily basis and medications formed part of the review, and residents and staff were consulted with regarding responses to changes in medication to enable best outcomes for residents. Residents had timely access to health care specialist services and timely referrals and consults with allied health professionals such as speech and language therapist and occupational therapist; associated plans of care were in place along with recommendations to support residents to have a better quality of life.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Notification submitted showed that, on average, approximately half of residents had bed rails in place which is a very high number, so it could not be assured that restraint was only used in accordance with the Department of Health national policy.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The following required attention to ensure residents' rights were upheld:

- there continued to be limited activity available to residents in accordance with their choice, interests and ability
- institutional practices were observed with just four residents in communal areas at 4:30pm with the remainder either in bed or in their bedroom; at 6pm there were a total of 2 out of 43 residents in the day room on a summer's evening
- the activities programme indicated that from 10:30 – 11:15am a 'tea/coffee meet-up' was scheduled, however, on one unit at 11:30am there were no residents in any communal space. Teas and coffees were served in residents' bedrooms. On the other unit there was one resident in the day room, so morning coffee was not seen as a social occasion where people met up with their friends to socialise,
- residents in multi-occupancy bedrooms could not independently move or adjust their privacy bed screens due to the mechanism. As these privacy curtains had a minimum of 10 foot brakes to be released to activate them, residents in wheel chairs or with mobility aids could not use these.

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	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ospideal Pobal Chorca Dhuibhne (West Kerry Community Hospital) OSV-0000569

Inspection ID: MON-0043230

Date of inspection: 11/07/2024

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Nursing management have commenced a review of meaningful activities scheduled within the centre in consultation with the residents. A new activities schedule will be implemented based on residents' preferences and interest and will be monitored by nursing management. • Nursing management has commenced a review of work practices in both modules. The work practices review incorporates the completion of Work Culture Critical Analysis Tools to support embedding person centred care practices. WCCATs will be undertaken at different times of the day and will be continued over a period of weeks. Nursing management will ensure surveillance and monitoring of practices to ensure a comprehensive and robust change of practice is implemented and embedded at ward level. • All rooms with oxygen in use or stored in now have the necessary advisory signage as part of their risk management.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • The centre-specific policy relating to the complaints procedure is under review. • The policy relating to the creation of, access to, retention of, maintenance of and	

destruction of records was revised 31.07.2024 and no longer allows for the transfer of records with residents within the Community Hospital group.
• Nursing management has worked in conjunction with the Fire officer to update the floor plans / Fire escape plans to ensure they are legible and important information can be obtained from them such as fire zones, compartments and the location of fire equipment completed 02.08.24.
• The Nursing Documentation Policy has been updated (01.08.2024) to reflect the criteria and time-lines relating to short and long stay residents regarding appropriate care planning documentation.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The new wardrobes purchased will be delivered and installed by the 30.09.2024. The new wardrobes will meet the needs of the residents and provide them with adequate storage space.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The new 'main dining room' will be accessible to all residents to both enjoy their meals and welcome their relatives to embrace the new 'café feel' environment. Completion date 01.10.24. Residents and relatives will be able to enjoy a new social space to meet and socialise at their leisure. The area will be open and available to residents throughout the day.
• The dining areas on each module have been reconfigured to enhance dining experience. The decoration and layout are being modified (ongoing) and adequate dining tables have been added to facilitate adequate space for residents to enjoy their meals. 02.08.24. Nursing management will monitor and audit the dining room experience to ensure compliance and that this practice is embedded within the daily dining experience.
• Nursing Management are linking in with maintenance to update and decorate Communal spaces to ensure they are decorated in line with a residential care setting or inviting places to go to socialize .

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
IPC link Nurse has completed environmental IPC audit. Findings have been highlighted and actioned.

• Nursing management linked in with maintenance and procurement arranged to update the protective surfaces of doors and handrails on corridors to ensure were effective cleaning can be assured.
• Paintwork has been arranged with maintenance
• Nursing management has arranged procurement for two new clinical hand-washing basins to replace the hand wash sinks, which were not compliant with current guidelines, approval on this was granted on 09.08.24. Management now linked in with Maintenance to arrange replacing of the Clinical handwashing basins
• The practice of moving bed tables between two areas has ceased and all staff are aware of the IPC precautions pertaining to same.
• Clean trolley are no longer stored in the sluice room and are now in the clinical room
• All staff have undertaken training on hand hygiene; nursing management have highlighted the importance of 'bare below the elbows' for best practice in hand hygiene technique on each modules safety pause. Nursing management have also highlighted the uniform policy to all staff members to further emphasise the importance of best practice. Nursing management will ensure surveillance and monitoring at ward level to ensure this change is embedded in practice. In addition, nursing management will undertake additional random hand hygiene and uniform clinical audits.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Management have completed a full compartment evacuation of the largest compartment with 10 beds on 01.08.24 and will continue to undertake evacuations on all compartments as per fire safety policy.
• Management has worked in conjunction with the Fire officer and updated the emergency floor plan and the legend for inclusion of the location of the zones. This will assist new staff in orientation and as part of review of safety precautions.
The emergency floor plans are being enlarged and printed to A2 sizing.
• Management have met and informed all staff of the importance of ensuring fire doors are correctly used as per fire safety policy and management are continuing to monitor this. All staff have completed fire training in 01.08.24 and this is ongoing as per fire safety policy.
• Nursing management have notified the Fire Officer and maintenance department regarding the need for a swing free mechanism on the main dining room doors.

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:

• Nursing management have liaised with all nursing team members to raise awareness on the importance of maintaining contemporaneous individualized person centred care plans and the legislative requirement to formally evaluate and review at intervals not exceeding 4 months.

• The resident care plan requiring updating on the 'communication aids' utilised has been undertaken and clarity regarding risk of absconsion.

• The resident care assessment that established no responsive behaviour has been reviewed and updated.

• Nursing management undertook a review of all care plan review dates to ensure reviews are undertaken within the minimum regulatory requirement of assessment every four months. All care plans have been reviewed by the assigned registered nurse and are in compliance with the regulatory requirement.

• The identified resident care plan has been reviewed by the assigned nurse to sufficiently detail the direct care and individual needs and preferences of the resident.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

All bedrails in use in the centre are risk assessed in compliance with the national restraint policy. All bedrails in use in the centre are recorded on the centres restraint log. Nursing management will consult with residents to strive to find alternative solutions to bedrails and lower the number of bedrails in use within the centre.

Regulation 9: Residents' rights	Not Compliant

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

• Nursing management have commenced a review of meaningful activities scheduled within the centre in consultation with the residents. A new activities schedule implemented will be based on residents' preferences and interest and will be monitored by nursing management.
• Nursing management has commenced a review of work practices in both modules. The work practices review incorporates the completion of Work Culture Critical Analysis Tools to support embedding person centred care practices. WCCATs will be undertaken at different times of the day and will be continued over a period of weeks. Nursing management will ensure surveillance and monitoring of practices to ensure a comprehensive and robust change of practice is implemented and embedded at ward level.
• The new 'main dining room' will be accessible to all residents to both enjoy their meals and welcome their relatives to embrace the new 'café feel' environment. Completion date 01.10.24. Residents and relatives will be able to enjoy a new social space to meet and socialise at their leisure. The area will be open and available to residents throughout the day.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	30/09/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	01/10/2024
Regulation 23(c)	The registered provider shall ensure that	Substantially Compliant	Yellow	01/09/2024

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	01/10/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	02/08/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	01/08/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief	Substantially Compliant	Yellow	02/08/2024

	Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	01/09/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	01/09/2024
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated	Substantially Compliant	Yellow	02/08/2024

	centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.			
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Not Compliant	Orange	01/10/2024
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	01/10/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	01/10/2024
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.	Not Compliant	Orange	01/10/2024