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

Issued by the Chief Inspector

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>St. Joseph's Hospital</th>
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<tbody>
<tr>
<td>Name of provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Address of centre:</td>
<td>Lifford Road, Ennis, Clare</td>
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<table>
<thead>
<tr>
<th>Type of inspection:</th>
<th>Unannounced</th>
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<tr>
<td>Date of inspection:</td>
<td>09 October 2019</td>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000613</td>
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<tr>
<td>Fieldwork ID:</td>
<td>MON-0027311</td>
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About the designated centre

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

St. Joseph’s Hospital is a designated centre for older people. Residents are accommodated in single and multi-occupancy shared accommodation bedrooms. The centre is divided into four units. The Ash unit can accommodate 24 male and female residents. The Hazel unit is a 42-bedded female only unit. The Alder unit is a 42-bedded, male only unit. The Holly unit is a 12-bedded dementia specific unit. There is a refurbished corridor that links the Ash, Alder and Hazel units with a variety of communal rooms provided for residents’ use, including sitting, dining and recreational facilities. The centre is located close to Ennis town. Residents have access to enclosed garden area. The centre provides accommodation for a maximum of 120 male and female residents, over 18 years of age. Each resident’s dependency needs are regularly assessed to ensure their care needs are met. There is a chapel in the centre and residents have access to the community and a wide range of activities.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 91 |
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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
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<tr>
<td>10 October 2019</td>
<td>08:00hrs to 15:30hrs</td>
<td>Una Fitzgerald</td>
<td>Lead</td>
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<tr>
<td>09 October 2019</td>
<td>17:30hrs to 20:30hrs</td>
<td>Una Fitzgerald</td>
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<td>10 October 2019</td>
<td>08:00hrs to 15:30hrs</td>
<td>Brid McGoldrick</td>
<td>Support</td>
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<td>08:00hrs to 15:30hrs</td>
<td>Susan Cliffe</td>
<td>Support</td>
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<tr>
<td>09 October 2019</td>
<td>17:30hrs to 20:30hrs</td>
<td>Brid McGoldrick</td>
<td>Support</td>
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What residents told us and what inspectors observed

Inspectors spoke with multiple residents during the course of this inspection and received very positive feedback about the care received on a day to day basis. Residents and relatives spoke positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. Residents told inspectors that their call bells were answered promptly and that staff knew residents likes and dislikes. Residents were happy with the food served and felt that there was adequate choice available. Residents felt that they were part of a community and described how they enjoyed the activities held in the centre for example, the concert held the evening prior to the inspection was enjoyed by all that had attended.

Residents were very vocal in identifying the improvements to their quality of life achieved as a result the reduction in the number of residents accommodated in the multi-occupancy rooms from six to four. Comments to inspectors included 'I need a bit of space', 'I need to be able to view the TV comfortably' and four is enough here now. Residents' verbalised concern on the future plan for the potential admission of more than four residents into the multi-occupancy rooms.

Residents told the inspectors that they have not had any more than four residents in any of the multi-occupancy rooms since the last inspection. Without exception, residents reported that this change was welcomed. Residents expressed real concern that this situation was going to change and asked inspectors for reassurance. Residents informed the inspectors that they had received conflicting feedback on the long term plan for the number of residents that were to be accommodated in the multi-occupancy rooms. Residents that had attended the last resident meeting in September 2019 were informed that there would be no more than four residents in multi-occupancy rooms. No resident had received formal communication from the management team on the long term plan. Some residents also described their intention to resist any effort to increase the number of residents in each room back up to five or six. Inspectors concluded from their conversations with residents that this constant uncertainty was an ongoing cause of concern and stress for residents.

Capacity and capability

The centre which is managed by the Health Services Executive (HSE) has a prolonged history of poor compliance with key regulations associated with residents' quality of life. The findings of repeat inspections were that regulatory
compliance, and consequently the quality of life for residents, improved when the number of residents living in the centre reduced. The HSE is currently required to notify the Office of the Chief Inspector within 72 hours if the number of residents in the designated centre exceeded 100, or fell below 100. A further condition required the HSE to ensure that if the number of residents accommodated in the centre does exceed 100, this does not impact negatively upon the lived experience and quality of life of residents. The rationale for this condition particularly referenced the occupancy of the multi-occupancy rooms in the Hazel and Alder wards exceeding four residents. The occupancy levels reports submitted by the HSE to the Chief Inspector since December 2017 show that occupancy levels have largely been maintained between 90 and 100 residents.

In June 2019 the Chief Inspector issued a notice of proposed decision to renew the registration of this centre but to reduce the occupancy to from 120 to 96 by reducing the occupancy of all multi-occupancy rooms on the Hazel and Alder wards to 4 people. In response the HSE made a submission to the Chief Inspector requesting a review of the proposed conditions. This inspection was carried out to inform the Chief Inspectors consideration of the HSE's submission. This condition was proposed for the purpose of providing residents in the multi-occupancy bedrooms a larger personal bedroom space. The larger space would have a direct positive impact on the residents' daily living. For example, the larger space would allow for care procedures to be carried out in privacy and in a dignified way, residents would be afforded sufficient space to personalise their bedroom space, residents would have sufficient wardrobe space to store their personal items of clothing and footwear. The condition would not only improve on the quality of lives for residents but also improve on compliance with the regulations.

The findings of this inspection are similar to previous inspections; improvements have been achieved through the provision of additional communal day and dining space, renovation of corridors, and the opening of doors improving access from the Hazel and Alder Units to the communal and dining space. The physical environment of these parts of the centre have improved significantly since 2016. On the day of this inspection no more than four residents occupied any room in the Hazel and Alder Units greatly improving the quality of life of residents in these rooms. However the reduction in occupancy was not associated with a reconfiguration of the rooms reducing the benefits to residents and creating anxiety among residents as to the temporary nature of the improved living arrangements.

Inspectors were informed that the staffing WTE for the Alder and Hazel units is currently based on an occupancy of 30 residents. Inspectors found that the number of staff and the skill mix on duty within the care team were adequate. Systems of communication had improved to support clinical staff with providing safe and appropriate care. Each afternoon the staff had a brief handover called "safety pause" to ensure good communication and update all team members of any change. Additional administration support had been put in place for some of the units. There was evidence that residents knew staff well and engaged easily with them in personal conversations.

Similar to previous inspections the findings of this inspection are that
the governance and management of the centre needed to be significantly strengthened and improved to ensure that there was sufficient monitoring and oversight. Increased supervision was required to ensure the service delivered was safe and that the services transitioned from a medical model of care to a social model of care.

Inspectors followed up on the actions required from the last inspection carried out in January 2019. Repeated non compliance were found in twelve of the regulations reviewed and are restated. The management team had not ensured that sufficient progress had been made to bring the centre into compliance with regulatory requirements, the details of which are set out in the rest of this report including:

- Poor oversight of the management of risk once it was escalated to senior management
- Failure to ensure that staff had sufficient knowledge of the procedures to be followed in the event of a fire
- Failure to ensure that all staff had attended up-to-date training in mandatory areas, such as fire safety, safe moving and handling, safeguarding vulnerable persons and management of responsive behaviours
- Failure to ensure that residents privacy and dignity was upheld at all times during the provision of care
- Failure to ensure that cleaning staff were appropriately supervised to ensure that the centre was clean

Regulation 15: Staffing

As found on the last inspection, the centre relied on agency staff to ensure that there were sufficient numbers with the required skill mix on duty to deliver care. Good progress was found on the regularisation of nursing and care staff to work in each unit to ensure continuity of care. This ensured that the staff were familiar with residents and the systems in place.

On previous inspections it was identified that staff in the role of Multi Task Attendant (MTA) who work in the cleaning and catering departments were often redeployed to other duties within the direct provision of care. This redeployment meant that the level of cleaning in the units was not consistent creating an infection prevention and control risk.

Following the inspection conducted in January 2019, the provider committed in the compliance plan that this issue would be addressed by April 2019. However the findings of this inspection is that this did not happen.

Records evidenced a large number of vacancies in the role of MTA with a significant gap in the staff allocated to cleaning and catering duties.
Judgment: Not compliant

### Regulation 16: Training and staff development

Inspectors reviewed the training records and found that not all staff had up-to-date training in mandatory areas, such as fire safety, safe moving and handling, safeguarding vulnerable persons and management of responsive behaviours.

The gaps identified under fire training posed a high risk for residents in the event of the activation of the fire alarm. Staff who held responsibility for taking charge in the event of the fire alarm being activated displayed poor knowledge including knowledge of the location of the fire alarm panel. A review of the training content was required.

Inspectors were not assured that staff were appropriately supervised as evidenced in the standard of cleaning. This is a restated non compliance form the last inspection.

Judgment: Not compliant

### Regulation 23: Governance and management

Governance and leadership arrangements required strengthening to ensure that management systems in place effectively monitored the totality of the service to ensure it was safe, appropriate, consistent and met regulatory requirements. Inspectors were concerned that senior managers with responsibility for the centre did not effectively communicate with the residents living in the centre. Residents were clearly seeking information and reassurance that was not forthcoming from the management team.

There continued to be repeated regulatory non-compliance's from the previous inspection dated January 2019 including:

- Failure to ensure compliance with fire regulations and inadequate oversight of fire safety management. Staff had poor knowledge of procedures for evacuation of residents.
- Failure to ensure compliance with the national policy on the use of restraint.
- Failure to ensure and uphold residents rights' to privacy and dignity.
- Failure to ensure that staff were appropriately trained in mandatory regulation requirements.
- Failure to ensure that staff were appropriately supervised for example cleaning.
- Failure to ensure that the supply of equipment was informed by residents needs for example there were not enough hoists, hoist slings or equipment...
that would assist in reducing the use restraints

- Information requested could not be supplied in a timely manner for example water sampling results.

## Regulation 3: Statement of purpose

The statement of purpose relating to the designated centre did not contain all of the information as set out in regulation Schedule 1 requirements. For example:

- The narrative description of the facilities did not align to the centre floor plans.
- Some information in the statement of purpose was not specific to the designated centre
- The WTE staffing does not clearly state that the centre is currently staffed for a capacity of 30 residents in the Alder and Hazel units.

Judgment: Not compliant

## Regulation 34: Complaints procedure

The centre had an up-to-date policy and procedure for the management of complaints. The HSE complaints procedure ‘Your Service, Your Say’ was displayed and a copy was included in the Resident's Guide. The person in charge informed inspectors that she monitored the complaints from each area.

The complaints log was reviewed and complaints were recorded in line with the regulations, including the outcome of whether the complainant was satisfied with the outcome. Further development of the management of complaints was required to ensure that the any actions or improvements identified were addressed to all appropriate persons. For example: a complaint received from one resident resulted in one resident moving bedroom. There was no evidence on the consultation process that took place with all persons effected by the outcome.

Judgment: Substantially compliant
Quality and safety

As acknowledged in previous reports significant improvements have been made to ensure that the communal sitting rooms and dining rooms are designed in a homely way that is welcoming. Walking along the corridor and communal rooms in the main is a pleasant experience. The activities room along the main corridor is a display of the art and craft work that has been completed by residents. Residents informed inspectors that they are happy with the activities held in the centre.

Systems in place to review and monitor the quality and safety of care required review to ensure that improvements are brought about in work practices and to achieve optimal outcomes for residents. On the day of this inspection the multi-occupancy rooms only accommodated four or less residents but the design and layout of the bed spaces had not changed. As a consequence the curtains that allow for privacy were laid out to accommodate six residents so that the four residents living in each room could not fully benefit from the reduced occupancy and were reluctant to take full advantage of the added space.

This also meant that residents were of the opinion that the space was for their use on a temporary basis only and that a fifth or sixth resident could be admitted at any time. As previously stated, residents looked for reassurance that they would not return to a situation where these rooms would be used to accommodate five or more residents. Previous inspection reports have highlighted in detail how having more than four residents in the multi occupancy rooms had a direct negative impact on residents quality of life. The limited space does not allow staff to provide care to residents while maintaining residents’ privacy and dignity. The space does not allow for residents to personalise their bedrooms.

The management had providing training on person centered care for staff and records evidenced that 88% of staff had completed the training. This training was to aid the bedding down of a social model of care and support the management and staff move away from a medical model of care. Inspectors acknowledge progress made to date.

Issues in relation to the segregation of cleaning and caring duties had not been appropriately addressed, leading to on-going concerns in relation to infection prevention and control. A commitment had previously been given by the provider that this would be addressed by the end of April 2019. This also contributed to deficits found on this inspection in relation to the cleanliness of the centre.

Regulation 11: Visits
Inspectors observed residents receiving visitors in the multi-occupancy rooms. Inspectors concluded that some progress had been made because there was no more than four residents occupying any bedroom during the two days of inspection meaning there were times when residents could be seen interacting with a number of visitors and utilising the nearby empty bed space for this purpose.

However, because bed screens had not been relocated visitors for one resident had to leave if another resident required assistance with personal care. This meant that visits from family were regularly shortened due to the needs of other persons in the shared room. Inspectors also saw limited use of the newly furnished and decorated communal space for the purpose of residents meeting with families.

Judgment: Not compliant

**Regulation 12: Personal possessions**

This inspection found progress in increasing the personal storage space available to some residents and this was appreciated by some residents and relatives.

However additional storage space had not been made available to all residents and some residents continued to have limited wardrobe space for clothing and possessions. For example: one resident had six garments hanging on the door of their wardrobe as there was insufficient space within the wardrobe. In addition, for some residents, much of the wardrobe space was used for storing hygiene items, such as incontinence wear.

The space vacated by the removal of two beds from each multi-occupancy room has not been utilised in a meaningful way to allow residents to personalise their living space and to influence the decor in their living area.

Judgment: Not compliant

**Regulation 17: Premises**

Extensive refurbishment and construction has taken place in recent years providing a marked improvement in facilities and communal space. Despite the change in the number of residents admitted into the multi-occupancy bedrooms since the last inspection the Alder and Hazel units have retained an institutional appearance that limited opportunities to create a homely and personalised environment for residents to reside long term.

Inspectors found that there was inadequate provision of shower facilities available on the Alder and Hazel units. The ratio of showers that are shared is up to 14 residents on the Alder unit and up to 22 residents on the Hazel unit. This calculation
is based on no more that four residents in the multi-occupancy bedrooms. In addition, the location of showering facilities meant that some residents had to travel a long distance along the hallway, passing the communal alcove sitting area to access the showers. This non compliance and the proposed schedule of works that will be undertaken by the provider will be addressed within the compliance plan response.

The overall upkeep and cleanliness of the centre was of poor standard. This was evidenced by:

- Taps have layers of limescale that are not amenable to cleaning.
- Cobwebs and spiders in bathrooms
- Resident bed tables and some wheelchairs were not clean
- Window sills had dead flies
- Multiple examples of resident equipment that was unclean.
- Bathrooms walls are stained
- One shower was out of order on the days of inspection and had been for a number of weeks
- A tap in the Adler unit was not working properly
- One sling observed and used for multiple residents for moving and handling was not in a clean condition

Judgment: Not compliant

**Regulation 26: Risk management**

There was a risk register in place that described a range of risk areas that had been identified and were being managed. For example: the register identified the high use of agency staff as a risk. The inspectors were informed that once a risk required escalation it was removed from the local risk register and put on the operational risk register. However inspectors found that once a risk was escalated there was no evidence of further follow up in addressing the risk.

Staff on duty in the centre were not informed of the progress in addressing risks that were escalated. For example: staff on one unit had escalated a risk associated with a lack of appropriate equipment which was identified as factor associated with a high use of on the high level of bed rails and requested that additional equipment be purchased. The management team informed the inspectors that a business case had been submitted for the purchase of equipment however progress on the decision was not known. It was unclear who had responsibility to follow up on issues on the operational risk register.

The inspectors saw other risks that presented a hazard to residents. Theses include:

- Residents did not have their own sling for use when mobilising from bed to chair using a hoist.
- Limited availability of showers for residents in the multi-occupancy bedrooms.
- Insufficient number of hoists for resident use.
- Staff did not wear identification therefore residents did not know what role they were undertaken
- No risk assessment had been completed on the storage of aprons and gloves on walls of corridors on the risk of choking to residents with a dementia

Judgment: Not compliant

Regulation 27: Infection control

Inspectors were not satisfied that sufficient progress in improving standards of hygiene had been made since the last inspection. The management team told inspectors that an internal hygiene audit had been completed in June 2018 which recommended that the centre develop a local cleaning policy. Inspectors were informed that the policy was awaiting final approval.

The MTA team that have the responsibility for the cleaning in the centre has multiple vacancies. Senior nurse management places the responsibility on each unit with the local manager ward manager to supervise the cleaning in place. When new staff commence in the role there is no guidance document for them to follow that outlines the practices and procedures on the units in the centre. Supervision on the standard of cleaning remains poor as evidenced by

- Taps have layers of lime scale that are not amenable to cleaning
- Cobwebs and spiders were evident on ceilings, walls and corners in bathrooms
- Window sills in some areas had dead flies
- Bathrooms walls are stained
- Resident bed tables and some wheelchairs were not clean
- Resident equipment was unclean
- Hoist slings used for multiple residents for moving and handling were not clean

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors were not assured that there were adequate arrangements were in place to protect against the risk of fire.

The fire policy was dated 05 July 2019 and information contained in the policy did not align with fire instructions. Inspectors were not assured that the larger
Compartments within the centre can be evacuated in a timely manner as evidenced by

- the poor responses given by multiple staff on what to do in the event of the fire alarm being activated
- the equipment resources available.

For example on one unit there were only two wheelchairs available when the Personalised Emergency Evacuation Plans (PEEP) identified that four wheelchairs were required to evacuate residents in the event of a fire.

The record of training provided on the inspection dated Quarter 2 2019 identified that only 70% of staff had up to date fire training. The information given to inspectors identified that 98 staff were due to participate in a fire drill. Management were unable to advise how many of this number had since completed the fire training.

A full review of the fire training that is delivered within the centre was required to ensure that the information given is centre specific. Additional concerns specific to fire safety identified by inspectors included:

- PEEP documentation was not always accurate
- The fire exit on the Alder unit from the end of the corridor onto the enclosed gardens was not wheelchair accessible with steps leading to the outside
- Fire exit doors were obstructed by bins, wet floor signs and pieces of equipment rendering exits ineffective
- One fire exit path had moss on it presenting a fall risk
- Poor external lighting was observed on one of the units
- Records of drills viewed had times of 6 mins and over for evacuation.

Judgment: Not compliant

### Regulation 29: Medicines and pharmaceutical services

Inspectors' followed up on the actions from the last inspection and were satisfied that medications requiring refrigeration were stored appropriately and the fridge temperature was monitored.

Judgment: Compliant

### Regulation 5: Individual assessment and care plan

Overall inspectors found that care plans were person centred and guided care. Inspector followed up on the actions from the last inspection and were satisfied with the progress made.
Judgment: Compliant

### Regulation 7: Managing behaviour that is challenging

Assessment and care plans in relation to the use of restraint required significant improvement. The ongoing assessment of the continued need for restraint was poor. For example, on one unit inspectors looked at the assessment of continued need and the records evidenced that there was more that a 12 month gap between assessment dates.

Bed rail assessments were completed by the nursing staff without evidence of input from the general practitioner or allied healthcare professionals in the decision process. In addition, the inspector was informed that less restrictive alternatives were not always available for example one unit did not have access to bed wedges.

The centre's management of the use of restrictive practices was not operating in line with national policy.

Judgment: Not compliant

### Regulation 9: Residents' rights

Residents told inspectors that they were happy with the activities schedule in place. For example, every Sunday mass is celebrated for residents and afterwards a coffee morning is held. The coffee morning allowed residents stay in touch with their local community.

As stated in the last three reports residents rights to appropriate standards of privacy and dignity is impacted on by the provision of insufficient personal space. This issue is outside the control of those working in the centre on a day to day basis and requires definitive action by senior HSE managers to effect the necessary action.

The curtain layout in some bedrooms was such that it was not possible for staff to deliver care in a dignified way. For example, screen curtains do not always meet and so the resident receiving the care is at high risk of being inappropriately exposed. Inspectors observed a resident receiving personal care in an undignified way. Another example of an affront to dignity was observed for a number of residents as a result of staff not managing and responding to a resident's specific continence needs appropriately. These observations confirmed that residents rights and dignity is not seen as a part of care delivery.

Televisions were located in the bedrooms and in the communal rooms. Due to the layout of the beds in multi-occupancy rooms and the placement of the televisions, it...
was difficult for some residents to see the television.

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:

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<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
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<tr>
<td>Regulation 15: Staffing</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 16: Training and staff development</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 34: Complaints procedure</td>
<td>Substantially compliant</td>
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<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
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<tr>
<td>Regulation 11: Visits</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 12: Personal possessions</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 17: Premises</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 26: Risk management</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 27: Infection control</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 28: Fire precautions</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 29: Medicines and pharmaceutical services</td>
<td>Compliant</td>
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<tr>
<td>Regulation 5: Individual assessment and care plan</td>
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<td>Regulation 7: Managing behaviour that is challenging</td>
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<tr>
<td>Regulation 9: Residents' rights</td>
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Compliance Plan for St. Joseph's Hospital OSV-0000613

Inspection ID: MON-0027311

Date of inspection: 10/10/2019

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. **Specific** to that regulation, **Measurable** so that they can monitor progress, **Achievable** and **Realistic**, and **Time 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:**

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
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<tr>
<td>Regulation 15: Staffing</td>
<td>Not Compliant</td>
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Outline how you are going to come into compliance with Regulation 15: Staffing:
- There has been a recent recruitment campaign for multi task attendant staff which is at an advance stage of recruitment. Staff have been identified for a number of posts and are currently been processed by HR. Once vacancies have been filled, priority will be assigned to the house-hold roster within the designated centre.
- As part of the recruitment campaign, an agency member of staff has been regularized to the roster on the Hazel Unit, temporarily filling their current vacant position.
- There is full segregation of roles for all staff grades, including household staff on cleaning and catering duties and health care attendant (HCA) staff who complete direct resident care.
- Some agency staff can complete both household and HCA duties but no cross over takes place during the same shift.
- No HSE staff redeploy from their dedicated role i.e. cleaning to care duties.
- The local cleaning team to support the units has been in operation since April 2019. The operation of this team may be interrupted due to unplanned leave.

| Regulation 16: Training and staff development          | Not Compliant  |

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
- All staff, including the newly recruited MTA who started on the 18th November 2019, have initial training in Safeguarding completed. Safeguarding Vulnerable Adults Training was completed on 14th November 2019 with 12 staff attending. Further training is scheduled for Jan 2020, date to be confirmed.
- Restrictive Practice Awareness sessions have been facilitated and delivered at Unit level
by the Practice Development Co-ordinator and completed on the 20th November 2019.

Actions in progress:
- Fire training is scheduled for 22.11.2019 and again on 06.12.2019, 100% of all staff will be trained by 06.12.2019.
- 11 staff are currently completing training, which is taking place on site, in the designated centre, the dates for training are 18.11.2019, 19.11.2019 and 22.11.2019. The training coordinator has completed a full hygiene audit on site prior to commencing the training to inform the content of the training.
- All Units will have up-to-date training matrix available, this will be completed post training 22nd November 2019.
- Restrictive Practice training is planned to be provided by an external facilitator, dates to be confirmed.
- Person Centered training is scheduled for 21.11.2019; takes place on site in the designated centre.

- Proposed timescale: 31st January 2020

<table>
<thead>
<tr>
<th>Regulation 23: Governance and management</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 23: Governance and management:</td>
<td></td>
</tr>
<tr>
<td>Fire safety:</td>
<td></td>
</tr>
<tr>
<td>Actions completed:</td>
<td></td>
</tr>
<tr>
<td>• Review of the management of the fire phone has been completed and was actioned immediately following the inspection, on 10th October 2019. The DON/ ADON ensure that the receiving staff member is aware of fire safety procedures on the handover of the phone.</td>
<td></td>
</tr>
<tr>
<td>• A new Fire Safety Awareness checklist has been developed, in line with the Fire policy. This has been distributed to all staff in the form of laminated cards and posters and located in high profile areas to increase awareness and education. The fire safety checklist is discussed at the Safety pause. This has been actioned since 21st October 2019.</td>
<td></td>
</tr>
<tr>
<td>• Daily Safety Pause fire awareness discussion commenced immediately following the inspection on the 10th October 2019</td>
<td></td>
</tr>
<tr>
<td>• All night and day PEEPs have been reviewed.</td>
<td></td>
</tr>
<tr>
<td>• All staff have been provided with evacuation guidelines card</td>
<td></td>
</tr>
<tr>
<td>• Sufficient numbers of equipment required for the safe evacuation of each resident as per the PEEP is in place.</td>
<td></td>
</tr>
<tr>
<td>• Daily fire checks continue and are completed by Staff nurse in charge on unit, PIC on</td>
<td></td>
</tr>
</tbody>
</table>
Actions in progress:
- Fire training has been scheduled for 22.11.2019 and again on 06.12.2019 to ensure 100% compliance with training for all staff by 06.12.2019.
- The Fire Officer facilitating training on the 22.11.2019 will conduct simulated evacuations based on night time staffing in the largest compartment, and demonstrate an effective fire drill to be replicated throughout the center.
- Once demonstrated simulated evacuation is completed then it is planned that all units will complete a fire drill every 6 months using night duty staffing/ evacuating largest compartment on the unit.
- Person in Charge daily identifies the fire responder if fire alarm is sounded ensuring that they are a competent person.

Proposed timescale: Training to be completed by 6th December 2019

National restraint policy and restraint practice:

Actions Completed:
- Assessments and care plans in relation to the use of restraint have been reviewed, revised and updated. Alternative approaches have been identified, implemented and documented.
- The revision of the use of restrictive practices and their purpose is discussed with the G.P, OT and Physio.
- There has been a renewed focus from management and staff in relation to restrictive practice.
- In addition, a Unit Based Quality Improvement Team has been established with the focus to promote quality improvements in the use of restrictive practice, to assess physical and environmental restraint as well as other forms of restrictive practice, e.g. involving the resident in the development of their own plan of care and review of same.
- A Care Plan Development and Implementation Policy has been issued to staff nurses at the staff nurse meeting. This has been discussed at the daily safety pause with all clinical staff.
- All staff nurses have read and signed the National Restraint Policy. The HIQA Guideline in relation to Human Based Rights approach to care delivery has been issued and discussed with staff at Unit based staff meetings.
- A restraint audit was completed in Alder Unit. A Quality Improvement plan has been developed and actioned.
- Instruction given to all staff that no newly admitted resident to have restraint initiated without MDT input and discussion with ADON/DON on duty, and to have demonstrated that alternates are trialled.
- Release and restraint charts and daily register on unit and in ADON office is maintained with ongoing checks by ADON each Sunday checks restraint record against practice on units.

Actions in progress:
- Audit schedule Quality Care Matrix ‘Test your Care’ is completed monthly. Time lined Quality improvement plans are developed by the CNM2 and actioned locally.
• Unit Based Quality Improvement Team has been established in the designated centre
in relation to documentation and care planning
• Restrictive practice training by CNME specialist coordinator will be scheduled for
January 2010, dates to be confirmedRestrictive Practice audit to be completed Quarterly,
with one scheduled for 8.12.19.
• Unit based restrictive practice awareness sessions have been facilitated by the Practice
Development Co-ordinator on the 18th, 19th and 21st of Nov 2019, with further sessions
planned

Residents Rights :

Actions completed:
• A Residents Forum is held monthly on site, chaired by resident, all minutes are
reviewed. Forum attended by ADON or DON when invited/ available.
• On site education sessions, facilitated by the Practice Development Co-ordinator have
been completed on site on the 18th, 19th and 20th of November 2019, with a ‘Person
Centered’ focus to care delivery.
• The Director of Nursing completed a ‘Back to the floor’ exercise for a morning to
observe standards of care delivery at Unit level on the 14.10.2019. Increased frequency
of Unit visits and ‘walk a rounds’ are in place by the DON and ADON’s to enhance
supervision.
• Currently there are 4 long stay residents accommodated in one bedroom in the Hazel
and Alder units, this is staffed as per resident occupancy. The short stay resident
population is accommodated in a separate bedroom from the long stay residents.

Actions in progress:
• Resident experience survey completed in July/ August 2019, due to be repeated in
• Person centered training is scheduled for 21.11.2019.

Proposed timescale : Repeat resident survey to be completed by 31st December 2019

Training:

Actions completed:
• All staff have Initial training in Safeguarding completed. Safeguarding Vulnerable Adults
Training was completed on 14.11.2019 with 12 staff attending. Further training is
scheduled for Jan 2020, date to be confirmed.

Actions in progress:
• Fire training is scheduled for 22.11.2019 and again on 06.12.2019, 100% of all staff
will be trained by 06.12.2019.
• Infection Prevention and Control training is scheduled for 11.12.2019.

Proposed timescale: Training to be completed by 6th December 2019

Supervision of cleaning:
Actions completed:
• Daily visits to units by DON & ADON with a ‘walk a rounds’ plan in place. This allows for observation of practice, immediate management of any concerns and discussion/informal feedback provided to staff.
• All units have a revised cleaning schedule for equipment and environment in place, oversight for cleaning at Unit level with CNM/PIC.

Actions in progress:
• 11 staff are currently completing training for 3 days on site in the designated centre, the dates for training are 18.11.2019, 19.11.2019 and 22.11.2019. The training coordinator has completed a full hygiene audit on site prior to commencing the training to inform the content of the training.
• A multidisciplinary audit team will complete an audit under the auspices of Infection Prevention and Control, Risk Management, Medication Management and health and safety on the 22nd November 2019. This is been facilitated by the QPS Department.

Proposed timescale: Training and audit to be completed by 22nd November 2019

Risk Management:

Actions completed:
• Full review of the Risk Register has been completed with the risk advisor.
• Escalated risks are discussed at monthly meetings
The governance for this action plan is through the cadence of reporting structures in place:
• Chief Officer meets Head of Service, Social Care on a 1:1 monthly
• Head of Service, Social Care, meets General Manager on a 1:1 every 3 weeks
• General Manager meets Director of Nursing on a 1:1 monthly

• Local work streams have been established with all grades of staff represented on the workstreams, to improve and standardize practice across all units and sustain progress and future development.

Proposed timescale: 14th October 2019

<table>
<thead>
<tr>
<th>Regulation 3: Statement of purpose</th>
<th>Not Compliant</th>
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</thead>
</table>

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• A revised copy of the Statement of Purpose was forwarded to the Regulatory Authority and the narrative description is now aligned with the floor plans. Information that is not specific to the designated centre has been removed.
**Regulation 34: Complaints procedure** | **Substantially Compliant**
--- | ---
Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
- All complaints are fully investigated by a trained Complaints Officer
- Any learning is shared via learning notices within the Hospital and across the CNUs
- The record summary for any complaint received has been reviewed to include any impact/outcome for all residents – where appropriate or required, who may have been affected by the issue of complaint, where relevant.
- Initiatives such as ‘What Matters to Me’ and ‘Making Every Contact Count’ are used
- Issues highlighted during a complaint that affect other residents may be discussed at the Residents Forum.

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**Regulation 11: Visits** | **Not Compliant**
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Outline how you are going to come into compliance with Regulation 11: Visits:
- There are a number of accessible, pleasant, inviting rooms available for residents to receive their visitors throughout the center on a daily basis. Staff will assist any resident who requires access to these rooms, which include the Seomra Cuirte, the sun room, and the dining rooms opposite the Alder and Hazel units, along with the relaxation room. There is also an annex area on the Alder and Hazel units equipped with TV’s and radio along with suitable seating for older persons, where families can spend quality time visiting with their relatives.
- Residents are actively encouraged and facilitated to avail of these rooms.
- The Ash Unit has a large sitting room attached to the unit, along with an annex area and dining room.
- The Holly Unit has a large sitting/dining room area and also a foyer area with seating for residents and visitors to sit and enjoy their company.

Proposed timescale: 14th October 2019

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**Regulation 12: Personal possessions** | **Not Compliant**
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Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• All residents on the Alder, Ash and Hazel Units have a large wardrobe available for personal items, with some residents availing of two wardrobes, pending on their needs. The Holly Unit has inbuilt wardrobe space in the bedrooms.

Proposed timescale: 14th October 2019

<table>
<thead>
<tr>
<th>Regulation 17: Premises</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 17: Premises: Actions completed:</td>
<td></td>
</tr>
<tr>
<td>• The cleaning schedule for environmental and equipment has been revised at Unit level, and all staff informed of same.</td>
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<tr>
<td>• A local ‘Cleaning’ work stream has been developed to improve and standardize practice across the site, with all grades of staff represented on same.</td>
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<tr>
<td>• The cleaning team schedule has been revised and all Units will receive high dusting once weekly, along with full floor deep cleaning.</td>
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<tr>
<td>• Additional slings are available on site for resident use.</td>
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<tr>
<td>• The shower in the Alder Unit was repaired to full working order, is fully functional, since the 15.10.2019.</td>
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<tr>
<td>Actions in progress:</td>
<td></td>
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<tr>
<td>• The household MTA staff, involved with cleaning duties, are engaged in training, 11 staff, which will be completed on the 22.11.2019.</td>
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<tr>
<td>• The training coordinator has completed a full hygiene audit on site prior to commencing the training to inform the content of the training. A QIP has been developed and communicated to all grades of staff during training and subsequently at staff meetings.</td>
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</tr>
<tr>
<td>• A multidisciplinary audit team will complete an audit under the auspices of infection prevention and control, risk management, medication management and health and safety on the 22nd November 2019.</td>
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<tr>
<td>• The provision of additional showers is currently under review. Options are been appraised and a design team has been engaged to progress the work. A tender will be produced over the next couple weeks.</td>
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<td>Proposed timescale: 31st August 2020</td>
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</table>

<table>
<thead>
<tr>
<th>Regulation 26: Risk management</th>
<th>Not Compliant</th>
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</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 26: Risk</td>
<td></td>
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</tbody>
</table>
management:
• A full review of the current Risk Register has been completed with the risk advisor.
• The Fire Safety risk associated with current fire practice has been added to the register along with the Infection Prevention and Control risk from shared equipment such as slings.
• The risk associated with Infection Prevention and Control due to standards of cleaning has been revised and actions added.
• There was a full review of current existing risks live on the risk register.
• Escalated risks are discussed at monthly senior management meetings

Proposed timescale: 8th November 2019 & ongoing

<table>
<thead>
<tr>
<th>Regulation 27: Infection control</th>
<th>Not Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 27: Infection control:</td>
<td></td>
</tr>
<tr>
<td>Actions completed:</td>
<td></td>
</tr>
<tr>
<td>• A baseline Environmental Audit was undertaken by an external auditor on 18 November 2019. A QIP has been developed and communicated to all grades of staff during training and subsequently at staff meetings.</td>
<td></td>
</tr>
<tr>
<td>• 11 staff will have completed training on 18.11.2019, 19.11.2019 and 22.11.2019. The training was delivered onsite.</td>
<td></td>
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<tr>
<td>• The cleaning team schedule has been reviewed and revised. The schedule has been discussed and cascaded to the CNM2 and cleaning staff. The schedule now includes issues highlighted in the report.</td>
<td></td>
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<tr>
<td>• Additional slings have been purchased for individualized residents.</td>
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<tr>
<td>Actions in progress:</td>
<td></td>
</tr>
<tr>
<td>• Infection Prevention and Control training is scheduled for 11.12.2019.</td>
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</tr>
<tr>
<td>• A Quality, Risk and Safety audit is scheduled for 22.11.2019. The auditors include, Quality Risk and Safety, Infection Prevention and Control, Health and Safety Officer and the Chief Pharmacist.</td>
<td></td>
</tr>
<tr>
<td>• Approval has been secured and the HR process is advanced in recruiting HSE staff for the house-hold roster (Cleaning and catering duties).</td>
<td></td>
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<tr>
<td>Proposed timescale: 31st December 2019</td>
<td></td>
</tr>
</tbody>
</table>

| Regulation 28: Fire precautions | Not Compliant |
Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Actions completed:
- The Fire Management Policy has been reviewed and updated. The information contained in the fire policy provides clear fire instructions.
- All staff working within the designated centre have completed a fire safety awareness check list since the last inspection.
- Fire exit doors are reviewed daily to ensure unobstructed egress in the event of a fire.
- The provision of external lighting across the designated centre has been audited and addressed.
- Fire training has been scheduled for 22.11.2019 and 06.12.20.
- The moss outside the fire exit has been removed and cleaned, this is no longer a falls risk.
- Weekly fire checks are maintained, daily fire equipment checks are maintained and a full service record of all equipment available.
- Person in Charge identifies daily the fire responder if fire alarm is sounded.

Actions in progress:
- Fire training has been scheduled for 22.11.2019 and 06.12.20 to include simulated unit based evacuation drills based on night time staffing levels.
- Further to the Fire Safety training, additional topics discussed following the HIQA inspection.
- Each Unit has a 3 minute safety pause in respect to fire management and emergency protocol daily.
- Following a review of each residents PEEP, the mode of transport in order to safely evacuate the individual resident is now documented.
- Sufficient number of equipment required for each resident as per the PEEP is in place.
- Ongoing weekly PEEP checks has been implemented in order to ensure accuracy

Proposed timescale: 10th October 2019

Training to be completed 6th December 2020

<table>
<thead>
<tr>
<th>Regulation 7: Managing behaviour that is challenging</th>
<th>Not Compliant</th>
</tr>
</thead>
</table>

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

Actions completed:
- A Standard Operating Procedure has been implements in Restrictive Practice dated October 2019
- All nurses have read and signed the National Restraint Policy. The HIQA Guideline in relation to Human Based Rights approach to care delivery has been issued and discussed with staff at Unit based staff meetings.
- Assessments and care plans in relation to the use of restraint have been reviewed,
revised and updated. Alternative approaches have been identified, implemented and documented.

- The revision of the use of restrictive practices and their purpose is discussed with the G.P., OT and Physio.
- There has been a renewed focus from management and staff in relation to restrictive practice.
- In addition, a Unit Based Quality Improvement Team has been established with the focus to promote quality improvements in the use of restrictive practice, to assess physical and environmental restraint as well as other forms of restrictive practice, e.g. involving the resident in the development of their own plan of care and review of same.
- A Care Plan Development and Implementation Policy has been issued to staff nurses at the staff nurse meeting. This has been discussed at the daily safety pause with all clinical staff.
- A restraint audit was completed in Alder Unit. A Quality Improvement plan has been developed and actioned.
- No newly admitted resident is to have restraint initiated without MDT input and discussion with ADON/ DON on duty, and can demonstrate that alternatives have been considered and trialled.
- Practice put in place whereby the ADON checks restraint record against practice on units weekly.

Actions in progress:
- Audit schedule Quality Care Matrix ‘Test your Care’ is completed monthly. Time lined quality improvement plans are developed by the CNM2 and actioned locally.
- Unit Based Quality Improvement Team has been established in the centre in relation to documentation and care planning
- Restrictive practice training by CNME specialist coordinator will be scheduled for January 2010, dates to be confirmed.
- Unit based restrictive practice awareness sessions have been facilitated by the Practice Development Co-ordinator on the 18th, 19th and 21st of Nov 2019, with further sessions planned.

Proposed timescale: 31st January 2020

<table>
<thead>
<tr>
<th>Regulation 9: Residents' rights</th>
<th>Not Compliant</th>
</tr>
</thead>
</table>

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Actions completed:
- Measures have been taken to ensure that the screen curtains meet in order to ensure that the resident receives care in a dignified manner.
- Awareness sessions with staff in relation to the importance of ensuring that care practice is delivered in a dignified and personal manner. Sessions were held on 18, 19th and due to take place on 21st November. 2019.
- The Practice Development Co-ordinator has provide feedback to all clinical staff in
Alder Unit, inclusive of the CNM2 of findings, new ways of working were discussed and agreed. The emphasis was on operationalising person centered care and Human Rights Based approach to Care delivery.

- The Director of Nursing completed a ‘Back to the floor’ exercise working clinically with staff, to observe care delivery on the 14.10.2019. This identified quality improvement requirements which was discussed at CNM2 meetings.
- Increased frequency of unit visits and ‘walk a rounds’ are in place by the DON and ADON’s.
- Currently there are 4 long stay residents accommodated in one bedroom in the Hazel and Alder units, this is staffed as per resident occupancy. The short stay resident population is accommodated in a separate bedroom from the long stay residents.
- Privacy signs in place and Doors closed with Curtains pulled for all care delivery.
- Monthly Quality Care Metric audits continue, with a follow up of quality improvement plans.
- Resident experience survey to be completed again in Q4, was completed in Q3.
- ADON’s attending unit based staff meeting once weekly.

Actions in progress:
- Person centered care training has been scheduled for 21.11.2019.

Proposed timescale: 21st November 2019
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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 11(1)</td>
<td>The registered provider shall make arrangements for a resident to receive visitors.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>20/11/2019</td>
</tr>
<tr>
<td>Regulation 11(2)(b)</td>
<td>The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident’s room, is available to a resident to receive a visitor if required.</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>20/11/2019</td>
</tr>
<tr>
<td>Regulation 12(a)</td>
<td>The person in charge shall, in so far as is reasonably practical, ensure that a resident has</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>20/11/2019</td>
</tr>
<tr>
<td>Regulation 12(c)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>20/11/2019</td>
</tr>
<tr>
<td>Regulation 15(1)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31/12/2019</td>
</tr>
<tr>
<td>Regulation 16(1)(a)</td>
<td>The person in charge shall ensure that staff have access to appropriate training.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>06/12/2019</td>
</tr>
<tr>
<td>Regulation</td>
<td>Description</td>
<td>Compliance</td>
<td>Color</td>
<td>Date</td>
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<td>------------</td>
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<tr>
<td>16(1)(b)</td>
<td>The person in charge shall ensure that staff are appropriately supervised.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>22/11/2019</td>
</tr>
<tr>
<td>16(2)(a)</td>
<td>The person in charge shall ensure that copies of the Act and any regulations made under it are available to staff.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>20/11/2019</td>
</tr>
<tr>
<td>17(1)</td>
<td>The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>20/11/2019</td>
</tr>
<tr>
<td>17(2)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31/08/2020</td>
</tr>
<tr>
<td>23(a)</td>
<td>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</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>20/11/2019</td>
</tr>
<tr>
<td>Regulation 23(b)</td>
<td>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.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>20/11/2019</td>
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</tr>
<tr>
<td>Regulation 23(c)</td>
<td>The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>20/11/2019</td>
</tr>
<tr>
<td>Regulation 26(1)(b)</td>
<td>The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>20/11/2019</td>
</tr>
<tr>
<td>Regulation 27</td>
<td>The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections</td>
<td>Not Compliant</td>
<td>Yellow</td>
<td>31/12/2019</td>
</tr>
<tr>
<td>Regulation 28(1)(c)(ii)</td>
<td>The registered provider shall make adequate arrangements for reviewing fire precautions.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>20/11/2019</td>
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<tr>
<td>Regulation 28(1)(d)</td>
<td>The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>06/12/2019</td>
</tr>
<tr>
<td>Regulation 28(1)(e)</td>
<td>The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>20/11/2019</td>
</tr>
<tr>
<td>Regulation</td>
<td>Description</td>
<td>Compliance</td>
<td>Date</td>
<td></td>
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<tr>
<td>03(1)</td>
<td>The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.</td>
<td>Substantially Compliant</td>
<td>20/11/2019</td>
<td></td>
</tr>
<tr>
<td>34(1)(g)</td>
<td>The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall inform the complainant promptly of the outcome of their complaint and details of the appeals process.</td>
<td>Not Compliant</td>
<td>20/11/2019</td>
<td></td>
</tr>
<tr>
<td>34(1)(h)</td>
<td>The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.</td>
<td>Substantially Compliant</td>
<td>20/11/2019</td>
<td></td>
</tr>
<tr>
<td>7(3)</td>
<td>The registered provider shall</td>
<td>Not Compliant</td>
<td>20/11/2019</td>
<td></td>
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<tr>
<td>Regulation 9(3)(a)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>20/11/2019</td>
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<tr>
<td>Regulation 9(3)(b)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>20/11/2019</td>
</tr>
<tr>
<td>Regulation 9(3)(d)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>20/11/2019</td>
</tr>
</tbody>
</table>