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:	Tralee Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Teile Carraig, Killerisk Road, Tralee, Kerry
Type of inspection:	Unannounced
Date of inspection:	27 November 2023
Centre ID:	OSV-0000566
Fieldwork ID:	MON-0042092

About the designated centre

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

Tralee Community Nursing Unit is a designated centre located in the urban setting of the town of Tralee. It is registered to accommodate a maximum of 43 residents. It is a single-storey facility set on a large site. Residents' bedroom accommodation is set out in two units, Loher unit with 22 beds and Dinish unit with 21 beds. Each unit is self-contained with a dining room, kitchenette, day room. Bedroom accommodation comprises of single, twin and four bedded rooms. The Rose Café is located at the entrance to the centre has café style seating. The atrium is a large communal space located between the two units with comfortable seating. The quiet visitors room is located between both units. The oratory is situated on the corridor by the main entrance. Tralee Community Nursing Unit provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	38

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
Monday 27 November 2023	09:30hrs to 17:50hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

This was an unannounced inspection which was carried out over one day. The inspector met with all residents living in Tralee Community Nursing Unit and spoke with seven residents in detail. Feedback was overwhelmingly positive in relation to the residents' relationship with the management and staff in the centre. Residents told the inspector that they were comfortable and that they were very well cared for. While residents expressed a high levels of satisfaction with the services, three residents expressed dissatisfaction with the quality and accessibility of the activities programme. They informed the inspector that there were some days that there were no activities available in the centre and there was little to occupy them.

Tralee Community Nursing Unit is a single storey, purpose built designated centre located in the town of Tralee, County Kerry. The centre is registered to provide care to 43 residents and there were 38 residents living in the centre on the day of this inspection. Operationally, the centre is made up of two distinct wings, Lohar (22 beds) and Dinish (21 beds), each with their own day and dining room facilities. Bedroom accommodation in the centre comprises of five four-bedded rooms, two twin rooms and 19 single rooms. Resident's privacy and dignity was maintained in so far as practicable in multi-occupancy rooms, with curtains around each bed.

The majority of residents use shared bathroom facilities and three residents in the centre have en-suites. En-suites and assisted shower rooms were seen to be clean and spacious, with adaptive and assistive devices such as grab-rails and shower chairs. The inspector saw that some single bedrooms were personalised with residents belongings from home such as book shelves, small pieces of furniture and pictures. Residents living in the single rooms spoke very positively to the inspector about their rooms and the privacy they had. One resident told the inspector that they had previously shared a room but were now much happier and were sleeping better in their own space.

The inspector saw that the centre was clean and generally well maintained, with the exception of some flooring in bedrooms that required repair and some paintwork in bedrooms that was chipped. These findings are actioned under regulation 17. Residents had unrestricted access to an enclosed garden that had been renovated since the previous inspection. It was observed to be appropriately furnished and maintained. This garden was accessible through an unlocked doors, which ensured residents could use it as they chose to.

Between the two units was a large open plan communal space for residents called The Rose Café and The Atrium. The inspector saw that in this area there were tables and chairs, comfortable seating, tables, bookshelves and a large flat screen television. There was also exercise equipment available for residents to use independently or with the physiotherapist. On the day of the inspection approximately 20 residents spent time in this area and there was a game of bingo and music, which residents enjoyed. However, two residents told the inspector that

this did not happen every day and may happen once a week, depending on staffing. Residents told the inspector that activities were decided on a daily basis by staff and could change at short notice and on some days that there was nothing to do in the centre and the days were long. The inspector saw that weekly activities schedule on display in the centre was not reflective of a social programme available for residents but was dated for the previous year. These findings are actioned under regulation 9, residents rights.

The inspector observed that a variety of drinks and snacks were offered throughout the day. The daily menu was displayed in the dining room and on the dining tables, which offered a choice. Residents told the inspector that that they were consulted regarding their preferred choice of meal and mentioned how they could get whatever they would like to eat. All of the residents spoken with reported satisfaction with the food provided. The inspector observed the dining experience for residents on the day of inspection, in the two dining rooms. Tables were observed to be nicely set and music was playing in each dining room. Residents were seen to be assisted with their meals in a discreet and respectful manner and there were adequate staff available to attend to the needs of the residents. Overall, mealtimes were observed to be a social and relaxed occasion.

Some residents living in the centre were observed to spend a large portion of their day in the sitting rooms in Lohar and Dinish. These rooms were observed to be very homely with fire places, comfortable seating, soft furnishings and a flat screen television. The inspector met with residents in these rooms and observed that there was no call bell facilities for residents to use if they required assistance and there was not supervision allocated to these rooms. This is actioned under regulation 17, premises.

Residents spoken with described staff as helpful, kind and respectful. One resident told the inspector " they would do anything for you here" and another stated that they knew the nurse manager and they always came around to check on them. Discussions with staff indicated that they knew individual residents well and were able to relate to the inspector residents specific care needs, on an individual basis. It was evident that staff were knowledgeable about each residents preferences for personal care and for their daily routines. Staff were observed communicating appropriately with residents who had a cognitive impairment and effective communication techniques were documented and evidenced in some residents care plans.

Respect for privacy and dignity was evidenced throughout the day of the inspection. Staff were observed to knock on doors and request permission before entering bedrooms. Residents were well presented and groomed and many of the ladies were seen to be wearing their own jewellery. There was a hairdressers room in the centre and the inspector saw that 11 residents were booked to have their hair done on the day of this inspection. Residents told the inspector they loved having their hair done and attending the salon as it was such an enjoyable experience.

The inspector had the opportunity to meet with four visitors during the inspection and they all stated they were very happy with the care in the centre and the kind

and compassionate nature of the staff.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered. The levels of compliance are detailed under the individual regulations.

Capacity and capability

This inspection was carried out over one day to monitor compliance with the Care and Welfare of Residents in Designated Centres for Older People, Regulations 2013 (as amended). Overall, this inspection found that residents were in receipt of a high standard of health care by staff that were responsive to their needs in Tralee Community Nursing Unit. However, action was required pertaining to residents rights, the management of incidents, records, protection, governance and management, staff training and fire precautions. Management systems required action and improvement and each of these areas are detailed under the relevant regulation of this report.

The registered provider of this centre is the Health Service Executive (HSE). There was a clearly defined management structure in place, where lines of authority and accountability were clearly defined. The centre was managed on a daily basis by an appropriately qualified person in charge responsible for the direction of care. This person had been recently appointed to the post and were supported in their role by a full time Clinical Nurse Manager and a team of nurses, healthcare assistants, catering, domestic, administration and catering staff.

The person in charge reported to a general manager in the HSE, who was available for consultation and support on a daily basis. The service is also supported by centralised departments, such as human resources, finance, fire and estates and practice development. There was evidence of good communication via monthly quality and patient safety meetings, to discuss all areas of governance. Staff meetings and shift handovers ensured information on residents' changing needs was communicated effectively.

From an examination of the staff duty rota and communication with residents and staff it was the found that the levels and skill mix of staff at the time of inspection were sufficient to meet the care needs of residents. However, the inspector was informed that due to a member of the activities team being on long term leave, there were days where staff were not allocated to the provision of a social programme for residents. This finding is actioned under regulation 9 and 23.

There was an ongoing schedule of training in place and staff training was being monitored. However, for a significant portion of staff mandatory training was found to be out-of date, as detailed under regulation 16. All records as requested during the inspection were made readily available to the inspector. Records were

maintained in a neat and orderly manner and stored securely. On review of staff personnel files it was evident that not all complied with Schedule 2 of the regulations, which is further detailed under regulation 24. Each staff member had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 on file, prior to commencing employment.

There were systems in place to manage critical incidents and risk in the centre and accidents and incidents in the centre were recorded, and they were followed up on and reviewed. All incidents and allegations had been reported in writing to the Chief Inspector as required under the regulations, within the required time period. However, the inspector found that one safeguarding incident in the centre was not managed in line with the centres policy, which is actioned under regulation 23.

The provider had an auditing systems were in place to monitor the quality and safety of the service provided to residents. This included a variety of clinical and environmental audits and monitoring of weekly quality of care indicators such as the incidence of pressure wounds, infection, restrictive practices and falls. There was evidence of actions taken as the result the audits to improve the quality of care for the residents. The centre had written policies and procedures which were reviewed and update in accordance with best practice guidelines.

Regulation 14: Persons in charge

The person in charge was full time in post and had been appointed three months prior to this inspection. They had the necessary experience and qualifications, as required in the regulations. They demonstrated good knowledge regarding their role and responsibility.

Judgment: Compliant

Regulation 15: Staffing

On the day of this inspection there were sufficient staff on duty in the centre, to meet the assessed care needs of residents given the size and layout of the centre. However, there provider had not ensured that there was adequate staff resources allocated to the provision of a social programme for residents, which is actioned under regulation 9 and 23.

Judgment: Compliant

Regulation 16: Training and staff development

Training records reviewed did not provide evidence that all staff had received and were up-to-date with mandatory training. Gaps were identified as follows:

- 20% of staff were due fire safety training.
- 22% of staff were due manual handling training.
- 18% of staff were due training in the management of responsive behaviours.
- 24% of staff were sue safeguarding vulnerable adult training.

Judgment: Not compliant

Regulation 21: Records

A sample of staff five personnel files were reviewed by the inspector and they did not comply with Schedule 2 of the regulations. For example:

- three staff did not have references obtained from their most recent employer.
- one staff file did not have a satisfactory history relating to a gap in employment.
- one staff file did not have evidence of a full employment history.

Judgment: Not compliant

Regulation 23: Governance and management

The governance arrangements in place required action to ensure the effective delivery of a safe, appropriate and consistently monitored service. Issues pertaining to the governance arrangements included:

- there were inadequate resources allocated to a social programme for residents, which was impacting on residents quality of life. This was also a finding on the previous inspection of January 2023.
- there was inadequate oversight of fire safety, safeguarding, staff recruitment, staff training and records in the centre as detailed under the relevant regulations.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared in writing a statement of purpose relating to

the designated centre and this contained all information, as set out in Schedule 1.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of incidents occurring in the centre was maintained. All incidents had been reported in writing to the Chief Inspector, as required under the regulations, within the required time period.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing, adopt and implemented polices and procedures on the matters set out in Schedule 5. However, the policy in relation to safeguarding was not seen to implemented fully in practice.

Judgment: Substantially compliant

Quality and safety

This inspection found that residents living in the centre received a high standard of nursing and medical care and support that was of a good standard. Residents reported they were happy living in the centre. However, action was required in relation to residents rights and in the provision of meaningful activities for residents, fire precautions, the premises and protection. These will be detailed under the relevant regulations.

Residents had very good access to medical care, and the inspector met the medical officer in the centre on the day of inspection. Allied health services were available, such as dietitians and speech and language therapists who reviewed residents regularly. Access to geriatricians and palliative care advice was readily available. There was a very low incidence of pressure ulcer development in the centre and appropriate preventative equipment allocated to residents such as air mattresses.

Improvements were found in care planning since the previous inspection. Care plans reviewed described individualised and evidence-based interventions to meet the assessed needs of residents. Validated risk assessments were regularly were completed to assess various clinical risks, including risks of malnutrition, pressure

sores and falls. These assessments informed the residents' care plans. However, the centres documentation used, when a resident is transferred to hospital was found to contain limited information, which is actioned under regulation 25.

The provider had taken action to improve infection prevention and control measures in the centre since the previous inspection. There was enhanced oversight of cleaning in the centre and an adequate amount of domestic staff allocated on a daily basis.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Allegations of abuse in the past had been notified to the authority and formal safeguarding plans for residents, if required, had been formulated and implemented. However, the policy was found not to be followed in relation to risk assessing an allegation and implementing appropriate protective measures based on the risk, which is actioned under regulation 8 & 23. Procedures were in place for the management of residents' monies. The provider supported a number of resident in the centre to manage their pension and welfare payments and the process as described to the inspector was in line with the Department of Social Protection guidelines.T

There were systems in place for the effective maintenance of the fire detection and alarm system and emergency lighting. Residents had personal emergency evacuation plans (PEEPs) in place, and these were updated regularly. These identified the different evacuation methods applicable to individual residents for day and night evacuations. However, some staff did not have up to date fire training and there were a very limited amount of fire evacuation drills completed in the centre, to provide assurances that compartments could be evacuated in a timely manner, with reduced staffing levels. These findings are actioned under regulation 28.

Residents had access to daily newspapers and shared access to TV in multi-occupancy rooms. Residents also had access to radio and Internet services. Systems for consultation with residents had recently been enhanced and a residents meeting had taken place in September 2023. However, this was the only opportunity for consultation which residents had in the year, which is contrary to that described in the centres statement of purpose and this did not afford residents opportunities to participate in the running of the centre. These findings and the lack of the provision of activities for residents, are actioned under regulation 9.

Regulation 17: Premises

The inspector found that action was required to ensure the premises complied with the requirements of Schedule 6 of the regulations. For example:

- some flooring in the centre was observed to be damaged and discoloured.
- some bedroom walls and door frames were observed to have paint chipped.
- emergency call facilities were not accessible in communal rooms used by

residents.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

On review of the documentation used, when a resident is temporarily transferred to the hospital the inspector found that the correspondence did not contain all relevant information about the resident. For example; their communication requirements and dietary requirements. The management team acknowledged this documentation.

Judgment: Substantially compliant

Regulation 27: Infection control

There was a comprehensive infection control policy in place. Hand sanitising dispensing units were located at the front entrance and throughout the building. The building was maintained in a clean condition throughout. Enhanced cleaning practices had been introduced in response to the findings of the previous inspection. Staff had received training on infection control procedures and were observed adhering to good hand hygiene techniques.

Judgment: Compliant

Regulation 28: Fire precautions

Action was required by the provider to ensure adequate precautions were in place to protect residents and others from risk of fire and to bring the centre into compliance with Regulation 28: Fire Precautions, as follows;

- fire evacuation drill records did not provide assurance that adequate arrangements had been made for evacuating residents from the designated centre in a timely manner. There was one fire drill of a compartment carried out in 2023. However, this evidenced that only a small number of staff had been facilitated to take part in a fire drill evacuation. Records reviewed also did not contain information with regards the time taken to evacuate the compartment and identify learning opportunities for staff. This is required to ensure appropriate containment of smoke and fire in the event of a fire emergency in the centre.
- there were some gaps in daily fire checks, mainly at the weekends, as no

staff member had been allocated this responsibility.
- fire training was due to over 20% of staff which is actioned under regulation 16.
- poor practices were observed where a fire door was being kept open by means other than appropriate hold open device connected to the fire alarm system. Therefore, this door would not close and contain smoke in the event of a fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Pre-admission assessments were completed to ensure the service could provide appropriate care and facilities. Residents had evidence-based risk assessments to guide care and relatives and residents reported that they were consulted with regarding care. The sample of care plans and assessments reviewed demonstrated that they were updated four monthly, as per regulatory requirements and contained person centred information to direct and inform care.

Judgment: Compliant

Regulation 6: Health care

Residents had access to general practitioners (GP), geriatrician and psychiatry of later life specialists. Services such as speech and language therapy and dietetics were available when required. Physiotherapy services were provided on a weekly basis. The inspector found that the recommendations of health and social care professionals were acted upon which resulted in good outcomes for residents.

Judgment: Compliant

Regulation 8: Protection

While action was taken to implement a formal safeguarding plan for a resident, following an alleged safeguarding concern, the inspector found that all protective measures, proportionate to the assessed risk were not taken, as per the centres policy. A significant proportion of staff were also due training in safeguarding vulnerable adults, which is actioned under regulation 16.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The following required action to ensure the rights of residents were fully met :

- residents did not always have access to meaningful activities in the centre and there were some days that there was minimal social stimulation for residents. This was also a finding on the previous inspection of January 2023. This had not been appropriately addressed by the registered provider.
- residents had only been consulted with once in 2023 for their feedback on the quality and safety of the service. Therefore, they had limited opportunities to be involved in the running of the designated centre.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Tralee Community Nursing Unit OSV-0000566

Inspection ID: MON-0042092

Date of inspection: 27/11/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The new PIC has conducted an audit of the Training Matrix and all mandatory training will be provided: Fire Safety Training - all staff have completed training for 2023. The plan for 2024 in place. Manual Handling has been booked for 7 staff Jan 2024, 2 staff Feb 2024, 2 staff March 2024, 3 staff Apr 2024, 3 staff May 2024 & 2 staff May 2024. This completes mandatory training up to and including Q2 of 2024. Safeguarding Vulnerable Adults for all staff will have been completed by 31st Jan 2024. Responsive Behaviours for all staff will be completed by 31st Jan 2024. The new PIC will oversee review of the Training Matrix quarterly so that going forward mandatory training is up to date for all staff.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The new PIC will ensure that all new recruitment going forward will follow the required policy and in line with HIQA guidelines. A review/audit of all HR files for current employees has been commenced any non-compliances identified will be completed by 31st Jan 2024.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
An existing member of staff has expressed an interest in the role of activities coordinator and has been rostered in this role since 1st Jan 2024. Sonas training has been booked and will be completed by 10th May 2024, whereby TCNU will be a registered SONAS Centre. New activities schedules will be drawn up to reflect this.

The new PIC has responsibility and oversight for fire safety, safeguarding, staff recruitment and staff training records, all of these will be audited and actioned to ensure compliance with national policy and HIQA guidelines by 31st Jan 2024.
The new PIC has conducted an audit of the Training Matrix and all mandatory training will be provided:
Fire Safety Training - all staff have completed training for 2023. The plan for 2024 in place.
Manual Handling has been booked for 7 staff Jan 2024, 2 staff Feb 2024, 2 staff March 2024, 3 staff Apr 2024, 3 staff May 2024 & 2 staff May 2024. This completes mandatory training up to and including Q2 of 2024.
Safeguarding Vulnerable Adults for all staff will have been completed by 31st Jan 2024.
Responsive Behaviours for all staff will be completed by 31st Jan 2024.
The new PIC will oversee review of the Training Matrix quarterly so that going forward mandatory training is up to date for all staff.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
'The Adult Safeguarding Policy was not seen to be implemented fully in practice': the new PIC will ensure oversight and implementation of the policy. All Safeguarding concerns will be dealt with in line with the policy and all staff have been reminded of their responsibility, the procedure to follow and how to report a concern should one arise. Refresher training has been schedule for Jan 2024 to be provided by the Adult Safeguarding Team in Kerry (Senior Social Worker).

As above the Training Matrix has been audited and all staff will have completed or refreshed mandatory Adult Safeguarding training by 31st Jan 2024.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Flooring: Engagement with the Estates department has taken place, to review the condition of flooring and the need for painting. The maintenance & upkeep is an ongoing work in progress.

'Emergency call bell facilities not accessible in communal rooms': Engagement with Estates department has taken place, the service provider has been contacted and a plan is in place to have these reviewed on 26.01.2023 with a plan to integrate wireless devices into the current system already in place in the communal rooms

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
All nursing staff received training on completing nursing transfer documentation for residents on 9th Jan 2024 to ensure all residents are discharged from the centre in a planned & safe manner.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A Fire Evacuation took place on 9th January 2024, the evacuation was attended by a large number of staff form various departments, timed and learning opportunities identified and shared with all staff.

Weekly fire checks: all staff responsible for these checks have been retrained and re-orientated to the location of same, all checks since the inspection have been completed and are overseen by the new PIC.

The new PIC will oversee review of the Training Matrix quarterly so that going forward mandatory training is up to date for all staff

'Poor practices, door held open' – all staff have been advised of the hazards of practices

similar to this and details of same have been highlighted to our Fire Training provider for inclusion in our mandatory training throughout 2024.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Formal Safeguarding Plan: all protective measures proportionate to the risk have been taken and overseen by the new PIC since the inspection on 27th Nov 2023.

All Safeguarding concerns will be dealt with in line with the policy and all staff have been reminded of their responsibility, the procedure to follow and how to report a concern should one arise. Refresher training has been schedule for Jan 2024 to be provided by the Adult Safeguarding Team in Kerry (Senior Social Worker).

Safeguarding Vulnerable Adults for all staff will have been completed by 31st Jan 2024
The new PIC will oversee review of the Training Matrix quarterly so that going forward mandatory training is up to date for all staff

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To ensure residents rights are promoted and upheld nursing management will ensure the existing member of staff that expressed an interest in the role of activities coordinator is rostered in this role from 1st Jan 2024. Sonas Training has been booked and will be completed by 10th May 2024, whereby TCNU will be a registered SONAS Centre. New activities schedules will be drawn up to reflect this.

A review of records by the new PIC found that a meeting was also held in June 2023. Going forward scheduled residents forums will be held to ensure residents are consulted allowing feedback and an action plan to support any necessary changes to ensure resident involvement with the running of TCNU, throughout 2024.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	01/11/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	23/01/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/01/2024
Regulation 23(c)	The registered provider shall ensure that management	Not Compliant	Orange	01/01/2024

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.	Substantially Compliant	Yellow	09/01/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	09/01/2024
Regulation 28(2)(iv)	The registered provider shall	Substantially Compliant	Yellow	09/01/2024

	make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	01/01/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	01/01/2024
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	01/01/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	01/01/2024
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	Not Compliant	Orange	01/01/2024

	organisation of the designated centre concerned.			