Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>St. Mary's Centre Nursing Home</th>
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</thead>
<tbody>
<tr>
<td>Name of provider:</td>
<td>St Mary's Centre (Telford)</td>
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<tr>
<td>Address of centre:</td>
<td>St. Mary's Centre (Telford), 185/201 Merrion Road, Dublin 4</td>
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<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>19 November 2019</td>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000104</td>
</tr>
<tr>
<td>Fieldwork ID:</td>
<td>MON-0022718</td>
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</table>
About the designated centre

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

The centre is located on a campus located beside St Vincent's Hospital on the Merrion Road in Dublin. It is close to beaches and a busy road which offers amenities and local transport options. The centre provides 24 hour nursing care for residents, including residents with visual impairments. It is governed and run under the ethos of the Sisters of Charity. The centres consist of two units; St. Oliver’s Unit and the Loyola Unit. It can accommodate up to 56 residents in a range of single and multi-occupancy bedrooms. Residents in both units have access to a main chapel, a coffee dock and a large dining area and a shop.

The following information outlines some additional data on this centre.

| Number of residents on the date of inspection: | 46 |
How we inspect

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

As part of our inspection, where possible, we:

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

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

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

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

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.
This inspection was carried out during the following times:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday 19 November 2019</td>
<td>10:10hrs to 17:30hrs</td>
<td>Sarah Carter</td>
<td>Lead</td>
</tr>
<tr>
<td>Tuesday 19 November 2019</td>
<td>10:10hrs to 17:30hrs</td>
<td>Michael Dunne</td>
<td>Support</td>
</tr>
</tbody>
</table>
**What residents told us and what inspectors observed**

Inspectors met with and spoke to a number of residents over the course of the inspection and on the whole residents were positive in their feedback about their experience of living in the nursing home.

Residents told the inspectors that they like their rooms and that they had sufficient space to store their personal belongings. They also mentioned that the staff keep their rooms clean and tidy.

Residents were observed being supported by staff to attend to their personal care routines. This was carried out in a discrete manner with staff ensuring that resident’s privacy and dignity was protected. Staff were observed engaging with the residents using a person centred approach, it was clear that staff were aware of each resident’s individual needs. All residents were observed to be well dressed in suitable clothing and footwear.

Residents told the inspector that they were happy with the quality of food provided by the centre. Observation of the dining experience at lunch time indicated that residents were in receipt of timely support from the staff supervising the dining service. The dining room was well laid out to meet the needs of the residents with sufficient space available for residents to enjoy their food.

Residents were content with the activity programme and informed the inspector they particularly enjoyed the music singalongs. Residents also commented that they were happy with the support received to continue their religious observance with a religious service held daily.

**Capacity and capability**

This inspection took place to follow-up on significant regulatory non-compliance identified on inspection in December 2018. In the intervening months inspectors of social services had corresponded with the registered provider and met with the registered provider on 3 occasions. The purpose of these meetings was to ensure that the registered provider took all necessary action to

- address identified regulatory non-compliance found in December 2018.
- to strengthen the governance and management of the designated centre
- provide costed time bound plans which would ensure that the designated centre would comply with SI 293 in time for the 31 December 2021 deadline
During these discussions

- the registered provider agreed to submit regular updates and costed time bound plans to the chief inspector
  - no updates or plans were received.
- the registered provider was repeatedly requested to provide a contact address that the chief inspector could be assured that if correspondence was sent to the registered provider they would receive, review and respond to it.
  - A key concern since the last inspection has been the repeated failure of the registered provider to acknowledge receipt of or respond to correspondence.
    - No address was provided

On a positive note this inspection found that the registered provider had taken the decision to reduce the occupancy of St Olivier's Unit in order to improve the privacy and dignity of the residents living in that unit. This change was found to positively impact on the quality of life of the residents occupying that unit.

In addition reviewed rosters indicated that sufficient staff were on duty to meet the needs of the current number of residents. The centre had a number of vacancies which, in the interim of a recruitment process, they were effectively managing through the use of both agency staff and nursing students.

Furthermore the registered provider had taken action to ensure that there was a full time person-in-charge of the designated centre and that this person did not fulfill any other roles within the designated centre or the wider campus.

A key concern of the previous inspection was that there was an ineffective system of governance and management in place in the designated centre. These findings were repeated on this inspection as the governance structure as described to inspectors was not evidenced on the day of the inspection and did not ensure effective management of the centre. The structure comprised of

- a board of directors responsible for the designated centre which met regularly.
  - a report was prepared by the joint CEO / PIC role for board meetings which included some data on key clinical activities and occupancy. However the minutes of these meetings raised questions about the accuracy of information provided to the board and any response to instructions issued by the board
- a "patient" safety forum described by the person in charge as embedded in the board meetings was only referenced once in the minutes reviewed
- a quality and safety committee (which had not formally met since March 2019),
- a management team (for which no minutes or evidence was available to indicate regular meetings and action)
- a residents council (for which no minutes or evidence was available to indicate regular meetings and action).

The absence of effective governance and management was evident in
- poor oversight of risk management, the centres policy described a structure of meetings, that were not actually taking place.
- inadequate oversight of the systems in place to manage staff recruitment
- inadequate oversight of the systems in place for staff training and development
- failure to ensure that the centres statement of purpose was accurate and fully described the designated centre
- failure to ensure that there is a system in place to receive, review and respond to requests for information from the office of the chief inspector

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**Regulation 14: Persons in charge**

The findings of this inspection is that there is one person employed full time in the role of person-in-charge of the designated centre in compliance with regulation 14.

Judgment: Compliant

**Regulation 15: Staffing**

The inspectors found that there were sufficient numbers of nursing and care staff on duty with the required skill mix to meet the needs of the residents. Planned and worked rosters were reviewed and were found to be consistent with the staffing levels described in the statement of purpose. The centre also uses volunteers to compliment services provided by the activity workers.

At the time of the inspection there were three vacancies for both staff nurses and three vacancies for health care assistants. Cover for ongoing staff vacancies and gaps in the rosters were being provided by an employment agency. In addition there was a process underway to recruit staff nurses and health care assistants to fill the above vacancies.

Judgment: Compliant
Regulation 16: Training and staff development

Staff who spoke with inspectors confirmed that they had attended a range of mandatory and supplementary training over the course of the year however complete training records were inaccessible to the person in charge.

When these records were provided, inspectors were unable to reliably ascertain from them how many staff had received training, when they had received it and what training they had received. This was a repeat finding of non-compliance that had not been addressed following the December 2018 inspection. In addition the person-in-charge could not produce a list of training dates that were planned for the future.

The person in charge had also failed to ensure a copy of the health act and its related regulations was available to all staff working in the designated centre.

**Judgment:** Not compliant

Regulation 21: Records

The registered provider had failed to ensure that all the records required under schedule 2 were maintained in the designated centre.

The registered provider had failed to ensure a record of staff training was maintained and as the records maintained were not available to the person in charge, the person in charge could not ensure all staff had received the required training appropriate to their role.

A small number of key staff members had commenced employment in the designated centre prior to receiving the mandatory garda vetting disclosures.

**Judgment:** Not compliant

Regulation 23: Governance and management

On the day of the inspection inspectors found that the governance systems in place were inadequate with little evidence available to demonstrate how these systems were measuring and monitoring the care of residents and the quality of the service they were receiving. On a positive note since the last inspection the registered provider had taken action to ensure that the role of the person-in-charge was filled
in a full time capacity by one person who did not fill any other roles within the designated centre and the larger campus.

The governance structure in place for the designated centre was described as follows:

- a board of management,
- a management team,
- a quality and safety committee,
- a residents council.

However, there was an absence of information regarding lines of authority and accountability, specific roles and details of responsibility for all areas of care provision.

Inspectors found that the board of directors responsible for the designated centre met regularly and received a report which included data on key clinical activities and occupancy. However, reviewed minutes of the meetings of the board raised questions about the accuracy of information provided to the board and the response to instructions issued by the board. In addition, the board’s oversight of senior managers and the process to measure the appropriate discharge of their duties remained unclear throughout the inspection.

Inspectors found that:

- there were no records to evidence any meetings of the management team,
- the quality and safety committee met once in 2019 (March) had not formally met since March 2019,
- there were no records to evidence any meetings of the residents council.

In addition, audits or meetings between the person in charge and clinical staff were described as informal arrangements which were not documented. Inspectors were informed that an audit of falls had taken place but it was unclear what:

- the findings of the audit were,
- if any action was required on foot of the audit findings,
- plans were in place to implement any required action.

No evidence of consultation with residents and their representatives was provided to inspectors. The last annual review had been completed in 2017, and no evidence was available to demonstrate that an annual review was in progress for 2018.

The consequences of ineffective governance are reflected in the non-compliance reported against:

- regulation 3: statement of purpose
- regulation 4: written policies and procedures
- regulation 16: training and staff development
- regulation 21: records
- regulation 26: risk management

Judgment: Not compliant

### Regulation 3: Statement of purpose

The centres statement of purpose was not correct and did not fully describe the designated centre.

Inspectors gave specific advice about required changes to ensure this document met regulatory requirements. However the required changes were not made and a statement of purpose submitted following the inspection still did no meet regulatory requirements.

Judgment: Not compliant

### Regulation 4: Written policies and procedures

The registered provider did not ensure that all policies and procedures that they are required to maintain in the designated centre in accordance with with Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were available.

In addition some of the policies that were available had not been updated or amended to reflect the new personnel involved in the management of the centre.

Furthermore there was no evidence that the registered provider had a policy review process embedded into the governance system.

Judgment: Not compliant

### Quality and safety

Care was being delivered to residents in a kind and caring way, and in an environment that had improved since the last inspection. Actions were required to complete the implementation of some of these changes.

Actions had been taken in the previous months to improve the laundry services.
available to residents, and laundry was now being provided by an external contractor. The person in charge had oversight of this new service.

The premises in St Olivier's Unit had improved. The changes noted included reduced occupancy in some bedrooms, and improvements to the signage throughout the unit. Storage arrangements had improved in the centre. St. Olivier's general decor was showing signs of wear and tear, and the inspectors were told painting was to commence shortly. Work to finalise the correct layout of privacy curtains to reflect the new layout of the bedrooms was also to commence shortly after the inspection.

In Loyola Unit some residents bedrooms which were overlooked by neighbouring public buildings had net curtains installed to protect their privacy. However this project was not yet completed.

There was an activity programme available in the centre. Inspectors were told by the person in charge that there were residents council meetings, however the meeting records were not shown to the inspectors to confirm this.

Risk management in the centre was guided by a policy that met the requirements of the regulations. The project defined a committee that met to oversee risk, however this committee had not met since March 2019.

**Regulation 12: Personal possessions**

A positive finding from this inspection was that the changes in the layout and occupancy of some bedrooms gave the residents occupying those rooms improved access to storage for their personal belongings.

The person in charge had also ensured that all residents had appropriate access to their clothing and that their clothes are laundered regularly and returned to the residents.

Judgment: Compliant

**Regulation 17: Premises**

Further positive findings of this inspection were the changes made to the number of residents residing in the bedrooms of St. Oliver's Unit. These improvements made by the registered provider in lieu of renovations to the premises ensured that residents who required the assistance of adaptive equipment were able to receive such assistance with privacy and dignity, and without intrusion on the person they shared their bedroom with.

Notwithstanding the above noted improvements St. Olivier's general decor was
showing signs of wear and tear, and the inspectors were told painting was to commence shortly. Work to finalise the correct layout of privacy curtains to reflect the new layout of the bedrooms was also to commence shortly after the inspection.

Equipment was mostly being stored appropriately, however a small dining room was used inappropriately to store catering equipment and large recliner wheelchairs.

Signage and the display of information for residents had improved.

In Loyola unit, some steps had been taken to ensure the privacy of residents whose bedrooms were overlooked by neighbouring buildings. However it is a concern that nine months after the previous inspection the project to install net curtains in these rooms was not yet completed.

Judgment: Substantially compliant

**Regulation 26: Risk management**

There was a risk management policy in place which reflected the requirements of the regulations. The policy outlined the arrangements for the identification or risks and learning from serious incidents. However these arrangements, as defined by the policy, were not in place. The centre was in breach of its own risk management policy as the quality and safety committee had not convened in the previous eight months.

Inspectors reviewed the current risk register which identified clinical and operational risks pertinent to the centre and associated risk assessments relevant to the risks identified. Relevant paperwork concerning risk assessments was not provided to inspectors until a very late stage in the inspection and therefore a full analysis of all risk assessments could not be undertaken.

Judgment: Not compliant

**Regulation 9: Residents' rights**

Inspectors observed interactions between staff and residents and noted that staff were always courteous and respectful of residents communication needs. Healthcare assistants were also supporting residents with activities until the activity worker arrived in the afternoon.

Discussions with residents indicated that they enjoyed the activities provided by the centre. A small group of residents were seen attending a music programme set up
by the activity worker. Residents who required support of staff to attend activities received appropriate support in a timely fashion. The activity worker gave an explanation of how residents who wished to pursue their own activities were supported explaining that there were arrangements in place where staff would regularly visit residents in their rooms and assist to set up their individual activity with them.

There was an improvement noted with regard to the maintenance and promotion of resident’s privacy and dignity. The reduction in the number of residents occupying some multi-occupancy rooms had resulted in more available space for residents to use and to have their needs attended to with privacy and dignity. There were plans to further improve the layout of these rooms so that residents could avail fully of their new spaces, and this included the correct layout of privacy curtains to reflect larger bed-spaces.

Newspapers were delivered to the centre on a daily basis and there were TV’s in place for some residents with. Staff told the inspectors that there was support available for residents to vote if that was their wish.

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:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
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<tbody>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 14: Persons in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 21: Records</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 3: Statement of purpose</td>
<td>Not compliant</td>
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<tr>
<td>Regulation 4: Written policies and procedures</td>
<td>Not compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
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<tr>
<td>Regulation 12: Personal possessions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management</td>
<td>Not compliant</td>
</tr>
<tr>
<td>Regulation 9: Residents' rights</td>
<td>Substantially compliant</td>
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</tbody>
</table>
Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.
Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be SMART in nature. Specific to that regulation, Measurable so that they can monitor progress, Achievable and Realistic, and Time bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider’s responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider’s response:

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
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<tbody>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Not Compliant</td>
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Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Regulation 16: Training & Development
- Staff have appropriate training, incl. refresher training, as part of CPD
- Staff are appropriately supervised
- Staff are aware of the 2007 Health Act, the Regulations, the Standards - & copies are available.
  * * *
- Monthly report to be sent to the general Manager, PIC and CNM’s for Loyola and St. Oliver’s detailing the current training records for the staff member in each unit.
  
- Health act and regulations to be posted to all staff.
  
- Training schedule to be completed for 2020.

<table>
<thead>
<tr>
<th>Regulation 21: Records</th>
<th>Not Compliant</th>
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Outline how you are going to come into compliance with Regulation 21: Records:
Monthly report to be sent to the General Manager, PIC and CNM’s for Loyola and St. Oliver’s detailing the current records for the staff member in each unit.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.
<table>
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<tr>
<th>Regulation 23: Governance and management</th>
<th>Not Compliant</th>
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Outline how you are going to come into compliance with Regulation 23: Governance and management:

Regulation 23 Governance & Management.
1. House is resourced to deliver on Statement of Purpose
2. Management structure indicates authority & accountability, roles, & responsibilities for all areas of service provision.
3. Systems to ensure service is safe, appropriate to person’s needs, consistent & effectively monitored.
4. An annual review of the quality & safety of care & support (in accordance with standards) – including consultation with people & their representatives – and copy available to people supported.
5. Unannounced visit every 6 months
   o written report on safety & quality of care & support,
   o a plan to address any concerns
   o copy to be available to people supported, their reps & HIQA.
6. Support, develop & manage performance of all staff, to promote personal & professional responsibility for the quality & safety of the service.
7. Encourage staff to raise concerns regarding quality & safety of the service.

Formal management team meetings recommenced in January 2020. Formal minuted meetings of the quality and safety committee recommenced in January 2020, replacing the informal arrangement that had operated in the absence of key staff.

2. Resident Council meetings were held every quarter in Loyola as follows:
   1. 05/03/2019
   2. 11/06/2019
   3. 03/10/2019
   These were minuted in the normal fashion.

Resident Council meetings were held every quarter in St. Oliver’s as follows:
1. 28/01/2019
2. 23/04/2019
3. 04/09/2019
These were minuted in the normal fashion.

*The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.*
Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

Regulation 3: Statement of Purpose.

1. Details from Certificate of Registration.
2. The specific care & support needs the house is intended to meet, the facilities provided, the services to be provided, & the criteria for admission.
3. The number, age range & gender of people.
4. A description of house including size & primary function of each room.
5. Any day care facilities.
6. The total WTE staffing (incl. management).
7. Organisational structure.
8. Arrangements for developing Personal Plans & reviews.
9. Details of any specific therapeutic techniques used, & their supervision.
10. How person’s privacy & dignity are respected.
11. Arrangements for people to engage in social activities, hobbies & leisure interests.
12. Arrangements for access to education, training & employment.
14. Arrangements for people to attend religious services.
15. Arrangements for contact with relatives, friends, representatives and local community.
16. Arrangements for dealing with complaints.
17. Fire precautions & emergency procedures in the house.

* * *

1. The Statement of Purpose will be corrected and updated by 28 February 2020.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

Regulation 4: Written Policies & Procedures
1. Protection from Abuse.
3. Procedure when a Person goes Missing
4. Provision of Intimate Care
1. By 31 March 2020 action will be implemented to:
a) Review the policies.
b) Set them up on the Q-Pulse document management system.
c) Set review timelines

<table>
<thead>
<tr>
<th>Regulation 17: Premises</th>
<th>Substantially Compliant</th>
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<tbody>
<tr>
<td><strong>Outline how you are going to come into compliance with Regulation 17: Premises:</strong></td>
<td></td>
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<tr>
<td>• Ongoing refurbishment to improve the residents privacy.</td>
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<tr>
<td>• By 31 March 2020 initial phase of refurbishment anticipated to be completed.</td>
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*The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.*

<table>
<thead>
<tr>
<th>Regulation 26: Risk management</th>
<th>Not Compliant</th>
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<tbody>
<tr>
<td><strong>Outline how you are going to come into compliance with Regulation 26: Risk management:</strong></td>
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<table>
<thead>
<tr>
<th>Regulation 26: Risk Management Procedures Risk Management Policy</th>
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<tbody>
<tr>
<td>1. Hazard identification &amp; assessment of risks throughout the house &amp; garden</td>
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<tr>
<td>2. Measures and actions to control the risks, including:</td>
</tr>
<tr>
<td>A. Unexpected absences</td>
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<tr>
<td>B. Accidental injury to the person, a visitor or staff</td>
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<tr>
<td>C. Aggression &amp; violence</td>
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<tr>
<td>D. Self-harm</td>
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<tr>
<td>3. Procedure for identifying, recording and investigating serious incidents / adverse events involving the person, and the learning from such incidents / events.</td>
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</tbody>
</table>
| 4. Procedure to ensure risk control measures are proportional, & the impact on the
person’s quality of life is considered.
5. Ensure systems in place to assess, manage and continually review risks.
6. Ensure system for responding to emergencies.
7. Service vehicles are roadworthy, regularly serviced, insured, have appropriate safety equipment, and drivers are licenced and trained.

* * *

The appointment of Director acting as nominee registered provider have all resulted in improvements in implementation of governance processes by 31 December 2019. Formal management team meetings recommenced in January 2020 with meetings scheduled monthly thereafter. Formal minuted meetings of the quality and safety committee recommenced in January 2020, replacing the informal arrangement that had operated in the absence of key staff. Monthly meetings scheduled thereafter.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.

<table>
<thead>
<tr>
<th>Regulation 9: Residents' rights</th>
<th>Substantially Compliant</th>
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<tr>
<td>Outline how you are going to come into compliance with Regulation 9: Residents' rights: Regulation 9: People’s Rights:</td>
<td></td>
</tr>
<tr>
<td>1. Non-discrimination on 9 grounds</td>
<td></td>
</tr>
<tr>
<td>2. Person participates in all decisions about his/her care &amp; support</td>
<td></td>
</tr>
<tr>
<td>3. Can exercise choice &amp; control in their daily life</td>
<td></td>
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<tr>
<td>4. Can exercise their civil, political &amp; legal rights</td>
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<tr>
<td>5. Has access to advocacy and information about their rights</td>
<td></td>
</tr>
<tr>
<td>6. Is consulted and participates in the running of the house</td>
<td></td>
</tr>
<tr>
<td>7. Privacy &amp; dignity re. personal space, intimate care, personal communications, relationships, personal information, and professional consultations.</td>
<td></td>
</tr>
<tr>
<td>• Ongoing refurbishment to improve the residents privacy.</td>
<td></td>
</tr>
<tr>
<td>• Furniture to be upgraded.</td>
<td></td>
</tr>
<tr>
<td>• Resident Council meetings were held every quarter in Loyola as follows:</td>
<td></td>
</tr>
<tr>
<td>4. 05/03/2019</td>
<td></td>
</tr>
<tr>
<td>5. 11/06/2019</td>
<td></td>
</tr>
<tr>
<td>6. 03/10/2019</td>
<td></td>
</tr>
<tr>
<td>These were minuted in the normal fashion.</td>
<td></td>
</tr>
<tr>
<td>Resident Council meetings were held every quarter in St. Oliver's as follows:</td>
<td></td>
</tr>
<tr>
<td>4. 28/01/2019</td>
<td></td>
</tr>
<tr>
<td>5. 23/04/2019</td>
<td></td>
</tr>
<tr>
<td>6. 04/09/2019</td>
<td></td>
</tr>
</tbody>
</table>
These were minuted in the normal fashion.
• Individual care plans updated and audited every 12 weeks

*The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations.*
## Section 2:

### Regulations to be complied with

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

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

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 16(1)(a)</td>
<td>The person in charge shall ensure that staff have access to appropriate training.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>29/02/2020</td>
</tr>
<tr>
<td>Regulation 16(2)(a)</td>
<td>The person in charge shall ensure that copies of the Act and any regulations made under it are available to staff.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>29/02/2020</td>
</tr>
<tr>
<td>Regulation 17(1)</td>
<td>The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>29/02/2020</td>
</tr>
<tr>
<td>Regulation 17(2)</td>
<td>The registered provider shall, having regard to the needs of the</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/03/2020</td>
</tr>
<tr>
<td>Regulation</td>
<td>Description</td>
<td>Compliance</td>
<td>Color</td>
<td>Date</td>
</tr>
<tr>
<td>------------</td>
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</tr>
<tr>
<td>Regulation 21(1)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Red</td>
<td>30/03/2020</td>
</tr>
<tr>
<td>Regulation 21(6)</td>
<td>Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.</td>
<td>Not Compliant</td>
<td>Red</td>
<td>31/01/2020</td>
</tr>
<tr>
<td>Regulation 23(a)</td>
<td>The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31/01/2020</td>
</tr>
<tr>
<td>Regulation 23(b)</td>
<td>The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care.</td>
<td>Not Compliant</td>
<td>Red</td>
<td>31/01/2020</td>
</tr>
<tr>
<td>Regulation 23(c)</td>
<td>The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.</td>
<td>Not Compliant</td>
<td>Red</td>
<td>31/01/2020</td>
</tr>
<tr>
<td>Regulation 23(d)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31/03/2020</td>
</tr>
<tr>
<td>Regulation 23(e)</td>
<td>The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31/03/2020</td>
</tr>
<tr>
<td>Regulation 23(f)</td>
<td>The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31/03/2020</td>
</tr>
<tr>
<td>Regulation</td>
<td>Description</td>
<td>Compliance Status</td>
<td>Colour</td>
<td>Date</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Regulation 26(1)(d)</td>
<td>The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/06/2020</td>
</tr>
<tr>
<td>Regulation 03(1)</td>
<td>The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>29/02/2020</td>
</tr>
<tr>
<td>Regulation 04(1)</td>
<td>The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.</td>
<td>Not Compliant</td>
<td>Red</td>
<td>31/01/2020</td>
</tr>
<tr>
<td>Regulation 9(3)(a)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/01/2020</td>
</tr>
<tr>
<td>Regulation 9(3)(b)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>31/03/2020</td>
</tr>
<tr>
<td>Regulation 9(3)(d)</td>
<td>A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31/01/2020</td>
</tr>
</tbody>
</table>