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:	Sacred Heart Hospital, Carlow
Name of provider:	Health Service Executive
Address of centre:	Old Dublin Road, Carlow, Carlow
Type of inspection:	Unannounced
Date of inspection:	14 June 2022
Centre ID:	OSV-0000549
Fieldwork ID:	MON-0034393

About the designated centre

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

Sacred Heart Hospital is a 63-bed facility located within walking distance of Carlow town centre. Residents' accommodation is arranged in three interconnecting units. The units are Sacred Heart unit has 20 beds, St Clare's unit has 21 beds, and St James' unit has 22 beds. The centre provides care for male and female residents over 18 years of age with continuing care, dementia, respite, palliative care and rehabilitation needs. The centre is registered to provide 44 long-term beds, 14 rehabilitation beds, including one respite bed for dementia care, two community assessment beds and four short-stay beds. Residents' accommodation is arranged at ground floor level in 14 multiple occupancy bedrooms with four residents in each, one twin bedroom and five single bedrooms. There is a combined communal sitting and dining room on each unit. The provider employs nurses and care staff to provide care for residents on a 24-hour basis. The provider also employs GP, allied health professionals, catering, household, administration and maintenance staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	59

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 14 June 2022	09:35hrs to 18:35hrs	Helena Budzicz	Lead
Tuesday 14 June 2022	09:35hrs to 18:35hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

On the day of the inspection, inspectors met with a number of residents and spoke with seven residents in more detail. The inspectors saw many positive interactions between staff and residents. It was evident that the staff knew the residents very well and were familiar with the residents' daily routines and preferences for care and support. However, the visiting arrangements in the centre observed on the day of the inspection and the gaps in the managerial oversight arrangements on staff practices had a negative impact on residents' rights and overall living experience in the centre.

The inspectors arrived at the centre unannounced and were met by the acting assistant director of nursing, who facilitated the inspection in the absence of the person in charge. Following an opening introductory meeting, the inspectors walked around the centre. There were 59 residents accommodated in the centre on the day of the inspection. Inspectors saw that many residents were up, dressed and ready for the day; however, they stayed mainly in their bedrooms and sat in the armchairs beside their beds. They were well-groomed and appeared content and comfortable. Residents told inspectors that staff were always available and willing to assist them when they needed help.

The designated centre is within walking distance of Carlow town, close to local amenities, and accessible from the main road. The centre accommodates residents in three units St James's, St Clare's and Sacred Heart unit and has a spacious car park. Inspectors observed that since the previous inspection, the centre had undergone some significant improvements to the premises, and saw that throughout the centre, the décor was modern and suitably decorated. Residents had access to communal space within communal/dining rooms on each unit, and some residents were seen to spend time within these spaces mainly in the afternoon. However, inspectors observed that parts of some communal rooms had been changed and were being used for storage purposes, and as a result, inspectors noted a limitation of the communal space for residents. Additionally, the double-occupancy bedroom on the Sacred Heart unit, as outlined in the attached condition of the registration, was not converted to the communal/dining room as declared by the provider.

Residents' bedrooms were neatly presented and had sufficient personal storage space available for residents. All bedrooms were observed to have sufficient space for residents to live comfortably. This included adequate space for residents to store personal belongings. Residents had unlimited access to television, radio, newspapers and books.

The inspectors saw that there was an activity schedule available on St James's and Sacred Heart unit; however, there was no clear schedule of activities for seven days a week. The staff informed inspectors that individual activity sessions were provided for most residents, such as shaving, nail clipping and personal care, especially in the morning. Inspectors found that the arrangements that were in place did not ensure

that residents, particularly those residents located in both units, had access to meaningful activities. Therefore, current arrangements did not ensure that all residents had the opportunity to participate in the social activities available in accordance with their interests and capabilities.

Inspectors saw that enclosed courtyards were available for residents in St James's and St Clare's units; however, the access doors were key-locked. This meant that many of the residents required staff assistance to unlock these doors when they wished to use them, which restricted their independence.

Inspectors observed residents eating their lunch in dining rooms in St James's and St Clare's units. Residents spoken with said they enjoyed the food served to them, and they were happy with the food provided. The choice of condiments was missing on all tables in St Clare's unit. Staff served the meals on trays and put one piece of salt, pepper or butter on the resident's serving tray without asking the resident about their choice. Furthermore, inspectors noted that the food menu was not updated according to the food menu plan and the format available was not always dementia-friendly. There was sufficient staff available in the dining rooms to assist residents as needed.

There was signage displayed throughout the designated centre, which informed staff, residents and visitors of procedures to follow to reduce the risk of infection, such as the wearing of personal protective equipment (PPE), hand hygiene and cough etiquette.

Most staff were observed following infection control guidelines with the correct use of personal protective equipment (PPE) and hand hygiene; however, five staff were wearing hand or wrist jewellery. This meant they could not clean their hands effectively. This could impact on good infection control (IPC) practices in the centre and could lead to cross-contamination.

There were ample hand hygiene sinks, and alcohol-based hand rubs located throughout the building. Residents who spoke with inspectors said that they saw staff wash their hands regularly when giving care. They said they were happy with the level of cleanliness in the centre and were complimentary about the cleaning staff and said they were "very good and always cleaning".

The next two sections of this report will summarise the findings of the inspection and discuss the levels of compliance found under each regulation.

Capacity and capability

This was an unannounced risk inspection carried out over one day to monitor compliance with the Health Act (2007), as amended and the Regulations and Standards made there under. Inspectors followed up on the actions taken to address non-compliances found on the previous inspection dated 06 November 2020

and reviewed the registered provider's application to vary conditions 1 and 3 and to remove condition 4 of the registration. Discrepancies were identified in the application to vary, including the statement of purpose and the floor plans. The discrepancy on the application to vary has been clarified; however, inspectors noted that the statement of purpose and the floor plans do not correlate with each other, and the designated purpose of some rooms assigned for residents to use as a part of their communal space was in reality used for storage purposes. Consequently, inspectors found that the registered provider is not operating the centre in line with the regulations. In addition, the provider failed to fully address the refurbishment plan as outlined in the attached condition 4 and key-risks within the centre, such as ensuring a full-time person in charge was in place at all times, as further outlined in this report.

The Health Service Executive (HSE) is the registered provider of Sacred Heart Hospital, Carlow. The acting assistant director of nursing facilitated the inspection in the absence of the person in charge and responded to any queries that arose during the day. Since the previous inspection, the governance and management oversight of the centre did not improve as the person in charge continues to have managerial responsibilities in other centres, which are managed by acute services. The person in charge was appointed to their role in April 2022 on an interim basis. However, the registered provider failed to submit all relevant documents in respect of the person in charge as requested by the regulation, and as a result, there was no appointed person in charge in the centre at the time of inspection. A warning provider meeting was held with the registered provider after the inspection to discuss the registration of the centre, the findings of the last inspection and provider's previous commitments and the significant risks identified during this inspection, some of which are recurrent findings.

The centre had experienced a recent COVID-19 outbreak, which finished in March 2022. It affected a small number of residents and staff. A formal review of the management of this COVID-19 outbreak had not been completed.

Inspectors were informed that staff had received education and training in infection control either through e-learning or a combination of face-to-face training and e-learning. They had access to up-to-date IPC policies and national guidance to inform their practice. There was a developing antimicrobial stewardship program (AMS) in the centre. While monitoring some healthcare-associated infections, such as multi-drug resistant organisms (MDROs) and indwelling catheter use, not all MDROS were monitored to allow for early identification of infections or colonisation so that the provider could promptly put in place measures to prevent possible onward transmission.

Overall accountability, responsibility and authority for infection prevention and control within the centre rested with the person in charge, who was also the designated COVID-19 lead. The infection control program was supported by an IPC lead nurse, and each unit had an infection control link practitioner. There were formalised links with the regional Community Health Organisation (CHO) infection control team. The infection control lead, link practitioners and the community infection control team completed audits and supported training and practice in the

centre.

There were systems in place to monitor and respond to risks that may impact on the safety and welfare of residents. This included risks specific to COVID-19. A review of management meeting minutes outlined that the management team were meeting regularly and were discussing key performance indicators (KPIs) and topics relevant to service delivery.

Staff were supported and facilitated to attend training appropriate to their role. However, the supervision of staff was not effective as inspectors observed staff practices in respect of storage practices, management of restrictive practices, and fire safety were not appropriate.

The annual review of the service for 2021 was completed, and there was evidence of consultation with residents and their representatives.

There was no centre-specific complaints policy and procedure in place. Consequently, details such as the key-personnel involved in the management of complaints were missing.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

An application to vary conditions 1 and 3 and to remove condition 4 attached to the current registration of the Sacred Heart Hospital had been received, albeit not in a timely manner. However, the registered provider failed to inform the chief inspector with the additional information that bedroom 54 was not converted to a communal space/dining room, as stated in condition 4. Additionally, the provider had failed to submit correct floor plans and statement of purpose that accurately reflected the premises

Judgment: Not compliant

Regulation 14: Persons in charge

There was no person in charge in the centre as required under Regulation 14.

Judgment: Not compliant

Regulation 15: Staffing

On the day of the inspection, there was a sufficient number of staff available with

the appropriate skills to meet the assessed individual needs of residents, given the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix had not been updated on the day of the inspection to reflect mandatory training that had been attended. An updated training matrix was submitted after the inspection. On review of the matrix, the vast majority of the staff had attended the required mandatory training, and there was an ongoing schedule of training in place. Nevertheless, the observations made by inspectors on the day found that staff were not implementing the centre's policies and procedures, and there was a lack of oversight in staff practices, as further exemplified under Regulation 27: Infection Control, Regulation 21: Records, Regulation 29: Fire precautions and Regulation 7: Managing behaviour that is challenging.

Judgment: Not compliant

Regulation 21: Records

Records were not maintained and stored in a safe manner:

- Residents' files were stored in blue skip bins in the communal corridor area and in the multi-purpose function room. An urgent compliance plan letter was issued to the provider after the inspection to address this issue immediately in order to come into compliance with Regulation 21: Records (S.I. No. 415/2013 Health Act 2007) Care and Welfare of Residents in Designated Centres for Older People Regulations 2013.

Records, as outlined in Schedule 4, were not managed appropriately:

- The roster did not fully set out the staff working in the centre. There was no evidence that the senior management personnel from the HSE was identified on the roster when attending the centre to ensure continued governance and management oversight of the centre and to support staff working in the centre.
- The activities staff was scheduled to work for three, four or five days a week. For the rest of the weekdays, the caring staff was in charge of the activities. However, the activity duties were not clearly delegated on the roster.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider was in breach of conditions 1 and 4 of the registration. The inspectors found that the bedroom 54 was not converted into a communal space/dining room to achieve compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Statutory Instrument 293 and National Standards for Residential care Settings for Older People in Ireland 2016, in accordance with condition 4 of the registration.

In addition, the management structure outlined in the statement of purpose did not correspond with the current management structure in the designated centre as found on the day of the inspection. Inspectors were informed that the person in charge and other management personnel in the centre had continuous management and oversight responsibilities in other centres run by the provider. Furthermore, an assistant director of nursing listed as a whole-time equivalent in the statement of purpose was found to have oversight over another centre. As a result, the centre did not operate according to the management structure outlined in the centre's statement of purpose. This is an ongoing finding from the previous inspection completed in November 2020. Despite the action plan outlined in the compliance plan from the previous inspection, the provider failed to ensure that the centre is operating according to condition 1 of the registration.

The management team's oversight systems, to ensure that a safe service was being provided to residents, did not identify a number of issues relating to resident care and safety. For example, a number of fire precaution issues were not identified by the registered provider in the daily oversight checks, and subsequently, the risks identified on the day of the inspection had not been included in the centre's risk register.

The audit, monitoring and supervision systems that were in place in the designated centre had failed to identify areas of improvement found on this inspection. The provider was issued with an urgent action plan in respect of the management of records.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed four contracts for the provision of services and found that the details of bedrooms offered to the residents, including whether the bedroom available for them is single or multi-occupancy, were not included in all contracts for the provision.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints procedure in the centre was not centre-specific. It did not clearly state who is the complaint officer. The appeal process had not been clearly identified, and the nominated person to deal with the complaint during the appeal process was also not specified.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider failed to review Schedule 5 policies and ensure their implementation in practice in order to support staff to align with best evidence-based practices. As a result, the policies were not readily available to staff. Furthermore, some policies were not updated in line with the latest national guidelines; therefore, the staff were not appropriately supported, trained and supervised in their practices. For example:

- The use of restraint policy was reviewed in December 2011, and it was the national policy on Physical restraint. The policy was not updated to include the chemical and environmental restrictive practices.
- The Complaints policy was the national Complaints policy and failed to identify centre-specific procedures as outlined in the Regulation: 34: Complaints.
- The Medication management policy was not updated in accordance with NMBI Guidance for Registered Nurses and Midwives on medicine Administration (2020).

Judgment: Not compliant

Registration Regulation 6: Changes to information supplied for registration purposes

The registered provider failed to supply full and satisfactory information in regard to the matters set out in Schedule 2 in respect of the new person proposed to be in in charge of the designated centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

While quarterly notifications were submitted as required, they did not include details of all restrictive practices used in the centre as required by the regulations.

Judgment: Substantially compliant

Quality and safety

Throughout the inspection, inspectors observed that the care and support given to residents were respectful and considerate of their needs. The inspectors found that action was required within resident care planning documentation, monitoring of restrictive practices, visits, residents' rights, premises, infection control measures and fire precautions within the designated centre.

In relation to care planning, it was evident that residents had a comprehensive assessment of their health, personal and social care needs undertaken on admission using validated tools, and care plans were developed based on these assessments. Nevertheless, when seeking to review care plans for residents in one unit with multi-drug resistant organisms (MDRO), there were no care plans for residents who were colonised with an MDRO. This may result in inappropriate precautions being used when delivering direct care to residents.

Residents had good access to medical care, and records indicated that residents were reviewed regularly. A local general practitioner (GP) attended the centre one day a week or more frequently as required. Multi-disciplinary team inputs were evident in the care documentation reviewed.

Restraint use in the centre was not being effectively monitored by the management team. As a consequence, the risk assessments were not reviewed regularly to ensure their usage was safe and remained appropriate.

Visiting facilitated in the centre was not in line with national guidance as there were continuous restrictions on visiting.

Notwithstanding the positive findings during this inspection, further review and development under Regulation 27: Infection Control was required. Details of issues identified are set out in detail under Regulation 27: Infection Control.

The provider had addressed improvements pertaining to the premises following the previous inspection; however, some further areas required immediate attention as outlined under Regulation 17: Premises.

While the centre had procedures in place for fire safety, including the servicing and

maintenance of fire safety equipment, the inspector found that fire precautions in the centre required action as discussed under Regulation 28: Fire precautions.

Regulation 11: Visits

Visits were not supported in line with the latest national public guidelines. The visits were pre-booked and accommodated in the rooms assigned for visiting. The visits for high dependency residents in four-bedded rooms were possible only if all other residents were outside of the room.

Judgment: Not compliant

Regulation 17: Premises

The Registered Provider failed to ensure that the units were designed and laid out to meet the needs of the residents. For example:

- Rooms 61 in St Clare's unit and 83 in St James's unit were converted to visiting rooms; however, they did not have a call bell for the residents' use and were partially used for storage purposes.
- The extractor in the smoking room in the Sacred Heart unit was broken. A number of ventilation units were not functional across the centre.
- There were hanging cables on the walls and exposed wires around the centre.
- Maintenance and cleaning work was required on the enclosed courtyards on St James's and St Clare's units to enable residents to use them safely.

There was inappropriate storage seen across all units, which impacted on residents' rights and infection control. This inappropriate storage decreased the homely environment of these areas:

St James's unit:

- A communal/dining room had items such as five reclining wheelchairs and a hoist. Residents' smoking room had items such as two fridges, boxes, chairs, and a hoist. The Activities kitchen had a number of boxes, and furniture, cabinets and appliances were in a poor state of repair and unsafe for residents' use.

St Clare's unit:

- Room 61 contained disused residents' equipment, including hoists, mattresses and pressure cushions. There was a two-seater leather sofa, pictures on the

floor, boxes, a trolley, PPE and equipment for activities.

Sacred Heart unit:

- Bedroom 54, from registration condition 4, was a double bedroom and was not converted to communal space for residents.
- The TV room was used for storage purposes and had items such as big reclining wheelchairs, boxes, two batteries for the hoist which were being charged on the floor, cabinets and rubbish.

Judgment: Not compliant

Regulation 27: Infection control

While the provider had appropriate measures and resources in place to manage infection prevention and control in line with national standards and guidance, a number of actions are required by the provider in order to fully comply with this regulation. This was evidenced by:

- Surveillance of antibiotic use, infections and colonisation were not always used to inform antimicrobial stewardship measures. This meant that information could not be used to track and trend MDROs to ensure that early identification of infection or colonisation so that the provider could implement preventative measures to prevent onward transmission.
- All laundry was sent out to external contractors, and only cleaning cloths and mops were cleaned on-site. The laundry contained domestic washing machines, whereby it is preferable that washing machines should be of an industrial standard (with accurate disinfection temperatures for washing soiled laundry items). The layout of the laundry room did not facilitate a dirty-to-clean process which could lead to the risk of contamination from body fluids.
- Safety engineered sharp management devices were used; however, nine sharps bins did not have the temporary closure mechanism engaged when they were not in use to ensure they were stored safely. One clinical waste bin awaiting collection in an external holding area was not locked. These practices could pose a risk of exposure to healthcare risk waste to individuals.

There was evidence of inappropriate storage seen in areas around the centre which could lead to contamination or cross infection respectively, in addition to reducing access to these areas for cleaning. This was evidenced by:

- Medical supplies and mattresses were seen on floors and continence wear on shelves, in open packets in store rooms and in a communal bathroom and toilet.
- In the laundry room, maintenance equipment and floor cleaning buffers were stored beside laundry equipment.

- There was excessive storage in sluice rooms where access to bedpan washers, sluice sinks and clinical waste bins were obstructed by other equipment such as commodes, dirty linen trolleys, and waste awaiting collection.

Finishes such as flooring, cupboards and tiles were damaged in areas around the centre which would not facilitate effective cleaning. For example:

- A high number of commodes had rusty wheels.
- Floors and surfaces seen in the laundry were damaged in areas and had a build-up of grime, dust or debris. There were exposed pipes running along one wall, exposed concrete on the floor and window sills, with high levels of dust present. This was similar to findings during the last inspection.
- Cupboards and tiles in the activity pantry were badly damaged. Edging on shelves in one sluice room was damaged or missing.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required to ensure adequate precautions were in place to protect residents in the event of a fire. During the inspection, inspectors observed the following and brought them to the attention of the management team:

- The fire exits leading to the secured courtyards in the St James's and St Clare's units were obstructed with breakfast trolleys, serving trolleys and cleaning equipment. Five blue recycle skips with residents' files were restricting the fire exit on the communal corridor. The inspectors requested the staff to remove these items; however, all items were observed back obstructing the fire doors in the afternoon.
- The Oxygen bottles were not securely stored, and the safety signs were missing where the oxygen bottle or oxygen concentrator was in use or stored.
- The fire extinguishers were not secured on the wall, and they were used as a support for the doors to stay open. Bins were also used as a blockage for the door to stay open.
- The fire extinguisher in the Activities kitchen in St James's unit was standing in the middle of the room and was last time tested in October 2017.
- Smoking rooms were missing call bells and proper ashtrays.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

There were gaps in the provision of care plans with regard to the management of residents with MDROs in one unit to ensure that staff had the correct guidance when providing direct care.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' health care needs were reviewed on a regular basis by the medical officer, and out-of-hours medical arrangements were also in place. Residents were supported to access health and social care professionals such as physiotherapy, occupational therapy, dietitian services and speech and language therapy.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The inspectors reviewed the restraint register for the centre and found that there was no restraint practice documented on the register. However, inspectors observed a number of instances where the restrictive practice was in use on the day of the inspection. For example, during the walkaround of the centre, inspectors observed several bedrails being used, as well as crash mats and sensory mats. The restrictive environmental practice was noted as the doors to units were locked and opened with a key-fob. The evidence for restrictive chemical practices were observed in the centre’s KPIs, the antipsychotic use monitoring, and the centre’s governance meeting notes.

Judgment: Not compliant

Regulation 8: Protection

A safeguarding policy was in place, and staff were knowledgeable about the reporting procedure. Residents said that they feel safe in the centre. The centre was acting as a pension agent for 11 residents.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors found that residents were not always facilitated to exercise choice, and the service was not always person-centred in nature:

- The meeting for residents was last time accommodated in September 2021. This arrangement did not ensure that residents were actively encouraged and facilitated to provide feedback on the designated centre and to contribute to a variety of aspects of the centre.
- The daily Food menu was not updated according to the daily food plan and was not presented in an accessible format for all residents.
- The residents had restricted access to go out to secure courtyards in St Clare's and St James's units.

Inspectors found that residents did not have appropriate opportunities to participate in activities in accordance with their interests and capabilities as follows:

- The activities were not scheduled for seven days a week in Sacred Heart and St James's unit. The activities schedule was prepared for some days only, and the activities schedule was limited to a choice of a few repetitive activities. The activities schedule format also required an improvement to make it more dementia-friendly and easily understandable for residents living with cognitive impairment.

Judgment: Not compliant

Regulation 20: Information for residents

The inspectors reviewed the current resident's guide available in the centre and found that it was not updated to reflect the changes in the management structure, current visiting arrangements and specific details were missing in the complaints procedure.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not compliant
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Registration Regulation 6: Changes to information supplied for registration purposes	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 11: Visits	Not compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant
Regulation 20: Information for residents	Substantially compliant

Compliance Plan for Sacred Heart Hospital, Carlow OSV-0000549

Inspection ID: MON-0034393

Date of inspection: 14/06/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration: Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration: Accurate Floor Plans and Statement of Purpose resubmitted on the 15TH July 2022. Action complete	
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • NF30 completed and register posted to HIQA Registration on the 5th July 2022. From the 11th of July 2022, there is a designated PIC in the centre supported by two Assistant Directors of Nursing. There are no shared resources of the PIC. This practice has ceased. Action Complete.	

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Clinical Governance and oversight to reach compliance will be provided by two Assistant Directors of Nursing. The agreed actions are as follows:

IPC-
• Self-Assessment Tool to manage outbreaks of infection and public health outbreak emergencies to be completed with Quality Improvement Plan by September 1st 2022.
• All Staff to complete HIQA National Standards for Infection Prevention and Control in community services: putting the standards into practice (HseLAND) –To be completed by August 3st 2022 and training matrix to be updated. On site IPC support is available also for training.
• Education of Regulation 27 to be provided to all staff and to be completed by September 30th 2022 and training matrix to be updated.
• Education on SECH Cross Divisional Cleaning Guidelines and Procedures
2021 has been provided to CNMS on the 12th of July 2022. Further education & training will provided to all staff with implementation of audit tool by 30th of September 2022 and training matrix will be updated to reflect same.
• ADON allocate to provide governance with all IPC Link Nurses which will provide Assessment, monitoring, evaluation and implementation for improvements. Updates to be provided at Governance, CNM and Quality & Patient Committee meetings.
• Monthly IPC Audits and Action Plans introduced on the 12th of July 2022 in line with IPC SECH Quality and Service Improvement Plan. All wards IPC audit results and actions to be displayed in wards for Staff, Resident's and Nominated Persons to read by August 1st 2022.
• AMRIC Antimicrobial Stewardship in Practice (Hseland) to be completed by all Nursing staff by 30th of August 2022 and training matrix to be updated.
• Antimicrobial Stewardship weekly data collection commenced the 5th of July 2022 and monthly analysis and action plans introduced.
• IPC SECH Sharps Awareness Training to be complete by all staff by 30th of October 2022 with support of IPCNS.
• Hand hygiene training to be 100% by 31st of July 2022 with support from IPCNS, IPC Link Nurses with evidence of Hand Hygiene Audits on a monthly basis.

Records-
• HseLand Health care record management completed by Clerical Staff and Nurse Management by 3rd of July 2022. Action Complete.

Fire Precautions-
• All staff to complete Fire Training Tutorial on a yearly basis to reach 100% compliance.
• Each Ward to commence monthly fire drills with over sight from ADONs commencing the 11th of July 2022.
• Fire Drills to be audited initially after first month and thereafter 3 monthly,
October 30th 2022 in order to be compliant.
• Daily and weekly fire checks to be action and to be completed in accordance to the Fire

Safety and Guideline Requirements with oversight provided by ADONs. Action Complete 11th July 2022.
• Daily environmental walk about checks on each ward with over sight from Nurse in Charge of Ward and ADON/DON. Action Complete July 11th 2022.

Managing Behaviour that is challenging-
• ANP in Dementia to provide training in Enabling & Enhancing People living with Dementia (2 day programme). Dates are 22nd of September 2022 & 6th of October 2022 (Group 1) and 17th of November 2022 & 1st of December 2022 (Group 2). Action and agreed for review by DON 31st of December 2022.
• Review of Restrictive Practice Policy in accordance with National Guidelines completed on the 11th of July which includes Physical, Environmental, Chemical and Emergency types of restraint. Action complete.
• Education provided to CNMs regarding Restrictive Practice Policy on the 12th of July 2022 by DON. CNMs to provide education and training to all staff on ward with oversight by ADONs. To be completed by 31st of August.
• Review of Guidelines for Staff on how to support people with the responsive behavioural symptoms associated with Dementia updated on the 11th of July 2022 Disseminated to CNMs on the 12th of July 2022. Action Complete.
• CNMs to provide education regarding to all staff, Policy to be read and signed by all staff by the 31st of August 2022. Governance provided by ADONs.
• Weekly Restraint Register updated to reflect Physical, Environmental and Chemical Restraint July 11Th 2022. Action Complete.
• Monthly Analysis of Use of Restraint to be completed with actions developed by CNMs with oversight from ADONs. Will be action on the 31st of July 2022 and monthly thereafter.
• Restrictive Practice Committee to be established by 30th of September 2022.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
All Records are now stored in lock file room. HseLand Health care record management completed by Clerical Staff and Nurse Management by 3rd of July 2022. Action Complete.

Each
Senior Management is identified on Nursing Administration when on site. Action Complete.

Each ward to enter on roster social care program staff for each day of the week from the 11th of July 2022. Action Complete.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In conjunction with action plan there has been a compliance plan submitted which outlines the plan to increase communal space for the Resident's. Action Completed 11th of July 2022.

Statement of Purpose updated 15th of July 2022 to demonstrate the current Management Structure.

From the 11th of July 2022, there is a designated PIC in the centre supported by two Assistant Directors of Nursing. There are no shared resources of the PIC. This practice has ceased. Action Complete

ADONs providing oversight on daily fire checks in all areas of hospital. Action Completed 11TH of July 2022

All Fire extinguishers to be reassessed of their location and type by McLaren by week ending the 22nd of July in accordance to Irish Standard I.S. 292:2015 .
Fire extinguisher selection is based on a risk assessment from the supplier and based on the fire classification expected in the building.

Review of Risks of the Risk Register discussed on the 15/07/2022 with DON, ADONs and Manager for Older Persons. Risk Register to be reviewed by the 31st of August 2022.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
Any admissions to centre will have a contract identifying whether resident is sharing a multi-occupancy room or located a single room as from the 4th of July 2022. Action complete.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Standard Operating Procedure updated and Complaints Process identifies the nominated person by name dealing with the complaint.
Disseminated to all wards on the 12th of July 2022 and discussed at CNM Meeting on the 12th of July 2022. Action Complete.
All staff to read and signed by 30th of July 2022.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Review of Restrictive Practice Policy in accordance with National Guidelines completed on the 11th of July 2022 which includes Physical, Environmental, Chemical and Emergency types of restraint.
CNMs have been provided with education regarding Restrictive Practice Policy on the 12th of July. CNMs to provided education and training to all staff on ward and to be completed by 31st of August with implementation of Policy on the 1st of September. With oversight provided with ADONs.

Standard Operating Procedure updated and Complaints Process identifies the nominated person by name dealing with the complaint.
Disseminated to all wards on the 12th of July 2022 and discussed at CNM Meeting on the 12th of July 2022. Action Complete.
All staff to read and signed by 30th of July 2022.

Review of the Medication Policy to be updated in accordance with NMBI for Registered Nurses & Midwives on medicine administration by 30th of August 2022.
Training/Education of updated Policy to all staff to be completed by September 30th 2022.

Registration Regulation 6: Changes to information supplied for registration purposes	Not Compliant

Outline how you are going to come into compliance with Registration Regulation 6: Changes to information supplied for registration purposes: NF30 completed and register posted to HIQA Registration on the 5th July 2022. From the 11th of July 2022, there is a designated PIC in the centre supported by two Assistant Directors of Nursing. There are no shared resources of the PIC. This practice has ceased. Action Complete.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Nf39A environmental, physical and Chemical restraints all submitted for Q2. Action Complete. NF39A will contain submissions as per Hospital Restraint Register.

Regulation 11: Visits	Not Compliant

Outline how you are going to come into compliance with Regulation 11: Visits: Visiting arrangement for Resident's are in place as per HPSC. Visiting Policy reviewed and SOP as per HPSC Guidelines for Visiting for RCF. Policy and SOP disseminated at CNM Meeting on the 12th of July 2022 and signatures required from all staff for acknowledgement of reading and understanding Policy and SOP by 30th of July 2022.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: • In conjunction with action plan there has been a compliance plan submitted which outlines the plan to increase communal space for the Resident's. Action Completed 11th of July 2022. • Rm 61 & 83 to have a battery operated call bell system and will be in place by 30th of July 2022.

• Environmental Walk about with IPC, Health & safety & Technical Services planned for the 15th of September and 8TH of December 2022. To be completed on a quarterly basis.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Weekly monitoring template of antibiotic use introduce to all wards from the 11th of July 2022. With governance provided by ADONs.
• Analysis of templates to complete monthly staring the 31st of July 2022 by ADON and results and actions to be disseminated to CNMs at monthly meetings and quarterly Drugs & Therapeutic Meetings. Audits results and actions to be displayed in ward areas.
• Sacred Heart Hospital continues to send monthly antibiotic stewardship HCAI AMR Data to Infection Control SECH. Action Complete.
• IPC SECH Sharps Awareness Training to complete by all staff by 30th of October 2022 with support from IPCNS.
• Sharp Audits to be completed monthly on each ward with relevant action plans if required.
• Nurse in Charge of each unit and ADON to provide daily environmental walkabouts. Action complete
• DON to introduce environmental walk about with IPC, Technical services and Health & Safety quarterly. Date planned for 2022 are 15th of September & 8th of December 2022.
• Monthly Environmental Audits introduced from 11th of July 2022. ADON to provide governance, actions plan to applied if required.
• Rusty commodes removed from service. Action Completed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Person in Charge of each unit and ADON to provide daily environmental walkabouts.
• Monthly fire drills to commence from the 11th of July 2022 with monthly audits of drills to ensure compliance and action plan if required.
• Fire Training continues to reach 100% by staff by end of September 2022
• All smoking rooms to be decommissioned by 30th of November 2022 and to be facilitated outdoors. Currently all smoking rooms have appropriate ash trays in place.
• All Fire extinguishers to be reassessed of their location and type by McLaren by week ending the 22nd of July in accordance to Irish Standard I.S. 292:2015 .
• Fire extinguisher selection is based on a risk assessment from the supplier and based

on the fire classification expected in the building.
• Safety signs for Oxygen Cylinders and evidence to be securely stored to be completed by the 1st of August 2022.

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:
• All Residents who have a diagnosis of a HCAI or any infectious disease to have a care plan that demonstrated the involvement of the Resident or nominated person. All care plans to be in place by 30th of August 2022 and to be commenced on admission for new residents. With oversight by ADONs.
• Resident's care plans to be audited 3 monthly. Action plan to be developed as a result. To commence October 30th 2022 Governance provide by ADONs.
• CNMS have been provided with education in regards to Regulation 27 on the 12th of July. Action Completed.
• AMRIC Antimicrobial Stewardship in Practice (Hseland) to be completed by all Nursing staff by 30th of August 2022 and training matrix to be updated.
• All Staff to complete HIQA National Standards for Infection Prevention and Control in community services: putting the standards into practice (HseLAND) –To be completed by August 31st 2022 and training matrix to be updated.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• ANP in Dementia to provide training in Enabling & Enhancing People living with Dementia (2 day programme), to facilitate 2 groups. Dates are 22nd of September 2022 & 6th of October 2022(Group 1) and 17th of November 2022 & 1st of December 2022 (Group 2).
• Review of Restrictive Practice Policy in accordance with National Guidelines completed on the 11th of July which includes Physical, Environmental, Chemical and Emergency types of restraint. Action Completed.
• CNMs provided with education regarding Restrictive Practice Policy on the 12th of July 2022. CNMs to provided education and training to all staff on ward and to be completed by 31st of August 2022 with implementation of Policy on the 1st of September 2022. Governance provide by ADONs.

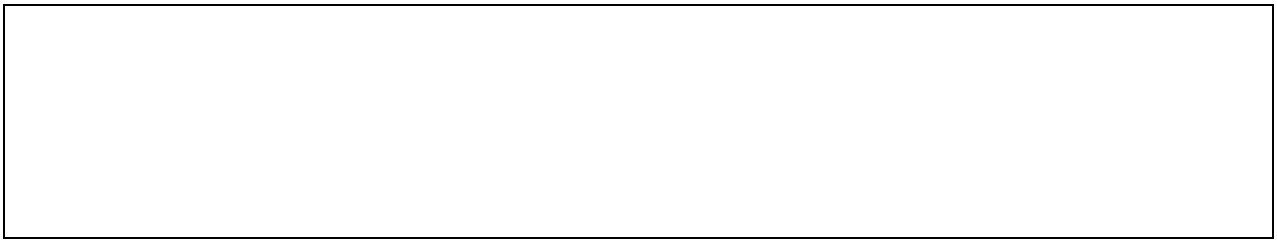
• Weekly Restraint Register updated to reflect Physical, Environmental and Chemical Restraint July 11th. Action Complete.
• Monthly Analysis of Use of Restraint to be completed with actions developed by CNMs with oversight from ADONs. Commencement on the 31st of July 2022.
• Restrictive Practice Committee to be established by 30th of September 2022.
• Person in Charge of each unit and ADON to provide daily environmental walkabouts to ensure all doors are unlocked for resident's to have access to gardens and courtyards.
• Review of the Medication Policy and use of Psychotropic to be updated in accordance with NMBI for Registered Nurses & Midwives on medicine administration by 30th of August 2022.
Training/Education of updated Policy to be provide all Nursing staff to be completed by October 30th

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Monthly Resident's forum meetings to commenced July 2022, to be facilitated by CNMs & Activity team and invitation to nominated persons to be provided. Action Plans to be submitted to ADONs each month commencing the 31st of July 2022.
• Food menus to be displayed /in a format for all resident's to recognize. Collaboration with Dietician, Catering Manager, CMNS and Resident's. To be completed by 30th of September 2022. Governance provided by ADONs.
• Nurse in Charge of each unit and ADON to provide daily environmental walkabouts to ensure all doors are unlocked for resident's to have access to gardens and courtyards. Action complete.
• Activities Schedule for each ward will have a visual picture and written schedule of Group Activities which will be displayed in main living areas but is also available weekly at Resident's bedside. This will be updated on a weekly basis by CNMs and activity team. Action to be completed by the 21st of July 2022. Governance provided by ADONs.
• Ward rosters reflect social care program staff for 7 days a week from the 11th of July 2022. Action Complete.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
• Resident's Guide updated to reflect the changes to management structure and current visiting guidelines as from the 12th of July 2022. Action Complete.



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
Registration Regulation 6 (1) (b)	The registered provider shall as soon as practicable supply full and satisfactory information in regard to the matters set out in Schedule 2 in respect of the new person proposed to be in charge of the designated centre.	Not Compliant	Orange	11/07/2022
Registration Regulation 6 (2) (b)	Notwithstanding paragraph (1), the registered provider shall in any event supply full and satisfactory information, within 10 days of the appointment of a new person in charge of the designated centre, in regard to the matters set out in Schedule 2.	Not Compliant	Orange	11/07/2022
Registration Regulation 7 (3)	A registered provider must provide the chief	Not Compliant	Orange	15/07/2022

	inspector with any additional information the chief inspector reasonably requires in considering the application.			
Regulation 11(1)	The registered provider shall make arrangements for a resident to receive visitors.	Not Compliant	Orange	30/07/2022
Regulation 11(2)(b)	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.	Not Compliant	Orange	30/07/2022
Regulation 14(1)	There shall be a person in charge of a designated centre.	Not Compliant	Orange	11/07/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/10/2022
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre	Not Compliant	Orange	31/12/2022

	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.			
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	31/12/2022
Regulation 20(2)(b)	A guide prepared under paragraph (a) shall include the terms and conditions relating to residence in the designated centre concerned.	Substantially Compliant	Yellow	12/07/2022
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure respecting complaints.	Substantially Compliant	Yellow	12/07/2022
Regulation 20(2)(d)	A guide prepared under paragraph (a) shall include the arrangements for visits.	Substantially Compliant	Yellow	12/07/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by	Not Compliant	Red	15/06/2022

	the Chief Inspector.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	11/07/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	11/07/2022
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	11/07/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Yellow	11/07/2022
Regulation 24(1)	The registered provider shall agree in writing	Substantially Compliant	Yellow	04/07/2022

	with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
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	08/12/2022
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	11/07/2022
Regulation 28(1)(c)(i)	The registered provider shall make adequate	Not Compliant	Orange	11/07/2022

	arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	22/07/2022
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	22/07/2022
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	11/07/2022
Regulation 34(1)(c)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall nominate a person who is not involved in the matter the subject of the complaint to deal with complaints.	Substantially Compliant	Yellow	12/07/2022
Regulation 34(1)(f)	The registered provider shall provide an	Substantially Compliant	Yellow	12/07/2022

	accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to.	Substantially Compliant	Yellow	12/07/2022
Regulation 34(3)(b)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that the person nominated under paragraph (1)(c) maintains the records specified under in paragraph (1)(f).	Substantially Compliant	Yellow	12/07/2022
Regulation 04(2)	The registered	Not Compliant	Orange	30/09/2022

	provider shall make the written policies and procedures referred to in paragraph (1) available to staff.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	30/09/2022
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	11/07/2022
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	15/07/2022
Regulation 9(2)(b)	The registered provider shall	Not Compliant	Orange	30/09/2022

	provide for residents opportunities to participate in activities in accordance with their interests and capacities.			
Regulation 9(3)(a)	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.	Not Compliant	Orange	30/09/2022
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	30/09/2022
Regulation 9(3)(c)(i)	A registered provider shall, in so far as is reasonably practical, ensure that a resident information about current affairs and local matters.	Not Compliant	Orange	30/09/2022
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre	Not Compliant	Orange	30/09/2022

	concerned.			