



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

## Issued by the Chief Inspector

Name of designated centre:	Fennor Hill Care Facility
Name of provider:	Blockstar Building Limited
Address of centre:	Cashel Road, Urlingford, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	19 February 2020
Centre ID:	OSV-0007180
Fieldwork ID:	MON-0027578

## About the designated centre

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

Fennor Hill Care Facility is situated on the outskirts of Urlingford in County Kilkenny and within walking distance from the village centre. Residents' accommodation is situated on two floors of the facility and accommodates 56 residents. It is a newly built facility opened in September 2019, and accommodation comprises 48 single rooms and 4 twin rooms, all of which have spacious ensuite bathrooms. Each ensuite bathroom consists of a toilet, hand sink and shower facilities. The centre has communal sitting and dining rooms on both floors. The centre can accommodate both female and male resident with the following care needs: general long term care, palliative care, convalescent care and respite care. The age profile of each resident maybe under or over 65 years but not under 18 years with low to maximum dependency levels.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	41
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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
Wednesday 19 February 2020	09:30hrs to 18:00hrs	Margo O'Neill	Lead
Wednesday 19 February 2020	09:30hrs to 18:00hrs	Mary O'Donnell	Support

## What residents told us and what inspectors observed

Inspectors met residents and visitors on the day of inspection. Most of the residents on both floors spent their day in the day rooms and some residents on the ground floor sat in the foyer beside the fire because it was very cosy there. The feedback from residents and relatives was positive. They all commented on how lovely the staff were. They recognised that staff were very busy but reported to inspectors 'They always take time to look after you'. Residents and relatives were pleased when staff and residents had moved to Fennor Hill when a local nursing home closed down. One relative said it had made the move so much easier for the residents, because they were with staff who knew them very well. One resident described staff as her friends. There was a sense of community in the centre, as inspectors observed that visitors chatted with other residents and staff. They seemed to know each other well and some of the staff also lived in the area.

Everyone commented positively on the standard of the accommodation provided. They were pleased to have a single bedroom and the ambiance in the foyer and communal rooms was pleasant. Most of the residents were glad to attend weekly Mass in the centre. Residents said they were rarely bored. One lady who spent her day in her bedroom was satisfied to read the daily paper, watch television and meet relatives when they called to visit. Another man said his favourite activity was eating. He commented that the food was gorgeous. All the residents who spoke with inspectors commented favourably about the food and the menu options. They agreed that the meal times suited them and that snacks were available any time.

There was plenty of seating areas and residents moved around to spend time together and chat when they had tea served in the afternoon. Both male and female residents were pleased that they got their hair done on the day of inspection. One lady who had curlers in place, said she did not like going up there (upstairs) to have her hair done. She mentioned too that the noise in the main foyer and ground floor sitting room 'just got' to her. She held her hands over her ears and said she 'wished the noise down here would stop'. She was referring to the noise of the call bells. Inspectors noted that the volume was high and the noise seemed unrelenting. A man who walked all day said he hated the racket and wanted to get away from it.

Residents on the first floor spent their day on that floor and many of the residents were unable to converse with inspectors. Staff were observed providing person-centred support to these residents. Inspectors observed that they spent their day in the sitting room and took their meals in the dining room. While some residents participated in activities such as drawing and playing board games with staff, or watching television on the morning of the inspection, very little activity was observed later that day. For example; residents were observed mainly walking along the corridors or between the day room and dining room to occupy their time. Inspectors noted that a number of residents on this floor exhibited responsive behaviours throughout the day of the inspection.

When asked about going outside to the garden, the residents said the weather had been miserable they were glad to be inside, where it was nice and warm. If the weather picked up they may go outside. Some residents sent their clothes home to be laundered and those who used the centre's laundry were satisfied with the service and remarked that their clothes were labelled so they did not get lost. Some residents confirmed that they had voted in the recent election and they were watching the news to see what kind of a government would be formed.

## Capacity and capability

This centre was registered in August 2019 to accommodate residents on the ground floor and first floor. Residents can be accommodated on the second floor after it has been inspected by an inspector of social services and deemed to be fit for purpose.

In July 2019 and at a subsequent meeting in November 2019, inspectors expressed concerns about the governance and management of the centre. On this inspection inspectors found the provider strengthened the management team and recruited an experienced nurse to fill a new post as clinical nurse manager. The post of person in charge which was vacant since November 2019 was also filled by a suitably experienced person.

However, the provider did not have adequate oversight of the service. There were no systems and processes in place to monitor the safety and quality of the service. Complaints were not recorded or analysed to inform service improvements, The provider representative visited the centre on a weekly basis but did not hold formal meetings with the person in charge.

The provider did not adequately resource the centre and the skill mix and numbers of staff on duty was inadequate to meet the needs of residents. A training schedule for mandatory training was completed for all staff recruited in August 2019 but staff who had been employed since had not completed mandatory training. There was no system in place to ensure that staff attended mandatory training and refresher training. There were inadequate experienced staff to mentor, induct and supervise staff who provided direct care to residents. Staff were not competent to use the computer based system to complete assessments and develop care plans for residents.

The new person in charge commenced employment in early January. The person in charge was suitably experienced and had a clear plan to develop the service and ensure that it met the requirements of the regulations. Significant improvements had been made in relation to residents' mealtime experience and their nutritional welfare. Improvement plans were in progress for risk management and infection control.

Following the inspection the provider agreed to cease taking admissions and work with the person in charge to develop a project plan for the service with

agreed timeliness to achieve specific outcomes. The provider agreed to submit the plan to the Chief Inspector within 10 working days.

#### Regulation 14: Persons in charge

The person in charge was appointed on 7 January 2020 and he worked full time in the centre. The records as set out in Schedule 2 were on file for the person in charge. The person in charge had the relevant management experience and held a management qualification. There was evidence that the person in charge engaged in ongoing professional development. He had a clear understanding of the role and regulatory responsibilities of the person in charge.

Judgment: Compliant

#### Regulation 15: Staffing

The staffing level had recently increased and there were adequate staff on duty on the day of inspection, but staffing arrangements for night duty were not adequate to meet the care needs of residents or to ensure that at least one registered nurse was on duty at all times. In addition there was no contingency staffing resource to cover staff training, sick leave or annual leave. On the day of inspection there were 41 residents and their dependency scores were three maximum, 20 high and 16 medium and two low dependency. One nurse on duty to cover two floors could not meet the needs of these residents.

A review of the staff rosters showed that until recently there was only one nurse working at the weekends. Inspectors noted that one weekend, one nurse was rostered to care for 39 residents including two residents who were receiving end of life care. There was no clinical manager on duty at the weekends. Complaints raised by concerned relatives had triggered a review of staffing and the person in charge told inspectors that a second nurse was now rostered for day duty at the weekends. The roster confirmed this and it also showed that the CNM worked every second weekend. However there was still only one nurse rostered for night duty and this presented a risk to the care and welfare of residents. Recently a replacement nurse or an agency nurse was not found to cover the night shift, when the night nurse phoned in sick. The clinical nurse manager (CNM) remained on duty until after midnight and a nurse came on duty at 06:30 hours the following morning, to ensure that medicines were administered to residents.

Inspectors were not assured that the skill mix was adequate to assess residents and meet their assessed care needs. Nurses who met inspectors appeared to be relatively inexperienced and they did not display an adequate professional knowledge pertinent to their role. For example they were not

competent to comprehensively assess residents who had complex needs or to develop and review care plans for residents using the computer system in the centre.

Judgment: Not compliant

### Regulation 16: Training and staff development

The person in charge had organised an education programme for staff with 13 training events scheduled for Feb and March 2020, Staff had attended five training events including medication management, HACCP, safeguarding and infection control and manual handling. The person in charge had a training matrix which he proposed to use to ensure that all staff had mandatory training and refresher training, as well as ongoing professional development.

On the day of inspection there were no records available of staff attendance at training events. Staff confirmed that they had attended mandatory training when the centre opened in July '19, but there was no effective system in place to induct and train staff who were recruited since then. There was no documentary evidence that staff had attended mandatory training. A staff member who was employed for eight weeks had not had fire training or manual handling training.

Mentoring and induction for new staff required significant improvement. A nurse told inspectors she was given an induction pack and advised to ask any questions after reading it. She had not been advised to read specific policies and had not read relevant policies such as the medication policy. Stronger supervision was required to ensure that training programmes were appropriate and that new learning was implemented in practice. Some nurses had recently completed medication management training but displayed no awareness of the issues of non compliance relating to medicine management which inspectors found.

There was no system in place for formal supervision meetings with staff to appraise their performance and support staff development. The supervision of staff providing care at weekends had been addressed now that two nurses were rostered for day duty. However supervision of staff at night was an issue given that there was only one nurse on duty.

Judgment: Not compliant

### Regulation 19: Directory of residents

The directory of residents was in place and contained all the relevant information as set out in paragraph 3 of Schedule 3.

Judgment: Compliant

### Regulation 21: Records

The registered provider had failed to ensure that all the aspects of schedule 2 were maintained.

Staff files were assembled when requested on the day of inspection and they did not have all the documents set out in Schedule 2. Three staff files were examined and one file held all the relevant documents including, two references. One file held one reference and the third file had no reference. The person in charge confirmed that all the staff had a Garda Vetting disclosure.

It was unclear how staff training was monitored but staff training records were not available to the person in charge and he could not ensure all staff had received appropriate training.

Inspectors were made aware of complaints that had been raised and dealt with but there was no record of complaints maintained in the centre.

The centre's restraint register contained details of physical and chemical restraint used in the centre. It required review to ensure that all forms of restraint in place were recorded, for example:

- environmental restraint such locked doors and the secure unit on the first floor
- physical restraint such as low-low beds, posey/falls alarms, crash mats.

Judgment: Not compliant

### Regulation 23: Governance and management

The governance and management arrangements in the centre were weak. The provider representative (RPR) had limited time to spend in the centre, as she held a part-time post as Person in Charge (PIC) in another centre and also represented the provider entity for four other centres. Following a meeting with the Chief Inspector in Nov 2019, the provider submitted a plan to strengthen the governance arrangements and ensure that the provider had oversight of the service. The plan included regular meetings with staff and management in the centre. The PIC confirmed that the RPR visited the centre on a weekly basis but no records of management meetings were available when requested. The RPR was not on site on the day of inspection and was contacted by phone for the feedback meeting.

The inspectors found that there was an over reliance on the person in charge and

the provider did not have adequate involvement or oversight of the service. The new PIC was working to acquire the necessary resources to provide the service, as set out in the statement of purpose. Additional staff had been recruited including clinical staff, a receptionist and a maintenance person. Although the risk register had not been updated, action was taken to mitigate identified risks. A still kitchen was created, so that staff were not frequently entering the kitchen without suitable attire. New arrangements for safer medication management were in progress. A contractor was contacted to put control measures in place to mitigate the risks of residents accessing the lift and the central stairwell.

There was no person in charge for a six week period until 7 January '20. An external consultant conducted audits in Oct 2019, which highlighted deficits in the service in relation to medication management, fire, care planning and the environment. The action plans generated following the audits identified the RPR as the person responsible but the action plans had not been implemented and this impacted on the care and safety of residents.

- Inspectors found unsafe practices in relation to the administration of medicines and monitoring stock controls for controlled drugs.
- Residents were being admitted without any pre admission assessment to ensure that that the service could meet their assessed needs.
- Residents did not have comprehensive assessments and person-centred care plans in place to guide staff to provide appropriate care.
- The standard of cleanliness in the residents' bedrooms was inadequate and there were no deep cleaning schedules in place.

These issues were identified over three months previously and the provider failed to take appropriate action.

- The compliance plans which the provider submitted to the Chief inspector on 7 August 2019 were not completed:
- There was no documentary evidence of the planned regular management and staff meetings.
- Additional grab rails were not installed in en suite bathrooms to support residents who may be at risk of falling.
- An audit schedule for infection control was not in place.
- The automated door was not in place to mitigate the risk of residents accessing the central stairwell.
- The risk register had not been updated since the inspectors did a site visit in July 2019.

The designated centre did not have sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. The provider did not employ adequate numbers of competent staff to meet the needs of the residents. There were no suitable arrangements in place to provide relevant training and supervise staff.

There was no system in place to monitor that the service provided was safe

appropriate consistent and effectively monitored.

It was unclear who and what level of oversight was in place to oversee record keeping and policy review and implementation.

The oversight and management of risk in the centre also required improvement.

Inspectors found no evidence of consultation with residents and their representatives. The provider did not have an annual review of the quality and safety of care delivered to residents.

Judgment: Not compliant

### Regulation 3: Statement of purpose

The statement of purpose had recently been updated to reflect the new management team. It contained the required information as set out in Schedule 1

Judgment: Compliant

### Regulation 31: Notification of incidents

Incidents and allegations had been reported in writing to the Chief Inspector, as required under the regulations within the required time period.

Judgment: Compliant

### Regulation 34: Complaints procedure

The centre had a complaints procedure but it was not implemented in practice. There was no record maintained of complaints or any investigation or the outcome of a complaint.

Judgment: Not compliant

### Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre

The provider submitted notice of the absence of the person in charge but did not

provide details of the arrangement that would be in place for the management of the centre for the interim period while a new person in charge was being recruited

Judgment: Substantially compliant

## Quality and safety

Residents were supported to engage socially and they enjoyed a reasonable quality of life in a pleasant environment. Staff knew residents well and were respectful of their wishes and choices. Residents' needs were being met through good nutrition and access to healthcare services. Improvements were required with risk management, infection control, assessments and care planning and medication management.

The quality of residents' lives was enhanced by the design and layout of the centre and opportunities for social engagement during the day. Inspectors found that an ethos of respect for residents was evident. Inspectors saw that residents appeared well groomed and well cared for. Residents and relatives generally gave very positive feedback regarding all aspects of life in the centre.

There was evidence that residents had access to medical and other allied healthcare professionals including, speech and language therapy, dietician, chiropody and ophthalmology services. Residents and relatives expressed satisfaction with the medical care provided and inspectors were satisfied that residents' healthcare needs were met. Medication was not subjected to ongoing audit or staff competency assessments. Inspectors found that medication management practices were not in line with the centre's policy or best practice guidance and this presented a potential risk to the safety and welfare of residents.

Residents were facilitated to exercise their civil, political and religious rights. Inspectors were told that residents were enabled to vote in national and local elections as the centre is registered to enable polling. Residents' privacy and dignity were safeguarded. However there was no evidence the feedback was actively sought from residents or relatives or that regular residents' meetings were held to facilitate consultation with residents.

There was a good menu choice available and residents were very complimentary about the food, the choice and the service. Mealtimes were seen to be social occasions with the majority of the residents attending the dining room for their meals.

The premises provided a homely environment with plenty of private and communal space for residents use. However, some maintenance work was required on the perimeter fence. Noise was an issue and improvement was required to adjust the volume of call bells and minimise the noise from traffic on the main

road which was adjacent to the garden area.

Improvements were also required to ensure best practice in infection prevention and control. The person in charge had already identified this as an area for improvement.

Not all residents were assessed prior to admission and some residents admitted for short stay did not have care plans in place. Additional training was required to support staff to complete assessments and develop care plans, using the computer system in the centre. Staff did not have adequate knowledge to comprehensively assess residents who presented with responsive behaviours.

The provider did not have effective systems in place to manage risks and ensure that the health and safety of all people using the service was promoted. The risk register was generic and did not specify the risks pertinent to the centre.

Fire training records showed that nearly all staff had fire safety training but there was no fire drill records made available to inspectors with assurance that compartments could be safely evacuated with night staffing levels. A fire drill report was subsequently submitted by the provider following the inspection. An evacuation time for one simulated night time scenario demonstrated a full evacuation of the centre's largest compartment, which can accommodate eight residents, was completed in three minutes and 12 seconds, with four members of staff. This drill indicated that, although good times were found some improvements were required and ongoing practice with all staff is required. This is to ensure that all staff are competent and familiar with the evacuation needs of residents and a full compartmental evacuation is required on an ongoing basis.

### Regulation 11: Visits

Suitable arrangements were in place for a resident to receive visitors. Inspectors saw that residents could meet with visitors in private if they wished to do so.

Judgment: Compliant

### Regulation 12: Personal possessions

Suitable arrangements were in place for residents to have access to and retain control over their clothes and possessions. Residents were satisfied with arrangements for labeling and laundering their clothes. Residents also had access to secure locked cupboard in their rooms

Judgment: Compliant

### Regulation 13: End of life

Suitable arrangements were in place for residents to discuss their wishes and make informed choices about their end of life care. End of life care plans were developed and implemented in line with residents' wishes. Residents had access to palliative care services.

Family and friends were facilitated to be with a resident who was very ill and both relatives and residents were satisfied with arrangements in place to meet their religious and spiritual needs.

Judgment: Compliant

### Regulation 17: Premises

The design and layout of the centre was modern and bright. Accommodation included large communal living and dining spaces. All bedrooms had full en suite facilities with an accessible toilet and shower. There were 19 bright, spacious, single bedrooms and two twin bedrooms on the ground floor. The first floor had two twin rooms and 29 single rooms. Work on the second floor were not in progress on the day of inspection. There was lift access and three stairwells to all floors.

The provider had completed a number of environmental improvements:

- A second communal toilet were now available close to the sitting and dining rooms on the first floor. Residents on the first floor also had access to a quiet room. There was plans to convert this room into a sensory room for residents
- Additional storage was available in communal sitting rooms and suitable furniture and chairs had been sourced. Shelving had been put into en suites and bedrooms for residents' personal possessions. Paper towel dispensers and bins were available in communal bathrooms and racking installed in the sluice rooms for storage of equipment.
- The outdoor space had been modified but it required further risk assessment. Works had been completed to the base of the perimeter fence and laurel hedging planted. Inspectors were not assured that the fence was high enough to deter a fit, determined resident from absconding and a part of the fence were falling down. There was constant noise from passing traffic as garden was beside a busy road. The noise levels could deter residents from using the garden. The walkways had been upgraded to make them safe for residents and the raised flower beds were

planted with blooming heathers.

-Plans to install a second grab rail in the ensuite bathrooms had not been progressed.

Judgment: Substantially compliant

### Regulation 18: Food and nutrition

Inspectors saw that residents had access to a safe supply of fresh drinking water. A project to enhance the mealtime experience for residents was being rolled out. A four week menu cycle was in place which had been evaluated by a dietitian. Choices were offered to residents for all main meals and snacks and refreshments were available at all times. Inspectors noted that catering staff were informed about the dietary requirements of residents who had specific dietary requirements and residents who required a modified consistency diet were offered the same menu options as other residents.

Inspectors found that there were adequate numbers of staff to provide assistance at mealtimes on the day on inspection.

Judgment: Compliant

### Regulation 26: Risk management

There was a risk policy in place which reflected the requirements of the regulations. Inspectors reviewed the current risk register which identified clinical and operational risks and associated risk assessments relevant to the risks identified. However the register was generic and did not detail the risks pertinent to the centre such as open access to the main stairs and unrestricted access via the elevator to the second floor which was not currently safe to access. The risk register had not been updated since July 2019.

The policy outlined the arrangements for the identification of risks and learning from serious incidents. However these arrangements, as defined by the policy, were not in place.

Judgment: Not compliant

### Regulation 27: Infection control

Household cleaning procedures were not consistent with the standards for the prevention and control of health care associated infections. The person in charge was aware of this and had arrangements in place for staff training. He informed inspectors that a new household cleaning system had been ordered.

On the day of inspection, inspectors observed the following:

- Ordinary mop heads were in use and they were used to clean en suites as well as bedroom floors.
- There was no deep cleaning schedule in place
- Toilets were cleaned once daily, which was not in line with recommended practice
- The chemical store room was not ventilated.
- Equipment such as a banana transfer board, vacuum cleaner, mops and mop buckets and a pressure relieving cushion were stored in sluice rooms.
- Residents with diabetes shared blood glucose monitors which were designed for individual use.

Judgment: Not compliant

### Regulation 28: Fire precautions

Staff who spoke with inspectors knew about fire safety and evacuation procedures. Training records showed that 95% of staff, including staff who worked on night duty had attended fire safety training. Staff who were employed more recently were scheduled to attend fire safety training on 27 February 2020. There was no fire drill records made available to inspectors to provide assurance that compartments could be safely evacuated with night staffing levels. Records of a fire drill on 27 February 2020 were subsequently submitted by the provider and they provided assurance that the largest compartment could be safely evacuated with night time staffing levels.

Records of daily, weekly fire checks were reviewed. More details of the weekly safety checks were required and testing of the fire alarm on a weekly basis should also be done. The servicing records for fire safety lighting and equipment was seen to be up to date.

Judgment: Compliant

### Regulation 29: Medicines and pharmaceutical services

Inspectors found that the medications management policy was not implemented in practice and some poor practices were observed which could potentially impact on

residents:

- Drugs were not stored securely. Inspectors found the door to the treatment room was unlocked and a tray with medicines was sitting on top of the medicine trolley.
- There was only one medicine trolley and drugs for residents on the first floor were placed in small containers and taken upstairs on a tray.
- Prescriptions were transcribed by a nurse into medication Kardex without a second signature to evidence that a second nurse had checked the Kardex to ensure that the prescribed medicine and correct dosage was accurately transcribed.
- Measures to ensure that residents were correctly administered to the correct residents were not consistently implemented. For example not all Kardex had the residents' photograph or their allergy status stated.
- Medicines that required specific controls were stored securely and a record of stock balances was maintained. However two nurses did not check that the drug stocks were correct at each change of shift. Only one nurse's signature was signed in the morning and the evening. Inspectors found that the sample of medicine stocks they checked were correct on the day of inspection.

Judgment: Not compliant

### Regulation 5: Individual assessment and care plan

Inspectors found that residents' clinical care needs were no longer assessed prior to admission, in line with the centre's policy. Staff confirmed that information was obtained during a telephone conversation to determine if a resident's care needs could be met in the centre. Nursing assessments were completed for the majority of residents and a care plan put in place within 48 hours of admission. Residents who were admitted for respite did not have an assessment of their clinical needs and they did not have care plans in place. The care plans were generic and lacked sufficient details to guide staff to provide consistent care to residents. Inspectors were told that staff were not competent with the computer system in place for care planning. Some staff had attended this training on 14 February 2020 and more training was planned.

When inspectors followed up on residents at risk of malnutrition they found that residents were weighed regularly and the specialist dietary advice communicated to the catering team and implemented.

Documentation relating to wound care was satisfactory. It included a full assessment of wounds. The documentation was available to monitor the progress of wound healing.

Judgment: Not compliant

## Regulation 6: Health care

Inspectors were satisfied that the health care needs of residents were adequately met. Residents could access to general practitioner (GP) services including GP services out of hours. Residents also had access to psychiatry of later life and community palliative care services. Residents who held a General Services Medical Card could access community services in the primary care centre such as occupational therapy, physiotherapy and ophthalmology. The provider also had arrangements in place to make allied health care services available to residents privately. All residents had been assessed by dietitian and a speech and language therapist to ensure their nutritional needs were met. There was no contracted Health Service Executive (HSE) dental service in the area and residents who required dental services accessed these in the community.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

Some residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Resident had access to psychiatry of later life services and staff were seen to interact in a person-centred way with the residents. However, the physical environment where these residents were confined to the first floor was not optimal for providing person-centred support to these residents.

Residents with responsive behaviours did not have suitable behavioural assessments completed or behavioural support plans developed to support a consistent team approach to their care. The person in charge said the assessment tools were on the computerised system and staff would be trained in their use when they completed care planning training.

Being restricted to a confined space and boredom may trigger responsive behaviours. The activity programme required development to ensure that the social needs of all residents are met. Further training for staff to ensure they can meet the social needs of residents and fulfill their roles to support residents with responsive behaviours was required.

The physical environment and staffing arrangements required review to ensure that the physical, social and emotional needs of residents with responsive behaviours were met.

Inspectors identified there was a low usage of physical restraint in the centre,

however; inspectors identified that 50% of residents received 'as required' or PRN medicines. Records of behavioural assessments and evidence that non-pharmacological person-centred strategies to de-escalate behaviours were not available on the day of inspection. This was not in line with best practice in the management of responsive behaviours.

Judgment: Substantially compliant

## Regulation 8: Protection

Residents reported generally feeling safe in the centre. The person in charge was aware of the requirement to notify any allegation of abuse to the Chief Inspector. The person in charge also told inspectors that, if needed, support and advice was also available from the local safeguarding team. Staff that spoke with the inspectors were aware of what to do if they ever saw or suspected a safeguarding issue and policies and procedures were in place to support their practice.

Judgment: Compliant

## Regulation 9: Residents' rights

Inspectors observed interactions between staff and residents and noted that staff were courteous and respectful of residents' communication needs.

Residents were not adequately facilitated and encouraged to participate in the running of the centre. In July 2019 the person in charge outlined plans to have regular fortnightly residents' meetings or forums to receive feedback and suggestions for service improvements. The records showed that only one residents' meeting was held since August 2019. There was no evidence that residents' feedback was actively sought to inform service improvements. Inadequate staffing was raised as a concern at the residents' meeting and it was still an ongoing issue.

Contact details for independent advocacy services were available for residents if required.

There are arrangements in place to meet residents' religious and civil rights. Residents voted in the recent election and weekly Mass was celebrated in the communal room on the ground floor on the day of inspection.

An experienced activity coordinator worked in the centre. There was room to improve the range of activities provided to ensure that the activity schedule were informed by residents' interests and ability and met the needs of the residents.

Residents had access to daily newspapers and radio. However access to broadband

was poor and this presented a challenge for residents to make and receive calls from family and friends. Inspectors noted that people went outside to get a signal in order to use a cell phone. A relative who wished to speak with a resident had to phone the land line and then be put through to an extension.

All rooms contained televisions however, twin bedrooms only had one television set restricting choice of residents' television viewing. When this was discussed at the site visit in July 2019, the provider gave an undertaking to install a second television in twin rooms.

There were measures and arrangements in place to protect residents' privacy and dignity such as privacy curtains in twin bedrooms and all rooms having full en suite facilities. There was an outdoor enclosed area for residents to use however, this was not freely available for residents to access. In July '19 the provider assured inspectors that this would be addressed. Noise levels in the centre from call bells ringing and outside from passing traffic also impacted on the welfare and residents' quality of life.

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
<b>Capacity and capability</b>	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	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 34: Complaints procedure	Not compliant
Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre	Substantially compliant
<b>Quality and safety</b>	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not 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 Fennor Hill Care Facility OSV-0007180

Inspection ID: MON-0027578

Date of inspection: 19/02/2020

## 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 15: Staffing	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:            As detailed in the inspection report, the person in charge has increased the numbers of registered nurses and healthcare assistants, from 08:00 – 20:00hrs each day and has made arrangements both locally and with 2 nursing agencies to ensure that the staff of the designated centre includes, at all times, at least one registered nurse. The person in charge has also increased the number of support/ancillary staff to support the healthcare staff including catering staff, cleaning staff, maintenance staff and administration staff.</p> <p>Since the date of the inspection an additional 2.5 WTE registered nurses have commenced employment in the centre as well as 4 WTE healthcare assistants. At present, between the hours of 20:00 – 08:00hrs, there is one registered nurse and 3 healthcare assistants on duty facilitating a current ratio for 37 residents of 1 staff member to every 9.25 residents. The centre plans to facilitate a twilight nurse from 6pm to 12 midnight from 30/03/2020 and then a 2nd registered nurse and 2 healthcare assistants on night duty from Monday 20th of April 2020. Until then, a 24-hour senior nurse manager on call service is available to registered nurses on night duty, which will include the senior manager attending the centre if necessary.</p> <p>Clinical supervision is facilitated daily by the person in charge and the clinical nurse manager which now includes Saturdays and Sundays.            To ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, the recruitment of clinical staff is on-going with advertisements having been placed with recruitment companies, newspapers and local radio stations. The centre endeavors to ensure there is an adequate number of staff available to facilitate unexpected leave, sick leave, annual leave, mandatory study leave going forward, through this on-going recruitment initiative.            Currently the Clinical Nurse Manager and the Director of Nursing ensure that the staff roster is completed and furnished to all staff 2 weeks in advance. The DON and the CNM review the staffing levels and skill mix to meet the current needs of the residents before the roster is finalized.            Following re-assessment by the DON on 18/03/2020, the current resident dependency</p>	

levels i.e. based on the updated Barthel 2 index on Care Monitor is (9) residents of Maximum Dependency, (12) residents of High dependency, (14) residents of Medium dependency, (2) residents of low dependency and no independent care residents.

Regulation 16: Training and staff development

Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

A newly developed induction programme has been created and will be implemented for all new and existing employees in the centre. This programme includes the recording of induction tasks on completion, as well as a named designated person/buddy/mentor to support the new employee through the induction process.

Records of training are currently being recorded on a newly developed training matrix to allow for accurate and contemporaneous training records to be maintained within the centre. This will also assist in the easy identification of those staff that are required to attend any mandatory training. The new training matrix will be completed by 30th April 2020. All external training facilitators are now being requested to complete an attendance sheet on the day of training to be furnished to the person in charges office. Training certificates are now being maintained in each staff members personnel file.

Fire safety training including evacuation drill scenarios and assessment and care planning training and practical floor sessions in the use of the computerised resident records system were facilitated since the most recent inspection. Training in fire safety, safeguarding, restrictive practices, moving and handling and dementia care to include behavioural and psychological signs and symptoms of dementia had been scheduled for March and April, 2020. Due to the current restrictions related to Covid-19, this training will be re-scheduled when it is safe to do so. The centre is also looking into e-learning courses and programmes being delivered online via live webinar in the interim.

Clinical supervision is being facilitated daily by the person in charge and the clinical nurse manager, which now includes Saturdays and Sundays. Additional support and supervision is being provided to some clinical staff based on their current needs and competencies. A newly developed form to record any clinical supervision sessions conducted by the DON/CNM will be utilized with any clinical staff that may require greater knowledge or guidance in the assessment of the residents needs and understanding of specific care planning for these needs. A 24-hour senior nurse manager on call service is available to registered nurses on night duty which can include the senior nurse manager on call attending the centre as necessary.

All Staff performance appraisals will commence with the DON/CNM on Monday 11th May 2020, utilising a newly developed staff performance appraisal form and this will be carried out on an annual basis thereafter by the line managers.

Regulation 21: Records	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:  To ensure that the centre is compliant with Schedule 2 of the regulation; documents to be held in respect of the person in charge and for each member of staff, a comprehensive audit of all staff personnel files is being undertaken and will be completed by 30th April 2020. This audit will also include any follow-up actions to ensure all necessary documents are received from employees and placed in their files. A new comprehensive contents page for the staff files has also been developed and this will be placed in each staff members file including new employees, to ensure all necessary documentation is received and maintained. Auditing of staff files will continue on a scheduled 6 monthly basis thereafter.</p> <p>As detailed in the previous regulation, records of training are currently being recorded on a newly developed training matrix to allow for accurate and contemporaneous training records to be maintained within the centre. This will also assist in the easy identification of those staff that are required to attend any mandatory training. The staff training matrix will be completed by 30th April 2020. All external training facilitators are now being requested to complete an attendance sheet on the day of training to be furnished to the person in charges office. Training certificates are now being maintained in each staff members personnel file.</p> <p>The centre’s updated complaints procedure is on display in the main foyer and the centre has an effective and accessible system for identifying, receiving, handling and responding to complaints from residents or people acting on their behalf. All complaints are investigated thoroughly, and any necessary action taken where failures have been identified. Feedback is always provided to the complainant.</p> <p>Going forward the person in charge will ensure that all complaints or concerns both verbal and in writing will be clearly documented, including all correspondence or engagements with the complainant, and with the investigation process and findings, actions taken where failure(s) have been identified and evidence of the complainants satisfaction or provision of the appeals process will also be more evident.</p> <p>The person in charge is also planning to erect new suggestion boxes on each floor to allow for any feedback from resident’s, relatives and staff as part of the quality assurance feedback and satisfaction surveys on a continuous basis from the service users perspective.</p> <p>The restraint/restrictive practices register has been updated to reflect all restrictive practices within the centre including sensory alarms, locked doors in units, ultra-low beds and crash mats.</p>	

Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The centre has recently established a quality and clinical governance committee, which will meet on a monthly basis. This committee will be representative of the various departments onsite and the agenda and outcomes of this monthly meeting will also be available to the RPR. The first meeting is scheduled to be held on the 30th March 2020. The clinical governance committee will be responsible for reviewing quality and safety data for the centre. A standard template will be used for recording the minutes of meetings and to prompt discussions to promote a cohesive approach to clinical governance. During the first meeting, the committee will identify and agree on key quality indicators that will be used to monitor the quality and safety of the centre on a continuous basis, e.g. the HIQA (2009) standard 30.2 listed key data that should be collected which reflects international key quality indicators for residential care. Other key quality indicators will include skin tears, bruising, safeguarding, hospital admissions other than those that are planned and sector specific infections, such as respiratory tract infections, catheter and non-catheter urinary tract infections, soft tissue infections and peripheral invasive device infections such as from subcutaneous or intravenous sites.</p> <p>Trending and analysis of key quality indicators on a scheduled basis will also be carried out to identify areas of concern and areas for improvement. This trending and analysis on a monthly basis will form the main part of the annual review report which will be completed by the DON/PIC in December 2020 and furnished to HIQA. The committee will develop and maintain a clinical governance/quality improvement action plan which will be informed by the trending and analysis of monthly key quality indicators, monthly audits and outcomes of clinical governance meetings. The action plan will be updated as actions have been completed or added.</p> <p>The clinical governance committee will also develop an annual audit programme for the centre, which will identify external 'must do' audits based on standards, national policies, legislation and thematic inspections, as well as internal 'must do' audits which are informed by findings from quality indicator trending/monitoring; inspection reports and results of previously completed audits.</p> <p>The committee will also facilitate a system for ensuring that policies, procedures, the centres statement of purpose, residents guide, clinical and occupational risk register and restraint register as well as other important documents are being kept under review. The committee will also ensure that changes to national policy, legislation, guidelines and evidence-based information are reviewed and discussed with regard to their implications for the centre, particularly, changes in practices required.</p> <p>Scheduled weekly meetings every Monday Morning with the registered provider representative commenced in March 2020 and minutes of these meetings are now being recorded and held in a folder in the DON office. Additionally, a weekly report is completed by the person in charge detailing resident numbers, dependency levels, staff</p>	

rosters, incidents/accidents, complaints, notifications to the inspectorate, as well as other topics. This report is furnished to the registered provider representative before each weekly meeting and informs the agenda for these weekly meetings.

Staff meetings will commence on the 8th of April 2020 and will continue throughout the year on a scheduled basis. Minutes of staff meetings will be maintained.

A residents committee meeting will be established following social isolation restrictions related to Covid-19. A nominated person, who is not a member of staff, will be invited to attend meetings to represent residents with dementia or cognitive impairment. The agenda for these meetings will be informed by the residents and also based on complaints, concerns, satisfaction surveys and feedback forms from the suggestion boxes. Minutes of these meetings will be maintained in keeping with the residents' preferences.

As detailed in the inspection report, in relation to the audits in October 2019, which highlighted deficits in the service in relation to medication management, fire, care planning and the environment, the following activities have been carried out:

- A new pharmacy service has been secured that will commence services to the centre in April 2020. This service will provide support to nursing staff, implement ordering and returns to pharmacy records, and participate in the scheduled auditing of certain aspects of medication management such as safe storage. More robust arrangements have been put into place for the monitoring of stock controls for controlled drugs and this is being recorded by two registered nurses.
- All long term and respite/convalescent prospective residents will now have a pre-admission assessment based on a newly developed more detailed pre-admission assessment form to ensure more detailed information and record reconciliation to ensure that the service can meet their assessed needs.
- All residents assessments and care plans are currently being reviewed to ensure they are detailed enough to guide staff to provide appropriate care. Care plans are including residents' abilities and strengths, likes dislikes and preferences as well as addressing any needs or risks and any monitoring that may be required.
- An external person with suitable experience has spent time with household and catering staff to provide practical education and support in relation to environmental hygiene. A flat mop system has been implemented in the centre. A new cleaning schedule has been developed that includes arrangements for deep cleaning.

Regarding the compliance plans which the provider submitted to the Chief inspector on 7 August 2019, the following measures have been implemented:

- Regular management and staff meetings are scheduled for March 2020
- Additional drop-down rails will be installed in all ensuite bathrooms by 30/04/2020 to support residents who may be at risk of falling or need to use these drop-down bars to allow them to stand up from the toilet independently.
- A key code access door on the ground floor restricting access to the passenger lift and central stairwell will be in place by 31/03/2020, to reduce the risk of wandering residents accessing the passenger lift and central stairwell to any unoccupied floors.
- The clinical and occupational risk register will be reviewed and updated at the Clinical Governance Committee meeting being held on 30th March 2020.
- An audit schedule for infection control will be developed at the Clinical Governance Committee meeting being held on 30th March 2020.

Regulation 34: Complaints procedure	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 34: Complaints procedure:</p> <p>As previously detailed in Regulation 21 Records: The centre's complaints procedure is on display in the main foyer and the centre has an effective and accessible system for identifying, receiving, handling and responding to complaints from residents or people acting on their behalf. All complaints are investigated thoroughly, and any necessary action(s) taken where failures have been identified. Feedback is always provided to the complainant. Going forward the person in charge will ensure that all complaints or concerns both verbal and in writing will be clearly documented, including all correspondence or engagements with the complainant, the investigation process and findings, actions taken where failure(s) have been identified and evidence of the complainants satisfaction following the investigation or provision of information on the appeals process. An independent complaint outcome appeals person has been identified in the current Fennor Hill Care Facility complaints policy. This person is not currently employed in any capacity by Blockstar Building Limited or Fennor Hill Care Facility.</p>	
Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre:</p> <p>The registered provider is aware of their responsibility to inform the inspectorate where the person in charge is absent from the designated centre for a period of 28 days or more. The clinical nurse manager is the named person to deputise for the person in charge during planned or unexpected absences.</p>	
Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Inspectors were not assured that the fence in the resident's garden to the rear of the building was high enough to deter a determined resident from absconding and on the day of inspection part of the fence was falling down. There was constant noise from passing traffic as the garden was beside a busy road. The noise levels could deter residents from using/enjoying the garden. Plans to install a second grab/drop down rail in all ensuite bathrooms had not been progressed. To allow residents to independently access their garden the installation of key code access for 2 doors is required.

1. The fence in the external garden will be further enhanced by the addition of an extra foot in height being added to the existing structure.
2. The noise levels should be reduced by the extra foot added to the existing fence. In addition, the side of the building will be assessed to establish if a quieter area can be created where residents can enjoy a quieter more relaxed environment.
3. A second grab rail will be installed in each ensuite shower-room as discussed previously.
4. A key code will be put in place on two doors accessing the external garden to enable Residents to independently access the garden when required.
5. The chemical storerooms on each floor will be fitted with a passive ventilation system by 30/04/2020.
6. A new key code access door will be put in place by 31/03/2020 to reduce the risk of wandering residents accessing the passenger lift or central stairwell from the ground floor to unoccupied floors.

Regulation 26: Risk management	Not Compliant
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Outline how you are going to come into compliance with Regulation 26: Risk management:  
 The centre's clinical and occupational risk register will be reviewed and updated at the Clinical Governance Committee being held on 30th March 2020. Thereafter, the risk register will be maintained as a live document that will be reviewed and updated, as required, at each monthly clinical governance meeting and formally on an annual basis. In order to identify risks and promote learning from serious incidents, the centre has established a quality and clinical governance committee, which will meet on a monthly basis. The first meeting is scheduled to be held on the 30th March 2020. The clinical governance committee will be responsible for reviewing quality and safety data for the centre including hazards and risks that have been identified by staff in the course of their work, scheduled walkabouts of the premises and buildings, audits, inspections carried out by statutory bodies and investigation of incidents and complaints. In the event of a serious incident occurring in the centre, the person in charge or clinical nurse manager will ensure that all record keeping requirements have been met, including completion of an incident form, witness statements, ensure that appropriate forms are completed as required for notification to any external agencies and make arrangements for carrying out an investigation of the incident. The investigation will include the completion of a

root cause analysis. Appropriate remedial actions and control measures will be documented in an action plan identifying responsible persons and timeframes. The centre's risk register will be updated in accordance with the findings of any investigation

Regulation 27: Infection control	Not Compliant
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Outline how you are going to come into compliance with Regulation 27: Infection control:

An external person with suitable experience has spent time with household and catering staff to provide practical education and support in relation to environmental hygiene. A flat mop system has been implemented in the centre. A cleaning schedule has been developed that includes arrangements for deep cleaning. Toilets are now being cleaned once daily with detergent and disinfectant as well as additional cleaning as identified during scheduled checks throughout the day. Aids and equipment are no longer being stored in the sluice rooms. Residents that require blood sugar monitoring now have their own individualized glucometers.

Regulation 29: Medicines and pharmaceutical services	Not Compliant
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Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

The door to the treatment room on the ground floor has a keypad lock in place and all nursing staff have been informed of the importance of keeping the door closed at all times. A sign has been placed on the door to the treatment room indicating this. As detailed above under Regulation 23: Governance and Management, a new pharmacy service has been secured that will commence services to the centre in April 2020. This will facilitate the requisition of two additional medicine storage/administration trolleys, there will be one trolley designated for the ground floor and two trolleys for the first floor. With the implementation of the new pharmacy services in April 2020, the practice of nursing staff transcribing medications will cease as a routine practice. Kardex's will be generated by the pharmacy and checked and signed by the general practitioner prior to use. The practice of nurse transcribing will only be used in exceptional circumstances based on a specific need in the best interest of a resident. Two nurses will be required to sign the transcribed kardex to demonstrate that the transcription is accurate. The newly procured pharmacy will be generating all new prescription kardex's in April 2020 and they will ensure that all necessary information required on the kardex is included, such as a photograph of the resident and any known drug allergies. More robust arrangements have been put into place for the monitoring of stock controls and this is

now being recorded by 2 registered nurses.	
Regulation 5: Individual assessment and care plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</p> <p>All prospective residents will now have a pre-admission assessment completed prior to admission to ensure that that the service can meet their assessed needs. All residents' assessments and care plans are currently being reviewed to ensure they are detailed enough to guide staff to provide appropriate care. Care plans will include residents' abilities and strengths, likes dislikes and preferences, as well as addressing any needs or risks and any monitoring that may be required. All assessments and care plans will be fully reviewed by 20th of April 2020. Additional training has been provided to clinical staff on the use of the computerized residents records system.</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>All residents that experience responsive or reactive behaviours as part of behavioural and psychological signs and symptoms of dementia, are currently having a comprehensive review of their assessments and care plans. Following review, behaviour support care plans will be more comprehensive to guide staff in caring for residents that display such behaviours. The behaviour support care plans will include identification of the behaviours that the resident displays, any known triggers to the behaviours, interventions to remove or reduce these trigger factors, and appropriate and inappropriate response interventions when the resident displays the behaviours. All care plans will be reviewed and updated by 31st May 2020. Training on caring for residents with Dementia and behaviours that challenge due to underlying behavioural and psychological signs and symptoms of dementia, was scheduled for March 2020, however this training has been postponed due to Covid-19. The training will be rescheduled once it is safe to do so. All non-pharmacological interventions to de-escalate behaviours and the resident's response to same are now being recorded prior to the administration of an as required PRN psychotropic medication in line with best practice in the management of responsive behaviours. A dementia specific interior design consultant was scheduled to review the interior of the building and both floors and make recommendations. As a result of restricted access to the centre due to Covid-19, this appointment will be rescheduled for</p>	

a letter date. Additional activities equipment has been procured such as DVD players, a bingo machine, CD players, board games, arts and crafts and so on.

Regulation 9: Residents' rights

Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: A residents committee will be established following social distancing restrictions related to Covid-19. A nominated person, who is not a member of staff, will be invited to attend meetings to represent residents with dementia or cognitive impairment. The agenda and minutes of these meetings will be maintained in keeping with the residents' preferences. The activities coordinator will review and up-date the activities schedule following engagement with residents to seek their opinions and feedback. The new schedule will be implemented on the 20th of April 2020.

The broadband in the centre has been upgraded and calls in and out of the centre have improved. The centre has also purchased a tablet so that residents can facetime or skype with family members.

An additional television will now be installed along with individual headphones in each twin room to allow Residents occupying the room choice.

Two doors will have keycodes added to them to ensure Residents can access the external garden independently.

The existing fence will be further enhanced to break noise levels from the busy adjacent road. An assessment will also be made to the side of the Nursing home to establish if another garden area can be created to enable Residents to have a more relaxed, quiet area to enjoy.

The company that originally installed the call bell system has been contacted by the person in charge and arrangements are made for a company representative to attend the centre to install a new system that will allow for control of the volume of call bells and provide a facility to access information on call bell answering times via a PC. This will allow the person in charge to monitor call bell response times and identify areas that may require improvement.

## 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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/04/2020
Regulation 15(2)	The person in charge shall ensure that the staff of a designated centre includes, at all times, at least one registered nurse.	Not Compliant	Orange	30/04/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/05/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately	Not Compliant	Orange	30/04/2020

	supervised.			
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	30/04/2020
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	31/03/2020
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	30/04/2020
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	29/02/2020
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe,	Not Compliant	Orange	31/03/2020

	appropriate, consistent and effectively monitored.			
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Orange	31/12/2020
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	30/04/2020
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	30/04/2020
Regulation 27	The registered provider shall	Not Compliant	Orange	30/04/2020

	ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	29/02/2020
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	30/04/2020
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken	Not Compliant	Orange	30/04/2020

	on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to.	Not Compliant	Orange	31/03/2020
Regulation 34(3)(b)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that the person nominated under paragraph (1)(c) maintains the records specified under in paragraph (1)(f).	Not Compliant	Orange	31/03/2020
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a	Not Compliant	Orange	30/04/2020

	resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	30/04/2020
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	31/05/2020
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/03/2020
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident	Substantially Compliant	Yellow	31/03/2020

	may be consulted about and participate in the organisation of the designated centre concerned.			
Regulation 33(1)	Where the registered provider gives notice of the absence of the person in charge from the designated centre under Regulation 32, such notice shall include details of the procedures and arrangements that will be in place for the management of the designated centre during that absence.	Substantially Compliant	Yellow	31/03/2020