Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

<table>
<thead>
<tr>
<th>Name of designated centre:</th>
<th>Lisdarn Centre</th>
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<tbody>
<tr>
<td>Name of provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Address of centre:</td>
<td>Cavan, Cavan</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Date of inspection:</td>
<td>25 July 2019</td>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000490</td>
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<tr>
<td>Fieldwork ID:</td>
<td>MON-0026784</td>
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About the designated centre

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

The designated centre provides care and support to meet the needs of both male and female older persons. It provides 24-hour nursing care to 32 residents (16 long-term and 16 short-term for assessment, rehabilitation, convalescence and respite care). The centre is a single storey building located in the grounds of a general hospital on the outskirts of an urban area. The philosophy of care is to embrace positive ageing and place the older person at the centre of all decisions while promoting their independence, health and well-being in a safe therapeutic environment.

The following information outlines some additional data on this centre.

<table>
<thead>
<tr>
<th>Number of residents on the date of inspection:</th>
<th>28</th>
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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>
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<tr>
<td>25 July 2019</td>
<td>09:30hrs to 17:30hrs</td>
<td>Manuela Cristea</td>
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What residents told us and what inspectors observed

Residents provided positive feedback to the inspector through conversation about the service they were receiving. Most described their experience as a good one, commenting how kind, helpful and efficient the staff were. They said that their choices were respected on a daily basis. Residents reported that they had plenty of activities to keep them occupied if they wished. However some of the long-stay residents commented that they would like more outings and more music. The inspector spoke with a number of relatives throughout the day who all expressed satisfaction with care and services available to the residents. They said that they were always made to feel welcome and kept informed of any changes in their relatives’ condition.

Capacity and capability

The findings of the inspection confirm that there were day-to-day systems in place to monitor the quality and safety of care. A good quality service was being provided for the benefit of the residents living in the centre and those residing there on a short-term basis. While there were clear and detailed governance and management arrangements in place, improvements were required to ensure all areas of the service were covered, including risk management, individual assessment and care planning, volunteers, directory of visitors and notifications of incidents. All findings from previous inspection had been acted on, and the action plan in relation to the redecoration of premises was still ongoing and due to be completed by December 2020.

There was a clear management structure setting out the roles of people involved in running the centre. Staff spoken with during the inspection were clear of who they reported to and those who were responsible for the running of the centre. The description of the service in the statement of purpose was found to reflect the service provided in the centre.

The person in charge had recently started in the centre and showed great enthusiasm and commitment to ensure residents’ views were heard and they experienced a good quality of life. She had the required qualifications and experience for the role. She provided leadership to the team and demonstrated a positive attitude to regulation and a proactive approach to quality improvement. The person in charge had introduced a number of initiatives in the centre and had ensured that they were conducted in a safe manner. For example, the new system of electronic records introduced, was regularly audited and monitored, with specific action plans created for identified issues. Similarly, based on a training needs
analysis and due to increased admissions of residents with wounds from hospital, a wound management training programme was provided to staff in order to ensure residents received care based on up to date best-evidence knowledge.

The registered provider for the designated centre is the Health Service Executive (HSE) and its representative attended the feedback meeting at the end of the inspection. The registered provider representative supported the person in charge and visited the centre on a regular basis. The systems were found to be of a good standard and provided good oversight and assurance to the provider that the service was being delivered effectively. Monthly governance meetings occurred where various strategic and operational issues were discussed with representatives from other services including risks, accidents and incidents, bed occupancy, complaints, staffing, resources and audit results.

The management team used a number of methods to monitor the quality of the service provided. This included seeking feedback from residents, relatives and staff. A system of regular audits was in place where various clinical indicators were measured such as: medicine management, pressure sores, care planning, nutrition, infections, falls and the use of restraints. Where areas of improvement were identified their progress was tracked during regular management meetings and action plans were formulated to address the findings. Risks identified were entered in the risk register and escalated to register provider representative where required.

There were good systems in place to ensure the information was effectively communicated to all staff, with formal monthly meetings in place. These meetings were minuted and had a set agenda. All staff had access to local and national policies, and those spoken with were very clear of their responsibilities. The inspector observed that staff followed centre’s policies and procedures. There were no staffing vacancies at the time of inspections. The centre employed one volunteer who attended residents’ forum meetings. While there was a valid An Garda Siochana vetting in place, the role and responsibilities for the volunteers and the supervision arrangements had not been set out in writing as per regulatory requirement.

Overall, the records were well-maintained with appropriate documents being kept in relation to residents, staff, complaints, incidents and food and drinks provided to the residents. However, the directory of visitors at the entry in the centre required better oversight to include the visiting times for residents’ protection.

Although there were multiple electronic systems of recording residents’ personal details in use, the inspector was satisfied that the directory of current residents set out all of the information about each resident who was admitted and discharged from the centre. A separate record was maintained for residents who died in the centre.

All residents had a contract of care in place which included a consent form and the terms and condition of residence in the centre, including the fees and services to be provided. The inspector found that the centre had complied with the condition of their registration and no further residents had been admitted to the centre on an extended care basis since February 2018.
There were no open complaints at the time of inspection and details of how to raise concerns or complaints were made available to residents on admission in a handbook about the service. They were also displayed in prominent positions through the centre. Residents spoken with during the inspection were clear of who to speak to if they were not happy, and felt they would be listened to.

**Regulation 14: Persons in charge**

The person in charge worked full-time in the centre and had the required qualifications and experience to manage the designated centre.

The person in charge was involved in the governance and management processes in the centre and provided regular updates to the management team, following reviews of audits, clinical data, staff supervision and resident feedback.

**Judgment:** Compliant

**Regulation 19: Directory of residents**

There was a directory of residents that clearly set out all the required information. For example, the name and address of the resident and their next of kin, when the resident was admitted to the centre and when they left. It was established and maintained in electronic format and was available when requested. A separate electronic system was in place recording residents’ deaths.

**Judgment:** Compliant

**Regulation 21: Records**

Records required under Schedule 2, 3, and 4 were available in the centre. They included records such as complaints, notifications that had been submitted to the Chief Inspector of Social Services, staff records and information about residents.

However the directory of visitors required further development and oversight to ensure residents’ protection and safe fire evacuation.

There were appropriate arrangements for retention of documents, including safe storage arrangements.

**Judgment:** Substantially compliant
### Regulation 22: Insurance

There was an insurance policy in place for the centre. It included public liability insurance and insurance against injury to residents.

Judgment: Compliant

### Regulation 23: Governance and management

The centre was appropriately resourced to ensure the effective delivery of care. There were no staffing vacancies at the time of inspection. There was also a clearly defined management structure in place to ensure the centre operated in line with the statement of purpose.

Overall, there was good oversight of service delivery to ensure residents were receiving a quality service, however some improvement was required to ensure all areas of the service were safe and effectively monitored as per the findings outlined in this report.

The 2018 qualitative report in the form of annual review had recently been completed and there was evidence to show it had involved consultation with residents and relatives.

Judgment: Substantially compliant

### Regulation 3: Statement of purpose

There was a statement of purpose in place clearly setting out the service being provided, the admissions procedure including maximum length of stay, age range and sex of residents, and the therapeutic supports available. It also gave clear information about arrangements for visitors, availability of religious services, fire precautions in the centre, and the arrangements for making complaints.

Judgment: Compliant

### Regulation 30: Volunteers

The inspector reviewed the file on record for the one volunteer that visited the
A valid Garda vetting was available and there was evidence that the local policy had been read and signed by the volunteer. The person in charge informed the inspector that supervision arrangements were in place and that the volunteer mainly attended residents’ forum meetings. However, the roles and responsibilities, and the specifics of the role had not been set out in writing as per centre’s own policy and the regulatory requirements.

Judgment: Substantially compliant

**Regulation 31: Notification of incidents**

Since the appointment of the current person in charge, all matters that were required to be notified to the Chief Inspector had been timely submitted, including three-day notifications, three monthly notifications, and any changes to the people identified in key roles in the centre. However, a series of quarterly reports in respect of the previous year had not been submitted as per regulatory requirements.

Judgment: Substantially compliant

**Regulation 32: Notification of absence**

The provider and person in charge were aware of the need to send in a notification if the person in charge was going to be absent from the centre for a period longer than 28 days.

Judgment: Compliant

**Regulation 4: Written policies and procedures**

All policies required by Schedule 5 were in place, and reviewed on a regular basis. They were also available to staff with copies in a prominent place on each of the two units.

Judgment: Compliant

**Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre**
The provider was clear of the need to set out the arrangements in place when the person in charge was absent for more than 28 days.

Judgment: Compliant

**Quality and safety**

Overall, residents were receiving a good quality service that met their identified needs. Residents were supported to maintain their privacy and dignity, exercise daily choices and overall they provided positive feedback about their experience of living there. However, improvement was required in relation to how risk was managed in the centre. This is further detailed under regulation 26.

The nature of the service was to support people for a short period of time before they either returned to their own homes, or moved on to other longer term services. This meant that there was a high turnover of residents with up to three admissions and discharges in the centre per day. To minimise the disruption to residents’ life in the centre, the person in charge had limited the number of admissions to the unit where long-stay residents resided to one per day.

Admissions and discharges were seen to be well-managed. The discharge planning coordinator was based in the centre and attended daily meetings with the person in charge and the clinical nurse managers (CNM) to ensure residents had a clear pathway for discharge. Most admissions were planned and a CNM ensured that a pre-assessment was completed prior to admission.

A review of health care records showed that assessments were completed on admission and reviewed when residents’ needs changed. These assessments informed healthcare plans, which were initiated within 48 hours. Where residents needs had changed appropriate referrals had been made, for example to community specialist services, or for support from other allied healthcare professionals.

There were good attempts at ensuring that the residents’ care plans were person-centred however, the inspector noted inconsistencies in the documentation. Some records were person-centred in the way they were written, setting out residents preferences and needs in relation to meals, personal care and how to spend their time in the centre. Others were generic, contained duplicated or contradictory information and did not effectively guide staff on how to adequately meet residents’ needs. The inspector was satisfied that this was a documentation issue and that staff knew the residents well and provided appropriate responses to meet their needs. Care planning documentation issue had already been identified and actioned by the person in charge, and some staff had attended a workshop in the use of person-centred language in care planning the day prior to inspection. The inspector saw evidence of further training scheduled for staff in the upcoming months.

There was good documentation in relation to the provision of wound care, with
evidence of input from the tissue viability nurse. Where clinically indicated and based on individual assessment pressure relieving devices were used. None of the extended care residents had any wounds or pressure sores at the time of inspection.

There was at least one medical practitioner visiting the centre every day and medical cover was also provided at the weekend. The residents received the healthcare they needed and appropriate referrals were made to community and specialist healthcare professionals. However, further improvements were required in relation to residents’ access to a pharmacist of their choice. The person in charge had appropriately identified and escalated through the risk register the absence of a pharmacist that residents could access in the centre. However, at the time of inspection this remained outstanding. Access to pharmacy services was available as required in the nearby healthcare facility located on the grounds where the designated centre was located.

There was a policy in place to guide staff on meeting the needs of residents with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). At the time of inspection there were low numbers of resident displaying such behaviours and the inspector was satisfied that the care plans provided clear guidance to staff on how to respond appropriately and in the least restrictive manner. Behaviour charts were used to record and identify patterns of altered behaviour, which informed the care planning in relation to initiating appropriate medical and social interventions. Where required, safeguarding arrangements were in place and implemented to ensure residents were protected at all times.

Policies and procedures that ensured the residents were protected from abuse were implemented. Staff had attended training in safeguarding vulnerable adults and displayed good knowledge on how to report concerns in relation to the safety of the residents living in the centre. The use of restraints was in line with national policy. There was one long-stay resident using bedrails at the time of inspection, and the inspector was satisfied that appropriate alternatives had been trialled for this resident. Regular assessments and discussion with residents informed the use of bedrails.

Following a review of the premises, the inspector was satisfied that some improvement had been made in relation to the redecoration of the designated centre, and the overall upkeep and maintenance of the building. Efforts to create a more home-like living environment for the residents were ongoing, and a new suite for one of the communal areas was expected to be delivered on the day of inspection. Large murals created focal points and a welcoming feel, however much of the corridors remained bare and retained an institutional look. The person in charge informed the inspector that further decorative works were planned in due course and due for completion as scheduled.

The building had a linear layout. The centre was divided into two units, that each accommodated 16 residents. One unit was designated for short-stay residents that could be accommodated for a period of maximum 12 weeks. The transitional care
residents included residents awaiting home care, Fair Deal, home improvements as well as intermittent respite basis. The unit included the Day Care Hospital, which provided opportunities to maintain links with local community. Two large and bright dayroom areas were available, and the inspectors saw residents mixing and interacting with each other and engaged in various activities throughout the day. Separate dining rooms were available that were adequately equipped and staffed to meet the needs of the residents.

The other unit accommodated a mix of long-stay and short-stay residents and there was a more focused approach to creating a homely environment. The bedrooms of the extended care residents were personalised, and large built-in wardrobes had been installed in the communal rooms to ensure residents had sufficient space to store their personal belongings. In addition, the shared bedrooms had a separate built-in wardrobe at the entry of the room that was used to store general day-to-day items such as linen, towels, blankets and clean dry equipment. This feature of design had effectively eliminated the use of communal trolleys and associated institutional practices by ensuring all the required equipment was available at the point of care delivery.

While there was no safe internal garden available for the residents due to the layout of the building, residents of both units could access a veranda at the front of the designated centre. At residents’ request, the person in charge had equipped this outdoor space with tables, chairs and parasols, where residents could sit and enjoy the sunshine and the outdoor grounds.

Risk management in the centre required improvement, as further outlined under Regulation 26. The risk register was kept up to date and under regular review. The person in charge escalated risks to the registered provider representative and the inspector was satisfied that mitigating controls were put in place.

There were no residents smoking in the centre at the time of inspection, however the smoking room was found to be heavily impregnated with the smell of smoke and there was evidence of cigarette ash in the sink and on the floor. The room was appropriately equipped with call bell, smoking apron, metal ashtray and an electric vent, which had been turned off. When the vent was activated at the inspector’s request, it was found that it was not effective at cleaning the air adequately. The flooring also required replacement as it was damaged in several area. The person in charge addressed some of these issues on the day and informed the inspector that there was an action plan in place to ensure the smoking room was safe.

In relation to clinical risk there was good oversight and support at governance level with access to a quality and risk manager and a practice development nurse. The inspector was satisfied that there was a proactive approach to risk management in the centre. A recent initiative introduced in the centre involved the daily allocation of a safety champion from among the staff, who would complete an environmental spot check and alert the team to the hazards identified at the pre-scheduled daily safety talks. This ensured staff accountability and enhanced awareness to risks and hazards throughout the centre.
Inspectors observed good infection control practices such as hand hygiene, the use of protective clothing, safe disposal of sharps and the segregation of waste. The action from previous inspection in relation to the storage of clean equipment in the sluice room had been completed. The designated centre was very clean, hygienic and free of odours. As a result of a local campaign to protect the residents against influenza, there had been a vast increase in the uptake of flu vaccine among the staff.

The inspector spoke to staff, reviewed training records and found that they had good knowledge to ensure safe evacuation in the event of fire. There was evidence of night-time and day-time fire drills. This was an action plan from the previous inspection. All fire-safety documentation was up to date and any issues identified were completed by the end of inspection.

**Regulation 10: Communication difficulties**

Where residents had specific communication needs in relation to their sight, hearing, ability to communicate verbally and their cognitive ability, these were detailed in their plan of care. Staff spoken with were very clear in relation to residents’ communication needs. The inspector observed staff ensuring residents’ communication needs were met and providing the necessary support to ensure residents could participate in various activities and communicate effectively.

Where necessary, appointments in relation to residents’ communication needs were arranged with the relevant services. Residents confirmed they felt able to communicate freely in the centre, and had access to phones to keep in touch with families and friends.

**Judgment:** Compliant

**Regulation 11: Visits**

There were arrangements in place for residents to receive visitors in private. The visitors’ room was equipped with sofa and chairs and had facilities for tea and coffee. The person in charge informed the inspector of further plans to upgrade and redecorate the room.

Information about visiting arrangements was clearly set out in the residents’ guide. The inspector noted that residents’ wishes regarding restricting visitors were respected.

Visitors who spoke with the inspectors confirmed that they were happy with the visiting arrangements in the centre. The maintenance of the directory of visitors
required better oversight as discussed under regulation 21.

Judgment: Compliant

**Regulation 12: Personal possessions**

Residents had access to lockable storage in their rooms.

The rooms of the long-stay residents were personalised and contained sufficient storage to accommodate their personal possessions. A property list of personal belongings was completed on admission for each resident, and reviewed twice a year. The extended care residents had access to laundry facilities. A discreet labelling system was in place.

The storage available for the other residents was smaller but provided sufficient space to meet the needs on a short-term basis. All residents who spoke with the inspector on the day confirmed that they were happy with their storage arrangements.

Judgment: Compliant

**Regulation 20: Information for residents**

A residents’ guide was available to each resident in the centre and included a summary of the services provided, the terms and conditions relating to their stay, the procedure for complaints and arrangements for receiving visitors. As the centre was no longer admitting residents on an extended care basis, the guide also included a list providing information on what to bring in the centre for the duration of the stay.

Various informative leaflets were available for residents or visitors on a range of health issues of relevance such as influenza vaccination, advanced decision-making, end of life, mobility and physical exercise in old age and living with dementia.

Residents’ meetings occurred on a regular basis with one scheduled for the day of inspection. All residents were invited to attend. The meetings were minuted and there was evidence that items discussed were followed up by management. Information on advocacy services was displayed throughout the centre.

Judgment: Compliant
Regulation 25: Temporary absence or discharge of residents

Appropriate information was communicated on admission and transfer of the residents in and out of the centre. Discharge arrangements were planned, discussed with residents and safely coordinated with other relevant agencies and community supports.

Judgment: Compliant

Regulation 26: Risk management

Overall, there was oversight of the risk in the centre, however further improvement was required as some risks identified on inspection had not been identified by the provider or acted on in a timely manner.

For example, maintenance issues identified in the fire risk register during checks, had been actioned by the person in charge but not promptly followed up and completed to ensure the safety of the residents. At the request of inspector, all identified issues in relation to fire safety (such as ineffective smoke seals or damaged strips on the fire safety doors) were completed on the day of inspection.

Other risks that required to follow up by the provider related to:

- The vent in the smoking room was not effective at cleaning the air. The flooring in the smoking room was also damaged in several areas
- In one corridor, the painting was peeling off the ceiling which posed a risk to residents, visitors and staff- a protective railing was placed to mitigate this risk, however the inspector was not assured that the risk was appropriately mitigated
  - In one unit, the charging point for the hoists’ battery was located in a resident’s bedroom. Although this room was not occupied at the time of inspection, the location of the charging point for assistive equipment required review as the room was registered as a designated bedroom.
- Residents did not have access to a pharmacist if they required

The hairdressing room, which was used for administrative purposes at the time of inspection, required refurbishment. The inspector reviewed the accident incident log which was maintained on an electronic format and noted that there were accurate records maintained with timely responses to all incidents in the centre. Service records showed that equipment was regularly serviced and in good order. There were good maintenance arrangements in the centre and all issues identified were promptly acted on.

All residents had personal emergency evacuation plans in place. The person in charge ensured that staff had participated in missing persons drill and knew how to
respond in such events.

**Judgment:** Substantially compliant

### Regulation 27: Infection control

Infection control practices were safe. There was a comprehensive policy in place and staff were knowledgeable of the standards for the prevention and control of healthcare associated infections. The centre was clean and hygienic and there were sufficient sanitary facilities for the number of residents. Alcohol gel was available throughout the centre and staff were observed using it.

**Judgment:** Compliant

### Regulation 28: Fire precautions

Records showed that fire-fighting equipment, emergency lighting and the fire alarm were serviced regularly. The fire procedures and evacuation plans were prominently displayed and staff spoken with were knowledgeable and confident in what to do in the event of fire. All staff had the mandatory fire training up to date.

The CNMs organised monthly fire evacuation sessions and there was evidence of simulated fire drills with night times staffing levels. Appropriate arrangements were in place to ensure the safe evacuation of residents with arrangements from nearby healthcare facility to provide support in the event of fire alarm activation at night. The person in charge did random fire safety spot checks to ensure that staff could appropriately respond to various scenarios in the event of fire. The learning from each fire drill was documented and communicated to staff.

**Judgment:** Compliant

### Regulation 5: Individual assessment and care plan

Care planning documentation was available for each resident. Residents had a pre-assessment prior to admission to ensure the centre could meet their needs. Care plans were reviewed on a three monthly basis or sooner if required and were based on validated assessments.

However, the care planning documentation required further review to ensure it was consistent and provided clear guidance to staff on residents’ current condition. The inspector was satisfied that the person in charge had identified the shortcomings in
relation to the nursing documentation and there was already a plan in place to address this.

Although residents and relatives reported they were satisfied with the care provided in the centre and how they were kept involved, in the new system of electronic records there was no documentary evidence of consultation with the residents in relation to their care planning arrangements.

Judgment: Substantially compliant

### Regulation 6: Health care

There was no allied healthcare professional attached to the centre, however the inspector was satisfied that residents had appropriate access to treatment, therapies and specialist consultations. There was evidence of appropriate referrals to specialist services, which included physiotherapy, occupational therapy, dietitian, speech and language therapist, tissue viability nurse and social worker.

Records showed residents' healthcare needs were being met in a timely manner. A general practitioner visited the centre every day and was also available at the weekend. Access to national screening programmes was integral part of the admission process and facilitated accordingly.

Judgment: Compliant

### Regulation 7: Managing behaviour that is challenging

Responsive behaviours associated with the care of residents with dementia were well-managed. Staff described to inspector good practices in how to provide appropriate responses to such behaviours and these correlated with the individual care plans. Staff had completed training in dementia and management of responsive behaviours. The use of restraints was low and in line with local and national policy. Alternatives to restraints were available and there was evidence of regular assessments prior to their use.

Judgment: Compliant

### Regulation 8: Protection

Records indicated that regular training on safeguarding vulnerable adults was provided. Staff members understood how to recognise instances of abusive
situations and were aware of the appropriate reporting systems in place, as per local policy.

There were clear policies in place to guide staff in how to ensure residents were safeguarded from abuse in the centre. Staff spoken with were very clear of the types of abuse residents may be at risk of and also the steps to take if they suspected, witnessed or had abuse reported to them. Residents who spoke with inspectors said they felt safe in the centre and that staff were respectful of their health and social care needs.

The centre was pension-agent for one resident and the funds were held in a centralised residents’ account. A sample of files reviewed on inspection showed that all staff had Garda vetting in place prior to commencing employment. All nurses had their registration active and up to date.

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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:

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<th>Regulation Title</th>
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<td><strong>Capacity and capability</strong></td>
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<tr>
<td>Regulation 14: Persons in charge</td>
<td>Compliant</td>
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<td>Regulation 19: Directory of residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 21: Records</td>
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</tr>
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<td>Regulation 22: Insurance</td>
<td>Compliant</td>
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<tr>
<td>Regulation 23: Governance and management</td>
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<td>Regulation 3: Statement of purpose</td>
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<td>Regulation 30: Volunteers</td>
<td>Substantially compliant</td>
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<td>Regulation 31: Notification of incidents</td>
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<td><strong>Quality and safety</strong></td>
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<td>Regulation 10: Communication difficulties</td>
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<tr>
<td>Regulation 11: Visits</td>
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<td>Regulation 12: Personal possessions</td>
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<td>Regulation 20: Information for residents</td>
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<td>Regulation 25: Temporary absence or discharge of residents</td>
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<td>Regulation 26: Risk management</td>
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<td>Regulation 27: Infection control</td>
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<td>Regulation 28: Fire precautions</td>
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<td>Regulation 5: Individual assessment and care plan</td>
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<tr>
<td>Regulation 7: Managing behaviour that is challenging</td>
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<td>Regulation 8: Protection</td>
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Compliance Plan for Lisdarn Centre OSV-0000490

Inspection ID: MON-0026784

Date of inspection: 25/07/2019

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>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 21: Records</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outline how you are going to come into compliance with Regulation 21: Records: A revised Directory of Visitor book (GDPR compliant) in now place in place.</td>
<td></td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outline how you are going to come into compliance with Regulation 23: Governance and management: The Registered Provider will ensure that all areas of the service are safe and effectively monitored. This will be done by the use of regular audit and feedback. The daily safety pause will continue and all issues will be addressed in a timely manner. The 2019 qualitative report in the form of annual review will be submitted for 2019 in January 2020 and will reflect monitoring process.</td>
<td></td>
</tr>
<tr>
<td>Regulation 30: Volunteers</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outline how you are going to come into compliance with Regulation 30: Volunteers: The clear roles and responsibilities of all volunteers/students have been set out in writing as per the regulatory requirements. This document has been signed by the current volunteer and a file is available for inspection.</td>
<td></td>
</tr>
<tr>
<td>Regulation 31: Notification of incidents</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The current Person in Charge will ensure that all notifications are submitted to the Authority as required to ensure compliance in this area in line with HIQA Regulations</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 26: Risk management</th>
<th>Substantially Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 26: Risk management: The Registered Provider will ensure that all areas of the service are safe and effectively monitored. This will be done by the ongoing identification of hazards and measures will be put in place to control the risks identified. The daily safety pause will continue and all issues will be addressed in a timely manner. The vent in the smoking room has been repaired and is working effectively. The painting and replacement of the floor covering in the smoke room will be completed by 30/09/19. An ongoing rolling painting and decorating programme is being agreed with the maintenance manager and all general painting repairs is in the process of being completed. The overhead protective mesh in the corridor has been cleaned and is free from debris. The ceiling above has been repaired. The charging point for the hoists' battery is now located in an office adjacent to the reception area. Discussions have taken place and are on going with the pharmacist in Cavan General and the head of Social Care for CHO1 in relation to additional human resources to provide support to the seven long term care residents in the Lisdarn Centre.</td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Regulation 5: Individual assessment and care plan</th>
<th>Substantially Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: Consultation with residents and/or their families in relation to their care planning arrangements is now in place and this is electronically recorded in the residents/family</td>
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</tr>
</tbody>
</table>
communication icon on epicare.

Person Centred Language in Nursing documentation workshops have commenced for all nursing staff in Lisdarn to support a more person centred approach to care planning and documentation.
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 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>Substantially Compliant</td>
<td>Yellow</td>
<td>30/08/2019</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>Substantially Compliant</td>
<td>Yellow</td>
<td>31/01/2020</td>
</tr>
<tr>
<td>Regulation 26(1)(a)</td>
<td>The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>30/01/2020</td>
</tr>
<tr>
<td>Regulation</td>
<td>Description</td>
<td>Status</td>
<td>Date</td>
<td></td>
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<tr>
<td>26(1)(b)</td>
<td>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.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>31/12/2019</td>
</tr>
<tr>
<td>30(a)</td>
<td>The person in charge shall ensure that people involved on a voluntary basis with the designated centre have their roles and responsibilities set out in writing.</td>
<td>Not Compliant</td>
<td>Orange</td>
<td>14/08/2019</td>
</tr>
<tr>
<td>31(3)</td>
<td>The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>14/08/2019</td>
</tr>
<tr>
<td>5(1)</td>
<td>The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>14/08/2019</td>
</tr>
</tbody>
</table>