



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

Issued by the Chief Inspector

Name of designated centre:	Unit 1 St Stephen's Hospital
Name of provider:	Health Service Executive
Address of centre:	St Stephens Hospital, Sarsfield Court, Glanmire, Cork
Type of inspection:	Unannounced
Date of inspection:	02 March 2021
Centre ID:	OSV-0000715
Fieldwork ID:	MON-0031099

About the designated centre

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

Unit 1 is a dementia specific unit situated within the 117 acres of grounds at St Stephen's Hospital, Sarsfield's Court, Glanmire, Co Cork. It is situated approximately two kilometres from Glanmire village and seven kilometres from Cork city. It is a single storey detached building and is registered to accommodate 21 residents. Residents' accommodation comprises of one single bedroom, and the rest of bedrooms are four-bedded rooms. There are no en-suite facilities but assisted showers toilets and bathrooms are across the corridor. Very colourful murals are painted on the wall at the entrance to the centre and at the entrance to each bedroom. Communal space includes a dining room and sitting room and a sensory room. There is also a seating area inside the main entrance to the centre that residents enjoy using. There is a visitors' room for families to visit in private and an over-night guest room with kitchenette facilities. Residents have access to an enclosed garden with walkway and garden furniture with panoramic views of the valley and countryside. All bedrooms open onto a veranda to the side of the building. The centre provides residential care predominately to people over the age of 65 but also caters for younger people over the age of 18. It offers care to residents with varying dependency levels ranging from low dependency to maximum dependency needs. It offers care to long-term residents and respite, and palliative care to older people with a diagnosis of dementia. The centre provides 24-hour nursing care with a minimum of three nurses on duty during the day and one nurse at night time. The nurses are supported by care, catering, household and activity staff. Medical and allied health care professionals provide ongoing health care for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13
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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 2 March 2021	10:30hrs to 17:30hrs	Mary O'Mahony	Lead
Wednesday 3 March 2021	10:00hrs to 15:30hrs	Mary O'Mahony	Lead

What residents told us and what inspectors observed

From what residents said and from what the inspector observed, it was clear that residents were treated with dignity and kindness. Throughout the two days of inspection the inspector spoke with all residents. While not all residents met with were able to tell the inspector their views on the quality and safety of the service they were observed to be well cared for, in good spirits and content in the company of staff. Family and friends spoken with said that they were satisfied that their relatives and friends were safe in the centre. They praised the staff and the effective communication during the COVID-19 pandemic. Local children had sent in letters and drawings to cheer residents. A number of 'thank you' cards were seen which were very complimentary of the staff and the care available to residents. During the inspection deliveries of cakes and other items for staff were received from friends and family members. Staff were heard and seen to interact with residents in a kind manner and were seen to respond to behaviour or verbal cues of distress. Relatives were understandable distressed by the restrictions on visiting and these concerns were seen to be documented and supported. The clinical nurse manager stated that relative and staff advocacy meetings had been held prior to the pandemic: these were now held over the phone. Residents' meeting were not facilitated.

In relation to the lived experience of residents, the age and era of the building meant that the centre had an institutional-like environment: examples of this included:

- there were five, four bedded bedrooms and one single room available to residents.
- none of the bedrooms had en suite toilets or showers: toilet and shower access was only available by crossing the hall to the other side of the corridor:
- it would not be possible to maintain social distance for all current 13 residents in the sitting room: not all residents were facilitated to maintain social distance in the dining room:
- four residents were confined to bed at all times:
- there were a large number of locked doors in the centre and some of these rooms such as the relaxation room and a visitor's room would have created alternative sitting areas for residents:
- the single bedroom had not been furnished with a wardrobe or any storage space:
- each resident had access to a small half-height wardrobe, which meant that a lot of their personal possessions were stored elsewhere out of reach and not easily accessible to them as required under the regulations.
- one resident was seen to be very distressed when all personal belongings were moved into a locked store room after the resident's morning care. The resident had some communication challenges but was well able to express to the inspector how this effected her equilibrium and mental state. This person was provided with a wardrobe and access to the personal possessions during

the inspection

- lunch was seen to be served at 12 midday which is very early for the main meal of the day.

A number of residents liked to sit in the small foyer to watch staff activity. This area was furnished with a couch and chairs. Nevertheless, the seating areas were not clean and the floor was old and very worn. As it was such a small area it would have been relatively easy to decorate it to a high standard and provide a suitable and clean environment for these residents which would demonstrate respect for the fact that this was their "home". There were a number of other significantly dirty areas identified throughout the centre which resulted in the provider being issued with an urgent action plan on infection control. An immediate action plan was also issued on the safe storage of oxygen in the centre.

Daily activities were described on a white board in the centre. However, while "mass" was listed on day two of the inspection only two residents attended this. The afternoon activity was listed as "snoozelan" activity (relaxation). As this could only be accessed on an individual basis with one staff member a maximum of two residents were facilitated to attend. This meant that residents were seen to spend long periods of time unattended. An organised activity such as flower arranging or a baking demonstration would have created a communal sense of involvement for residents some of whom were quite chatty and interested in what was going on. One family member expressed unhappiness that one resident was in bed all day as the resident was located remotely from the others. This resident was described as loving a chat, and having a history of being very active and energetic before the illness. The person in charge undertook to liaise with the relative following the inspection to arrange a suitable plan. Residents had access to the enclosed garden which included a long furnished veranda area. This area was not fully utilised during the two days of inspection. A review of the complaints book indicated that regular walks were not facilitated for one particular resident who had been "promised" regular walks" following his complaint.

Three male residents who were confined to bed every day, all shared the same bedroom. This meant that their privacy and dignity was impacted on at each care intervention and when being supported with their meals. There was little in the way of distraction in these rooms for residents who were confined there, except for the television or radio. As there was only one TV available in each four bedded bedroom all residents listened to or watched the same programme. Individual spaces were small and were rarely personalised. Where some personal items were seen on shelves next to a small number of beds this made a significant positive impact on the homeliness of the space.

Meal times appeared to be nice opportunities for a communal experience. Residents were seen to talk with each other at this time: one female resident helped a male resident to clean his jumper after the meal. She declared herself to be 'very happy' when this was done. This was an indicator to the inspector that residents would benefit from, and enjoy, a communal activity following the meal or at another suitable time.

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.

Capacity and capability

Unit 1 of St Stephen's Hospital (Unit 1) was operated by the Health Service Executive (HSE) who was the registered provider for this designated centre for older adults. There were 13 residents living there during the inspection with eight vacant beds. The provider was now applying to reduce the number of residents to 16 at full occupancy, in light of the COVID-19 pandemic and the unsuitability of the current layout to facilitate safe social distance and adequate bed room space. At the time of the inspection the overall day to day governance structure for the service was unclear as there was a lack of definition around the role and responsibilities of the person in charge and other managers assigned to the centre. Improvements were required in the governance and management structure of the service to ensure effective oversight of this centre. The person in charge felt that she lacked the authority required to initiate and sustain change and improvements in the centre due to the reduced hours available to her to manage the centre. The person in charge reported that she had made requests for resources for the required improvements and had been met with a negative response. The fact that she felt she was not afforded sufficient hours for the role meant that there was no time to follow up on the requests with a sustained approach, as there were competing responsibilities attached to her other roles.

This was an unannounced risk-based inspection conducted over two days. The person in charge and the clinical nurse manager (CNM1) supported the inspector throughout the two days. The CNM1 was on duty when the inspector arrived and even though the person in charge was on study leave she attended the centre in the afternoon of both days. The person in charge was not successful in contacting the registered provider representative (RPR) during the inspection and it was not clear when the RPR last visited the unit. However, he made contact with the inspector on the day following the inspection to provide assurances that all the issues identified in the urgent action plan would be addressed. Residents in the centre had remained free of the COVID-19 virus to date. One staff member had contracted the virus while absent from the centre and a number of staff had been close contacts or suspected cases. However, these all tested negative. The inspector acknowledged that a significant effort had been made by staff and visitors to keep residents safe and virus free.

The person in charge of the centre held the role of 'acting' assistant director of nursing in St Stephen's Hospital as well as person in charge of Unit 1. Due to the level of responsibilities for mental health services throughout the county the person in charge was unable to be fully involved in the effective governance, operational

management and administration of the centre. She stated that she visited the centre three or four times a week to meet with the staff, to discuss residents and staffing. The inspector saw that staff meetings were taking place and minutes of these were seen. Records were seen in these minutes where the person in charge had raised the need for improvements in premises. The person in charge told the inspector that her other commitments in the mental health sector meant that she could not spend more than a few hours in the centre weekly. Her office was based in another building on the campus. Additionally, the senior nurse managers, the CNM 2, and a number of senior nurses had just retired. This meant that there was now only one CNM 1 on the roster. Whenever the person in charge was off duty one of the nurses took on the role of person in charge. Neither the CNM or the assigned nurse in charge were supernumerary and they worked as one of the staff caring for residents on a daily basis. This meant they were not free to engage in effective management. At the feedback meeting assurances were received that the acting person in charge would move her office into the centre and an updated, meaningful governance and management structure would be developed.

The person in charge and staff told the inspector that the centre had experienced staff shortages due to a significant amount of absence among staff. Staff worked additional shifts and a number of agency staff were employed to fill vacancies caused by senior nursing staff retirements. Minutes of staff meetings indicated that staff found that the additional hours worked to cover absent colleagues were 'very tiring'. At the time of this inspection, staffing levels were adequate to meet the needs of the 13 residents. However, the issue of management oversight, staff supervision, auditing and residents' activities were impacted on by not having access to a full time person in charge within the centre, as well as a full senior management team. The roster seen was not correct: it did not include the name of the person in charge or the hours to be worked. The name and working hours for the multi-task attendant assigned to the kitchen duties were also not included on the roster. On a positive note training in mandatory areas such as the prevention of elder abuse, had been provided to staff. Training on infection control relating to the pandemic had also been facilitated. Nonetheless there was no evidence that the knowledge gained from on-line training courses was evaluated in practice particularly in relation to correct mask wearing and protocol for visitors to the unit.

There was evidence of effective communication with families and residents throughout visiting restrictions during the various waves of COVID-19. In relation to hearing the voice of residents in the centre, the last family advocacy meeting was held in November 2020. This was held over the phone. Staff said however, that relatives contacted the centre at least weekly and were informed if there were any changes in the health of residents. The inspector saw that there a number of window visits facilitated during the two days on inspection. Relatives and friends spoke with the inspector and expressed their opinion that staff were very kind and caring. They felt that residents were safe in the centre. However, the inspector discussed one issue which had not been satisfactorily resolved and this was referred for follow up action by the person in charge. The name and identity of the person in charge was not known to the person who raised the concern. This was further evidence that the presence of a person in charge and senior management team on a full time basis was important for continuity of care and oversight of a more person-

centred approach to care.

The inspector found that some quality improvement strategies and monitoring of the service were in place. Comprehensive audits were carried out in relation to medicines and the use of psychotropic medicines. However, these were carried out by the consultant and the pharmacist and not by staff assigned to manage the unit. There was no evidence of any comprehensive audit schedule for the year on, for example, aspects of care, performance, rational for the use of psychotropic drugs and effective cleaning. This had not been developed, according to the CNM 1, who stated that this was impacted on by the lack of dedicated administration time. Auditing of the key performance indicators, for example, falls, incidents, complaints, and infection control processes were absent or haphazard and not carried out within the unit on a regular basis to enable improvements and evaluate the sustainability of improvements.

The provider had compiled the regulatory annual review of the quality and safety of care delivered to residents in April 2020. This was detailed and set out how the centre had improved the quality and safety of care as well as identifying areas to be completed during 2020. Not all the actions were completed however, in particular the development of a comprehensive effective audit of cleaning and infection control processes, staff recruitment and the premises upgrade.

In relation to records required to be maintained in the centre the inspector found that there was a record of accidents and incidents in place. Appropriate action was taken for residents such as medical review or first aid. Nevertheless, not all required notifications had been submitted to the Chief Inspector as required by the regulations, for example where staff were suspected of having contracted COVID-19. Garda vetting disclosures were kept on site for staff. The person in charge informed the inspector that all staff were fully vetted prior to commencing work in the centre. A sample of staff files were reviewed. As found on the last inspection however, all documents required under Schedule 2 of the regulations were not available in staff files.

Procedures in accordance with the HSE money management policy were in place for the management of residents' monies. Locked storage was provided for residents' valuables in each wardrobe space.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider had not completed the required registration renewal documents and had not submitted them within the required time frame.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge was suitably qualified for the position and was found to be generally knowledgeable of her remit as the person in charge of a designated centre as set out in the regulations.

However, due to her additional external responsibilities she was not present on the centre for a sufficient period of time each week to enable supervision, planning and effective governance. This was actioned under governance and management in this report.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels were adequate at the time of inspection. There were three nurses on duty as well as one care assistant to meet the needs of 13 residents. Additionally there was a multi-task attendant assigned to kitchen duties and two externally contracted cleaners for two hours each morning.

At the time of the inspection there were no staff specifically dedicated to activities on the unit and this will be discussed and actioned under 'residents rights' later in the report.

Judgment: Compliant

Regulation 16: Training and staff development

- A copy of the Health Act 2007 and the regulations made under it, were not available to staff.
- A copy of the Standards developed for the sector was not available to staff.
- A copy of the Infection Control Standards was not available to staff.
- Training in effective environmental cleaning had not been provided to relevant staff and cleaning practices were not adequately audited: this was impacted on by the absence of senior management staff in the centre to facilitate supervision.

On a positive note, one of the senior nursing management staff was currently undertaking a post registration qualification in infection control and a second member of staff was undertaking a post graduate gerontology qualification.

Judgment: Substantially compliant

Regulation 21: Records

The roster was viewed. This did not correlate with the staff names and the details of the management arrangements contained in the Statement of Purpose.

Staff files were not complete and were not well maintained: in the sample seen there was no photographic identification for one staff member and not all gaps in the curriculum vitae (CV) were documented.

Judgment: Substantially compliant

Regulation 23: Governance and management

The system of governance and management in place for the centre did not provide adequate oversight to ensure the effective delivery of a safe, appropriate and consistent service. Issues with the governance arrangements included:

- Due to the multi-faceted role of the person in charge, which included leading teams in the mental health division throughout Cork county, she accepted that she had not been present for sufficient hours to be fully engaged in the effective governance, operational management and administration of the centre.
- There was a lack of a clearly defined management structure that identified the lines of authority and accountability, specified roles and detailed responsibilities for all areas of care provision.
- There was inadequate oversight of the day-to-day operation by the management team. A review of the roles of senior management team members assigned to the centre clearly showed that each member of the team were assigned to other duties within the campus and the service. In other words the management of the centre was not prioritised by the presence of the assigned management staff on the unit to manage and supervise on a daily basis. For example, there was a CNM3 assigned to the unit on the Statement of Purpose. This role did not transform into active practice on the unit and the person was not included in the roster to provide management oversight when the person in charge was not present. The CNM3 organised mandatory training but did not have any role beyond this in following up with adherence to training or care of residents on the unit.
- Audit processes and systems had not been fully developed. This meant that there was a lack of oversight of the service, a lack of follow-up on required actions and no evidence of improvements in sustaining residents rights: in relation to a meaningful activity programme, their personal possessions and daily lived experience.

- The COVID19 contingency plan was not sufficiently detailed to describe how two care teams would be facilitated to use a separate entrance, dine separately and access separate changing rooms in the event of an outbreak: There was no contingency for the provision of two nurse led teams for night duty in the event of an outbreak.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Contacts had been reviewed since the previous inspection. These now contained the number of the room to be occupied by any resident and stated if the room was a shared room.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications had not been submitted on a number of occasions in relation to informing the Chief Inspector when any staff member was suspected of COVID-19. Management staff were not aware of this regulatory requirement.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints were documented and were seen to be related to lack of satisfaction with the visiting restrictions. Relatives had been spoken with on each occasion and the health protection surveillance centre (HPSC) guidelines were explained to them. There were notices on display in the front hallway related to COVID-19 restrictions and precautions.

One complaint had not been followed up satisfactorily however. A promise had been made to a resident in relation to a daily walk or access to same: this had not been followed up: for example ensuring access to his cap and coat, or access to an open door to the garden on mild days. This was not included in his care plan as part of the resident's daily experience.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The policy on infection control had been updated to include the management of COVID-19.

The policy on safeguarding in use in the centre was the HSE national policy on Safeguarding Vulnerable Older Persons 2014.

All the policies required to be developed under Schedule 5 of the regulations were available and updated within the regulatory three year time frame.

Judgment: Compliant

Quality and safety

Resident's health care and general welfare was maintained by a good standard of evidence-based care and support. However, improvements were required in the area of infection control, residents' personal possessions, a meaningful activity programme and premises.

Under the quality and safety section of this report an immediate action plan was issued on the storage of oxygen and an urgent action plan was issued under infection control processes.

Care planning and health care in the centre were well managed generally. Residents had regular access to a consultant and a senior house officer (SHO) for the mental health services on the campus. However, incremental improvements were required in the centre to ensure residents were supported and encouraged to have an optimal quality of life which was respectful of their wishes and choices. These improvements were required to ensure a more person centered approach to care was promoted including opportunities for exercise and social engagement.

The inspector found that the COVID-19 contingency plan was not detailed enough to cover the basic aspects of a COVID-19 outbreak such as staffing arrangements, PPE donning stations, preparation of the isolation room, the stocking of dani centres, developing effective cleaning processes and supervision. The centre was not clean nor well maintained.

A range of health care professionals were available to residents such as dietitians and speech and language therapists (SALT) who reviewed residents regularly and now remotely during the outbreak. Input from these professionals was seen in the

sample of care plans seen. Access to geriatricians and palliative care advice was readily available. However, access to occupational therapy (OT) and activity personnel had been withdrawn in recent times and these services were greatly missed in the day to day care and social world of residents. Access to a general practitioner (GP) service had yet to be addressed, according to the person in charge, for the day to day medical care of residents. While funding had been approved for a medical officer post to meet the general physical health-care needs of residents the inspector was informed that a suitable candidate was not appointed at interview on 11th January 2021.

Residents' individual assessments and care plans were updated within the required time frames. End of-life care plans were seen with evidence of collaboration with residents and their families to ascertain the preferences of each resident. There was a need to revise some elements of communication in relation to end of life wishes as there was a lack of clarity on the ceiling of care document seen, which set out the advance care wishes of the residents. Additionally, care plans required review to include for example, a plan to facilitate walking outdoors for one resident and a plan to facilitate short periods of time out of bed for another resident. This would ensure a more proactive and person-centred approach to care delivery. There was a centre-specific restraint policy in place which promoted a restraint-free environment and included a direction for staff to consider all other options prior to its use. Risk assessments were seen to be completed and there was evidence that some less restrictive alternatives such as low-profiling beds and alarm mats were in use. Bed rail use was low with less than 30% of residents using bed rails at the time of inspection.

Residents had access to a daily newspaper and had shared access to the TV in each multi-occupancy room and in the sitting room. One resident was seen to avidly read the paper while sitting in the foyer. While there was a sitting room and dining room in the centre these were not sufficiently spacious to allow for social distancing. Staff found it difficult to seat more than eight residents in these rooms in a manner that maintained the recommended social distance. While this was achievable at present it was only achievable due to the fact that there were eight vacancies and four residents nursed in bed every day. Other suitable rooms for communal activity were locked during the day. There was no religious services and no visitors within the centre at present. Mass was shown on television during the inspection as the morning 'activity'. Only two residents were facilitated to watch this however, even though seven other residents were seated in the main sitting room where there was another TV. This was not a communal activity and was the only activity for the morning. The lack of interaction meant that the majority of the rest of the residents slept in their chairs throughout the morning. Resident's privacy and dignity needs were supported by the best efforts of staff, in as much as this could be done in multi-occupancy bedrooms with curtains as the only source of privacy. The lack of en suite shower and toilets in these rooms meant that residents had to be supported to cross a corridor to access hygiene opportunities during the day and night. Otherwise a commode had to be utilised which was not at all conducive to maintaining personal dignity. Assisted toilets were not furnished with supportive grab rails which would support safety and independence. Not all these shared toilet

and wash areas were modern, clean or well maintained.

There was a risk register in place to promote safety and effectively manage risks. Nonetheless, not all risks were included in the risk management policy such as the lack of effective cleaning or the failure to check the temperature of each visitor prior to entering the centre. On a positive note, systems were in place for the maintenance of the fire detection and alarm system and emergency lighting. Residents all had Personal Emergency Evacuation Plans (PEEPs) in place and these were updated regularly. This identified the different evacuation methods applicable to individual residents for day and night evacuations. Fire training was completed for all staff in 2020. The person in charge confirmed that fire drills were facilitated regularly with the next fire evacuation drill due in March 2021.

The outdoor garden area which was suitably spacious, required some painting and upgrading to make it a more pleasing and welcoming environment for residents. Its location required highlighting and signage for residents to encourage independent access particularly for the active male residents.

Regulation 10: Communication difficulties

Residents were facilitated to use mobile phones to talk with family members. Thank you cards and cards for residents were on display. Electronic tablets were also available to facilitate video calls. A pastoral visitor was accessible if required and the complaints process was on display for residents. Residents with behaviour associated with the effects of dementia had been seen by a consultant and medicines had been regularly reviewed to optimise residents' abilities. Residents were found to be chatty and some were interested in the inspection process when spoken with. Residents were found to be able to effectively communicate both distress or contentment to the inspector.

Judgment: Compliant

Regulation 11: Visits

Visiting was currently taking place through the windows. Beds were moved to facilitate better views of visitors for those residents who were confined to bed. A dedicated visitors' room and kitchen, including overnight accommodation, were in place for end of life visits. Currently, due to level 5 restrictions visiting was not allowed, except in compassionate circumstances. Visitors said they were looking forward to being able to make real contact when restrictions were lifted and residents said they looked forward to the visitors coming into the centre again. Staff explained how visitors to any person created a sense of excitement among all residents, which they missed during the lockdown. The inspector found that the well

being of these residents with dementia had been negatively impacted on by the lack of visits from those closest to them who understood their life story and family connections.

Judgment: Compliant

Regulation 12: Personal possessions

Not all residents possessions were easily accessible to them. There was a lack of personal space in each room to facilitate the display of personal items and photographs.

- Extra clothes were stored in wardrobes due to the existing small half-height wardrobes not being big enough to accommodate all residents' possessions.
- There were also 'spare' clothes stored in the store room as well as clothes from residents who had died as far back as late last year.
- Some of the clothes were stored in plastic bags which were pushed into the excess storage wardrobes. This did not assure the inspector that there was appropriate respect and care given to the clothes of residents.
- A sample of lovely clothes belonging to residents were not labelled, which created a risk in relation to the inadvertent sharing of clothes between residents as well as the risk of loss of these expensive looking shirts, jumpers and underwear.
- A number of pictures frames which were broken had not been repaired and replaced on walls by residents' wardrobes.

Judgment: Not compliant

Regulation 17: Premises

There were some issues identified with the premises during the inspection which required action from the provider.

A significant number of rooms required painting and new flooring to enable effective cleaning, as a large section of the flooring consisted of broken tiles, deep and numerous indentations in the entrance foyer and on all bedroom lino, which meant that the floors could not be cleaned effectively: the carpet in the sitting room was stained, fabric covered chairs were stained.

- In the small staff dining area the flooring required replacement as it was very dirty, it had been patched in places and subsequently the surface was not intact.
- Generally storage space was poorly maintained. Storage rooms were seen to

be cluttered with boxes stored on the ground, making effective cleaning of the areas difficult.

- The 'surgery room' still had an old sink in situ even though a new sink had been installed.
- The staff shower required replacement as it was rusty all over and the flooring in this area required replacement.
- Wooden bed-ends were chipped in some rooms and the legs of a number of bed tables were rusty which inhibited effective cleaning.
- There was no single room suitable for isolation as there was no en suite facility in the existing small single room.
- All other rooms were multi-occupancy four bedded rooms. There were no en suite facilities available. Wall and wood paintwork was cracked and scuffed in a number of rooms.
- There were insufficient hand washing sinks available to any visiting managers, the public and staff, apart from those in bedrooms and in locked rooms.

Judgment: Not compliant

Regulation 26: Risk management

An immediate action plan was issued on the storage of oxygen:

- Eight oxygen cylinders were stored in the small clinic room and were not properly secured.
- Staff could not move the heavy cylinders for effective cleaning and in addition there was no signage in place to alert personnel to the presence of oxygen which was a highly combustible gas. This had not been properly addressed in the identification of hazards and risks in the risk management policy in the designated centre.

The risk management policy did not include the controls set out for the various risks specified under the regulation.

The signage and storage of oxygen had been addressed before the end of the inspection.

Judgment: Substantially compliant

Regulation 27: Infection control

The centre was not in compliance with infection control guidelines and protocols. As a result of the significant findings of non compliance an urgent action plan was

issued to the provider. This meant that the Chief Inspector had set out a time frame by which the issues were to be addressed. This indicated that the findings were of a serious and concerning nature.

The importance of following infection control guidelines and protocols had always been central to the prevention of health care associated infections (HAIs) and had now gained additional significance due to the COVID-19 pandemic risks.

The findings related to poor cleaning and infection control processes were listed in full detail on the aforementioned urgent action plan issued directly to the provider on the day following the inspection.

A small sample of the issues included:

- Not all people entering the centre had their temperature checked on arrival: there was a need to set up an appropriate area for temperature check and filling the COVID-19 questionnaire before entry was allowed.
- Dani-centres (a wall mounted metal container) in each bedroom were not stocked with PPE, which necessitated staff using a key to go into the locked clinic room to get clean PPE, following each care intervention.
- The staff shower room, the staff office, the janitorial room, the staff dining room and the laundry room were very dirty: the flooring was dirty and damaged in these rooms, the windows were dirty and covered in mould, and the staff shower was rusty all over,

Two examples of infection control issues in these rooms follow:

- The floor and window of the janitorial storage room was dirty: there was visible dust in the room, mould stains on the window and a toilet brush left in the 'janitorial' sink. Dirty dusters were lying against the wall. Containers of chemicals were left open.
- The laundry room, used for residents' personal items, was very dirty and very small. There was a lot of dust and dirt all around both machines. The window frames were dirty as above. There was a stained wooden clothes horse in use which could not be cleaned effectively. This was removed on day two and the inspector saw that a large bed quilt had been placed on the small radiator to dry. Two thirds of this quilt was resting on the floor.

Other issues included, but were not limited to, the following:

- There were no commodes available which could be cleaned in the bedpan washer in the event that they were required for a person in isolation or otherwise: the two commode pans available were part of the two shower chairs and had to be manually cleaned by staff, as they did not fit into the bedpan washer. This created a risk of splashes of waste material and subsequent possible infection.
- A detailed cleaning schedule was not available indicating that: for example, the shower chairs, hoists and showers were cleaned between each use.
- There was no evidence that effective deep cleaning was carried out in the rooms on the right side of the corridor as described above.

- Cleaning hours were limited to two hours each morning which was insufficient, inadequate and ineffectively unsupervised.
- A staff member was seen to wear a mask inappropriately and touching the front of the mask on numerous occasions throughout the two days of inspection.
- Notification of a suspected cases of COVID-19 had not been made to the Chief Inspector as required under the regulations. This was attributed by staff to inadequate dedicated management hours in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

All residents had a written care plan and they were updated within the regulatory time frame. The inspector viewed a number of residents' care plans during the inspection. Residents were assessed prior to admission and they had a comprehensive assessment following admission.

- However, some care plans were not updated with recent changes for example, residents' mobility needs.
- In addition, while end of life care plans were detailed there was a need for more detail and updating on the quick reference sheet available to staff in the event of a resident's deterioration. For example, it was not always clear whether a resident was for resuscitation or not in the event that a natural death occurring or if hospitalisation was necessary. It was clear to the inspector that this quick reference sheet was not regularly updated as residents who were no longer in the centre were included.

The CNM stated that she would oversee the updating and additions required to care plans, a number of which had been audited.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had adequate access to medical services and they had regular pharmacy service. Both of these services provided comprehensive audits which were viewed during the inspection. The pharmacist support staff training on medicines management. Staff were seen to manage medicines in a safe manner in the small sample checked. Medical notes from the consultant were up to date and the consultant informed staff that he was available during the inspection if required. The centre also had access to a consultant geriatrician for residents.

The inspector found that other health care professionals such as, the occupational therapist (OT) the physiotherapist, dietitian, chiropodist, speech and language therapist (SALT) had inputted information in residents' files. Staff explained that access to these services was limited at present due to the virus, even though referrals were continuing over the phone, thereby maintaining a holistic health care service for residents. Advice from these referrals was documented.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

- A PRN (use when required) psychotropic (a type of sedative or mind altering medicine) medicine use record was not maintained. This record would describe the need for the PRN dose of the medicine, any alternatives tried prior to the use of chemical restraint and the effect of the medicine on the behaviour.
- Use of a recognised tool such as, the ABC chart (describing the behaviour in terms of the Antecedent, the actual Behaviour and the Consequence of the behaviour or intervention) was not in place.

The aforementioned strategies, used in tandem, would ensure the application of best evidence based practice and ensure a non pharmaceutical, person centred, tailored approach to the behaviour and psychological symptoms of dementia (BPSD) and the communication challenges which can be experienced by these residents.

Judgment: Substantially compliant

Regulation 8: Protection

- Staff working in the centre had received training in safeguarding vulnerable adults and were aware of how to report and address issues.
- Procedures were in place for the management of residents monies and locked storage was provided for residents' valuables.
- The centre was a pension agent for one resident.
- Performance management and staff appraisals formed part of the quality improvement system for staff.

Judgment: Compliant

Regulation 9: Residents' rights

Before the restrictions residents had opportunities to participate in meaningful activities and recreation as staff from the campus activity centre were assigned to facilitate activities in the unit. On this inspection the activities did not include the majority of residents and were very dependant on the knowledge and enthusiasm of the staff team on duty. The inspector saw for example that one staff nurse facilitated each resident to go for a good walk after their meal.

- The withdrawal of the OT and activity staff from this vulnerable group was a huge loss to residents and had a negative impact on their mental well being at this time of isolation from other social opportunities.
- There no minutes maintained of meetings with residents and there was inadequate follow up on issues raised by those family members advocating on their behalf.

Throughout this time of restrictive visiting, family contact was maintained through telephone, video calling and letters.

On a positive note, residents were well known to the staff on duty both days and staff informed the inspector about residents' backgrounds. This knowledge enabled the inspector to have a meaningful conversation with one resident who had worked as a wood turner and another who had played football in their youth. It was evident to the inspector that residents' past experiences were recorded and used to inform care planning for the most part.

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 4: Application for registration or renewal of registration	Not compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Unit 1 St Stephen's Hospital OSV-0000715

Inspection ID: MON-0031099

Date of inspection: 03/03/2021

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 4: Application for registration or renewal of registration	Not Compliant
<p>Outline how you are going to come into compliance with Registration Regulation 4: Application for registration or renewal of registration: Registration application Re-Registration Application has been submitted for review in relation to Centre ID : OSV-0000715. The application to re-register was submitted by the PIC on Tuesday 30th March 2021.</p>	
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development: A copy of the Health Act 2007 was available on the unit on the day of Inspection however, the A/CNM2 could not access it when requested .A copy is now at hand on the Nurse`s desk. A copy of the "National Standards for Residential care Settings for older People in Ireland." was available on the day; however the A/CNM2 could not access it when requested. A copy is now at hand on the Nurses desk. A copy of the Infection Control Standards were also available in the nurses' office on the day of the inspection, however the A/CNM2 could not access them on the day. There were also copies of the self-assessment tool, the quality improvement plan and the COVID-19 assurance framework for registered providers. The self-assessment tool had been issued to the CNM2 in October 2020. A system for training relevant Staff in environmental cleaning has been developed by the</p>	

contract cleaning supervisor and the house keeping supervisor which will be monitored going forward by the aforementioned and A/CNM2/ PIC. Cleaning schedules are in place and cleaning audits carried out weekly. Training records for the MTA are now captured on the Staff training template kept by the CNM2/PIC. A checklist for cleaning patient equipment was in place on the day of Inspection... A cleaning manual has been developed to aid with training and identifies all cleaning duties and how they are assigned. One of the senior management Staff completing an Infection Control Course will complete an assignment in environmental hygiene and will share learning from research carried out.

Regulation 21: Records	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 21: Records:
 The roster has been amended to reflect the presence of the PIC on the unit. The roster also captures the presence of the Multi-task –attendant.
 The administration support to the PIC will review all Staff files .The PIC has requested that the files will be reviewed at least annually going forward in order that they are adequately maintained...

The Staff file which had gaps in C.V with no photo-graphic identification has been reviewed and non-compliance rectified.

Regulation 23: Governance and management	Not Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:
 The PIC will be assigned to the unit and will establish an office on the unit.

An audit schedule has been developed and all reports available in the CNM2 office. The CNM2 and PIC will ensure that all actions will be communicated to Staff and followed up. Staff had been trained in the metrics system developed by the NMPDU and a folder was kept in the CNM2 office with findings. This had not been monitored in recent months due to the absence of the CNM2.

All Staff have now been directed to complete the HSE-land metrics training module. The completion of all training will be followed by an up-date on the system by Johanna Downey NMPDU. The audit findings will be included in the audit schedule.

The COVID-19 contingency plan has been up-dated to reflect how care teams will use a

separate entrance, dine separately and access different changing rooms in the event of an outbreak. It also reflects the availability of a workforce planning group for extra resources in the event of an out-break.

Regulation 31: Notification of incidents	Not Compliant
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

All relevant Staff are now aware of the reporting requirements of suspected and positive COVID -19 cases. The CNM2 has been provided with portal access in the absence of the PIC in order to ensure that reports are submitted in her absence.

Regulation 34: Complaints procedure	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

All Staff have been requested to review all HSE policies which are available on the unit including the "your service your say" policy. All Staff are requested to sign that they have read and understood these policies. All complaints are captured on the monthly complaints log including the actions needed to resolve the complaint to the satisfaction of the complainant. Any action required should be included in the resident`s care plan.

Regulation 12: Personal possessions	Not Compliant
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Outline how you are going to come into compliance with Regulation 12: Personal possessions:

A previous HIQA inspection highlighted inadequate space in existing wardrobes at the patient bedside. In response to this one extra wardrobe for each resident was installed in the store room to accommodate any surplus personal possessions which could not be accommodated by the bedside. These wardrobes have now been removed from the store room and placed by the resident`s bedside. Built –in wardrobes are included in the development plan for the unit which will be sufficient to accommodate all patient property and serve to maintain patient dignity. Both existing wardrobes will then be removed.

All clothes from deceased residents have been removed.
 All clothes are appropriately stored.
 The CNM2 will ensure that wardrobes are tidied on a weekly basis going forward and that all personal possessions are treated with respect and items broken are attended to.

Regulation 17: Premises	Not Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:
 The Staff dining room is to be re-decorated in full. The scheduled works to include replacement of the window and existing kitchenette. The room will be re-floored and re-painted with replacement furniture. A maintenance request has been progressed to remodel the laundry room and improve access to space within the room. A new window will also form part of the enhancement including re-flooring with a moulded skirting and re-painting of the room. Mechanical extract will be added to assist with room ventilation.

The store room has been emptied of any excess items and will be fitted with adequate storage shelving.
 The CNM2 will ensure that the space is tidied on a weekly basis going forward.

The old sink in the surgery room has been removed.

The Staff shower was included in the request dated 14/11/21 sent from the PIC. A maintenance request has been logged to redesign the space. An architectural design drawing is required and the schedule is to re-design the current space adding a new shower, replacing the window new sanitary wear, re-flooring and re-painting as required.

10 new beds have been ordered to replace any damaged beds.

The single room is available for isolation as set out in the up-dated outbreak plan and is stocked with PPE.
 An extra hand-washing sink will be installed on the main corridor for visitors and Staff.
 Overall the unit is to have a large volume of refurbishment works undertaken across the unit. New flooring in addition to re-painting of all general areas internal and external.
 Wall Murals on the internal walls will also be updated.
 The access point to the external veranda and garden area will be signposted with suitable signage specified with the support of the OT professional supporting the unit.
 The access to the outdoor space will be re-engineered to facilitate ease of exit and entry for clients to the outdoor space.
 The garden area is to be enhanced supported by a landscape contractor to make the external space a more inviting for clients to assist with the space enjoyment.

Regulation 26: Risk management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management:</p> <p>Two Oxygen cylinders are now stored in the clinical room. There are no items stored in front of the cylinders to allow for easy access by the cleaning operatives. The risk associated with injury from Oxygen is captured on the Unit risk register (no 15). The unit 1 risk register was available on the unit on the day of inspection.</p> <p>The risk management policy has been up-date with guidance from BOC on the safe storage of Oxygen. Signage has been placed on the door of the clinical room</p>	
Regulation 27: Infection control	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Infection control:</p> <p>All persons entering unit 1 are now required to have their temperature checked prior to entering the unit .A risk assessment is carried out.</p> <p>All Dani-centres are stocked with PPE and new dani-centres have been ordered.</p> <p>All infrastructural issues which contributed to non-compliance with Infection Prevention and Control standards are being addressed in the up-grading works planned.</p> <p>The Out-break plan has been up-dated.</p> <p>The PIC/CNM2 will carry out monthly IPC audits.</p> <p>Hand hygiene audits are carried out weekly.</p> <p>New commodes have been ordered for the unit and a new bed –pan macerator.</p> <p>A detailed cleaning manual has been drafted which encompasses all cleaning duties, frequency of cleaning and person responsible identified.</p> <p>The domestic supervisor and cleaning operative supervisor are carrying out weekly audits and following up on any actions necessary. The MTAs have received up-dated training on their cleaning responsibilities including IPC training. .The CNM2/PIC will monitor cleaning on a daily basis.</p> <p>A daily log has been developed which captures cleaning of shower facilities between resident`s use.</p> <p>Extra cleaning hours have been allocated to the unit.</p> <p>All staff are aware of the requirements in relation to notification of COVID-19 suspected cases and the CNM2 has access to the portal system in the absence of the PIC.</p>	
Regulation 5: Individual assessment	Substantially Compliant

and care plan	
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</p> <p>An update on care-plan training will be provided to Staff. All care plans have been replaced with a new care plan which includes more personal details for the Resident and enables a more person-centered approach to care. The care plan also encompasses end-of-life care and will allow for more detail. The quick reference sheet will be update on a monthly basis .The CNM2 has placed a reminder in the daily diary. The new care plans were developed by the NMPDU and are evidence based.</p>	
Regulation 7: Managing behaviour that is challenging	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:</p> <p>The ABC chart has been introduced.</p> <p>The administration of PRN /psychotropic medication is recorded on the Medication Prescription and Administration Record for patients of Unit 1. This record documents the drug name, the prescribed dose, frequency and route. The prescriber may write the indication in the "special instructions box" provided. There is a communication sheet which can be used for additional information by both prescribers, pharmacists or nursing staff members involved in patient care, this is integral to the MPAR, on the last page. The MPAR provides space for documenting the date and time the PRN medication was given and the route and dose, and the signature of the staff member who gave this medication. Using the date and time documented, this allows for cross-reference the patient care plan and nursing notes where additional information relating to the plan agreed for this patient, any alternatives tried prior to the use of psychotropic medication and the effect of the medicine on the behaviour is documented. The pharmacists review the MPARs for residents of Unit 1 and submit reports to the MDT for their review which highlight the need for regular assessment of the risks and benefits of PRN psychotropic medication including licensed and evidence based use, and appropriate indication, dose, frequency and highlight particular risks including falls risk</p>	
Regulation 9: Residents' rights	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 9: Residents' rights: OT services and access to day activities on site were initially withdrawn to support</p>	

resident safety from Covid-19. The PIC had requested non-essential staff not access the patient area. OT services have always been available to patients on the unit and OT services support any patient's needs as requested by the PIC or Nurse management. In addition the onsite Activity centre is now operational which will support the clients with group activities. A new day resource bus with disability access has also been introduced into the site. This will allow transfer of clients to the activity centre as required. The PIC has engaged with other peers locally to support access to patients from unit 1 to the day resource centre.

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 4 (1)	A person seeking to register or renew the registration of a designated centre for older people, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Not Compliant	Orange	13/04/2021
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Not Compliant	Orange	02/03/2021

Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Not Compliant	Orange	01/05/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	01/01/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	02/03/2021
Regulation 16(2)(a)	The person in charge shall ensure that copies of the Act and any regulations made under it are available to staff.	Substantially Compliant	Yellow	02/03/2021
Regulation 16(2)(b)	The person in charge shall ensure that copies of any relevant standards set and published by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act are available to staff.	Substantially Compliant	Yellow	02/03/2021

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	31/05/2021
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.	Substantially Compliant	Yellow	09/04/2021
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	02/03/2021
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	Orange	02/03/2021
Regulation	The registered	Substantially	Yellow	02/03/2021

26(1)(a)	provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Compliant		
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	02/03/2021
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Substantially Compliant	Yellow	02/03/2021
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Substantially Compliant	Yellow	02/03/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the	Not Compliant	Red	12/03/2021

	standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	02/03/2021
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Substantially Compliant	Yellow	02/03/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with	Substantially Compliant	Yellow	02/03/2021

	the resident concerned and where appropriate that resident's family.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	02/03/2021
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	10/05/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	28/04/2021
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.	Substantially Compliant	Yellow	02/03/2021
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	Substantially Compliant	Yellow	02/03/2021

	organisation of the designated centre concerned.			
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