Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	St Eithne's Rest Care Centre
Name of provider:	TSP Suil Ar Aghai Company Limited by Guarantee
Address of centre:	Corbally, Tulsk, Castlerea, Roscommon
Type of inspection:	Unannounced
Date of inspection:	10 December 2018
Centre ID:	OSV-0000699
Fieldwork ID:	MON-0025884

About the designated centre

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

St Eithne's Rest Care centre is a 10 bed centre in Tulsk Co.Roscommon and is operated by TSP Suil Ar Aghai Company Limited by Guarantee. It is located in a small housing estate beside the parish church in Tulsk, just off the N5 and a short walk from the village. The centre accommodates residents with low and medium dependency needs from the local community. The building is an adapted bungalow which comprises of a sitting room, dining room, kitchen and a small visitors room. The bedroom accommodation comprises two single rooms and four two bedded rooms. All bedrooms have access to en-suite bathrooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

To prepare for this inspection the inspector or 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
10 December 2018	10:00hrs to 17:00hrs	Brid McGoldrick	Lead
10 December 2018	10:00hrs to 17:00hrs	Paul McDermott	Support

Views of people who use the service

Residents who communicated with the inspectors were positive regarding the care received and expressed satisfaction that they were living in the area known to them. One of the residents spoken with was looking forward to a Christmas carol service which was planned for them. Residents spoken with were complimentary about the staff and said that staff were very kind and approachable. Residents were satisfied that they were supported in their religious practices and enjoyed saying the rosary.

Capacity and capability

This unannounced inspection was carried out to determine what progress had been achieved in addressing issues of regulatory non-compliance following an inspection on 13 September 2018. The findings of the September 2018 inspection were that the provider, TSP Suil Ar Aghai Company LTD, had failed to ensure that:

· the governance and management of the designated centre was reviewed and strengthened

· all possible action had been taken to reduce and manage the risk of fire in the centre

· only residents that could be safely cared for were living in the designated centre

During this inspection, inspectors found that the provider had not taken the necessary action to mitigate these serious risks and had failed to improve regulatory compliance.

On 17 October 2018, a meeting took place between the Office of Chief Inspector and the provider (representative) to discuss the governance and management arrangements in place to ensure that only residents that the service could safely care for resided in St. Eithne's, and to ensure that the significant fire safety issues were receiving attention. However, this inspection identified that the governance and management systems in place required review and significant improvement to ensure that the service provided was safe and effectively monitored and that risks identified in relation to fire safety were addressed. The provider was aware that urgent action was required to address the fire safety risks.

As a result of the findings of the September 2018 inspection and following a review of documentation subsequently received by the Office of the Chief Inspector, this

designated centre was referred to the Chief Fire Officer for review, on notice to the registered provider. During this inspection, completed on 17 December, inspectors found that actions to definitively address fire safety issues remained outstanding.

In June 2017 the registration of this designated centre was renewed to enable the provider to accommodate 10 residents with low to medium dependency needs as set out on page 15 of their statement of purpose, and referenced in condition 5 of their conditions of registration. However, on the day of this inspection some of the residents living in the centre had high dependency needs which the designated centre was neither structured nor resourced to safely care for. This issue had been discussed with representatives of TSP Suil Ar Aghai Company LTD on 17 October 2018, but the provider had yet to take definitive corrective action.

On the day of this inspection, inspectors were not assured that there was sufficient staff with an appropriate skill-mix available to effectively meet the needs of residents. A complete staffing review was required to ensure that a safe standard of care was delivered to meet the social needs of residents, and to ensure safe and effective infection prevention and control practices were in place.

Other findings that indicated that effective governance arrangements were not in place included:

- Not all staff had up-to-date training in fire safety, moving and handling, infection control and prevention, or food hygiene education.
- There was a lack of suitable equipment available to safely move or transfer residents from a wheelchair to a chair.
- Not all residents had access to the type of bed that they required and some mattresses were worn and therefore did not provide effective pressure relief.
- There were no service records available for many of the specialist beds and mattresses in use.
- The bed linen is use was threadbare and required replacement.
- Areas of the centre required painting and refurbishment.

Regulation 15: Staffing

The staffing arrangements in place in the centre were not appropriate to meet the care needs and dependency levels of residents. Inspectors observed that residents were sitting in the sitting room for most of the day unsupervised. This occurred as staff were attending to other residents' individual needs in their bedrooms. Other indicators that staffing levels were not adequate included:

- The person in charge did not have sufficient time to carry out her management duties as she was the only registered nurse on duty on the days she was working in the centre. The person in charge was allocated seven hours per week to complete her management duties;, however, on the roster reviewed for weeks 10 December 2018 and 17 December 2018 this arrangement was not in place.

- The nursing roster comprised of a variety of nurses working a minimum of 7 and a maximum of 20 hours per week, an arrangement which was seen to adversely impact on continuity of care.
- There was no dedicated cleaning, laundry or activity staff employed. Care staff were engaged in laundry, kitchen, catering, activities and cleaning duties on any given day.
- The chef was only on duty from 10.00am to 2pm each day.
- Activities were scheduled to be provided by a person from the community who had not been available for six months. This added to the duties to be undertaken by nursing and care staff
- Some records required and maintained by staff were unreliable and this was attributed to a lack of available time to complete records.

Judgment: Not compliant

Regulation 16: Training and staff development

Not all staff had the required up-to-date training in

- Fire safety,
- Moving and handling,
- Infection control and prevention,
- Food hygiene education.

Judgment: Not compliant

Regulation 19: Directory of residents

Following the last inspection, the directory of residents had been revised and now included all of the information required by the regulations.

Judgment: Compliant

Regulation 21: Records

There were no individual resident assessments or care plans for residents who needed support with moving and handling manoeuvres. In the sample of care files

reviewed, some assessments were last updated in June 2018 and not at quarterly intervals as required.

Weekly checks to assess that the fire detection and alarm system were operating effectively were not being carried out. The fire alarm test log book was incomplete.

Judgment: Not compliant

Regulation 23: Governance and management

This provider, TSP Suil Ar Aghai Company limited by Guarantee was governed by a board of voluntary members. The statement of purpose on page 17 identified a manager with responsibility for laundry, and financial administration. Lines of responsibility and accountability within the governance structure for the operation of the designated centre were unclear. The person in charge reported on a monthly basis to a board of voluntary members.

This inspection identified that the governance and management systems in place required significant and sustained improvement to ensure that the service provided to residents was safe and that risks identified in relation to fire safety were addressed. An urgent action plan was issued following the inspection to address fire safety matters.

In addition, the registered provider has not ensured that the centre is resourced to ensure the effective delivery of care to residents with high dependency needs. Aspects of the physical design of the premises do not support the specific needs of residents, for example residents with cognitive impairment or mobility needs. Suitable equipment was not available for the safe moving and handling of residents. Therefore the current service cannot ensure the sustainable delivery of safe and effective care.

There was insufficient staff available to ensure the effective delivery of safe and appropriate care. The staffing model required review as the majority of staff worked part-time hours, resulting in lengthy gaps between shifts which did not support continuity of care for residents. Arrangements were not in place to ensure an effective and regular cleaning routine was in place to maintain appropriate hygiene standards.

There was no clearly defined management structure in place that outlined the specific roles and responsibilities for care provision. The care assistants carried out multi-task duties involving care, catering, activities and cleaning duties: however, their role was not clearly defined. Training for staff appropriate to their roles and to ensure they were competent to undertake their duties was not up to date as they did not have up- to date training in food hygiene or in infection prevention and control. A system to ensure the safe management of laundry and waste was not in place.

There was a lack of oversight to ensure that the premises was kept in a good state of repair. A number of areas required painting and refurbishment.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose and function was revised following the September 2018 inspection. However, it was noted to require further revision as it did not contain all the information set out in Schedule 1. It lacked the following required information:

- An accurate description (either in narrative form or a floor plan) of the rooms in all parts of the designated centre including their size and primary function.
- The criteria used for admissions to the centre, including the designated centre's policies and procedures (if any) for emergency admissions
- The total staffing complement, in whole time equivalents, for the designated centre with the management and nursing complements as described in regulations 14 and 15
- The emergency procedures in the designated centre..
- The arrangements made for consultation with, and participation of, residents in the operation of the designated centre.

In addition, the detail on complaints management requires revision as the 0ffice of the Chief Inspector does not have role in responding to individual complaints.

Judgment: Not compliant

Regulation 34: Complaints procedure

Verbal complaints were now being recorded and monitored.

Judgment: Compliant

Quality and safety

The findings of this inspection were that provider, TSP Suil Ar Aghai Company Limited by Guarantee, had failed to ensure that the service provided was safe and effectively monitored. They had failed to provide effective oversight to ensure adequate resources were maintained to care for the changing needs of residents.

This negatively impacted on the safety and quality of care provided.

Risks in the centre were not appropriately managed, for example fire safety and infection control practices were not of a standard to ensure the safety and well-being of residents. The provider representative was asked to take immediate action to address the fire safety risks.

The bedroom accommodation area of the building is not compartmented, which means that in the event of a fire, all 10 residents in the centre must be evacuated to an external assembly point. The corridor serving the bedrooms is not subdivided and could become filled with smoke in a very short period of time further reducing the time available for the evacuation of the premises. The bedroom corridor area also contained storage presses which were not of fire-rated construction.

The evacuation assistance needs of the residents are varied, with two residents requiring the assistance of two staff for their safe evacuation, and four other residents requiring wheelchair evacuation and the assistance of at least one member of staff to ensure their safe evacuation. While six wheelchairs are required for the evacuation of the centre, only three have been supplied by the provider.This means that multiple journeys would need to be made by staff with the wheelchairs further delaying the evacuation of all residents.

Recent upgrade works to the fire detection, fire alarm and emergency lighting systems in the centre have improved the fire safety measures but staff have not received sufficient training to enable them to operate and interpret the fire alarm panel.This presents a significant risk and could further delay the commencement of evacuation. Alarm zoning and fire procedure notices have not been updated to reflect the upgraded alarm system and revised building zoning.

Since the previous inspection, night time staffing levels have been increased to ensure that two staff are now on the premises at all times. While this is an improvement on previous staffing levels, fire drills have not demonstrated that the premises can be evacuated in a safe and timely manner by just two staff.

Inspectors found that improvements were required to provide adequate containment of fire. Breaches in the fire-rated enclosure to a room or corridor that requires fire resistance, results in a passage for fire and smoke which compromises escape routes. For example, a large glazed panel next to the door to the visiting room was not fire-rated.

Recently fitted bedroom doors were found to be fitted with swing free devices. These devices improved the day-to-day manoeuvrability through the centre and allowed each resident the choice to have doors open. However, due to the adhoc nature of the upgrade works to the original door frames, and no clear identification of the likely performance of the fire door panels, inspectors had concerns about the likely fire performance of the recently fitted doors in the centre.

Inspectors were not satisfied that sufficient measures were in place to ensure the safety of residents if a fire was to occur in the building.

Overall, residents had access to reviews by their general practitioner(GP). All residents had received the flu vaccine. A review of residents' care documentation evidenced that assessments and care plans were not reviewed at four month intervals as required. The care assessments and care plans reviewed did not accurately describe the current and changing needs of residents.

Infection prevention and control practices did not reflect best practice and increased the risk of infection spread in the centre. There were no cleaning schedules available. Systems for cleaning and disinfection were not available. The systems for the management of laundry and waste did not reflect good practice guidance.

Regulation 17: Premises

Aspects of the premises were not designed or organised to meet the needs of the residents currently living there. A number of residents have cognitive problems, however, there was no signage available to assist residents to recognise their own bedrooms or the main facilities. There was no designated cleaner's room, laundry room, or sluice in the centre.

The premises provided did not conform to matters set out in schedule 6 regulation 17 - Premises. The areas that required attention included:

- The premises was not clean
- Grab rails were required in a number of toilet areas
- Hand rails did not extend fully along hallways throughout the centre
- Appropriate curtain screening was not available in all shared bedrooms to ensure privacy
- Suitable storage in the kitchen area was not provided
- Sufficient storage for linen, equipment and records was not available.
- Suitable adaptations and supports, equipment and facilities as required for residents were not available.
- Appropriate sluicing facilities were not available
- Adequate laundry facilities including a wash hand basin where laundry was washed were not available
- Equipment to safely move residents with mobility problems or should they sustain a fall was not provided.

In addition mattresses in use were observed to be worn and may not provide appropriate pressure relief or comfort for residents.

Judgment: Not compliant

Regulation 26: Risk management

There were inadequate arrangements to identify, assess, mitigate, monitor and report all risks. A risk assessment was not carried out to determine if there was suitable equipment available to alert staff in the event a resident sustained a fall. No risk assessment had been carried out to determine if the seating provided for example for dining met the current assessed needs of residents. There was insufficient equipment available to transport residents if required.

There was a lack of effective risk management that compromised the safety of residents, staff and visitors. The inspectors identified risks that included the following:

- Inappropriate storage of hand sanitizers on hand rails which posed a risk of ingestion and disrupted the use of the handrails
- Inappropriate storage of a sharps container in an unsecured area behind the office
- Trailing leads in a number of areas for example in bedroom 3.
- There were no service contracts available for eight of of the 10 beds in use in the centre.

Judgment: Not compliant

Regulation 27: Infection control

TSP Suil Ar Aghai Company Limited by Guarantee, did not ensure that the procedures and practices for infection control were consistent with good practice standards for the prevention and control of healthcare- associated infections and were implemented by staff.

For example

- There were no systems in place to ensure equipment used by residents was in a clean and hygienic condition
- There was no dedicated time allocated to cleaning of the designated centre and cleaning schedules were not completed.
- Practices in place to underpin the management of laundry and linen required review including a system for the
    - segregation of clean and used linen,
    - the washing, drying and storage in line with best practice was required.
- The waste management system also required attention.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire or to ensure that adequate systems were in place to ensure the safe and effective evacuation of residents.

The centre did not meet the requirements of the regulations in the following areas:

Adequate arrangements had not been made for maintaining all means of escape, building fabric and building services.

- A designated escape route was impeded by office furniture
- Inspection certificates were not available for the electrical installation.
- There were no records in the fire and safety register regarding the maintenance or inspection of fire doors, it was observed that closers had been removed from some doors that were intended to be fire doors.

Adequate arrangements had not been made for reviewing fire precautions.

- There was no documented process in place for identifying and mitigating fire hazards and risks throughout the premises.
- It was observed that all necessary evacuation equipment was not provided and fire zoning notices did not reflect the recently installed fire detection and alarm system. Some findings and recommendations of the fire risk report prepared for the provider in October 2018 were not being fully implemented.

Adequate arrangements had not been made for testing fire equipment.

- Weekly checks on the operation of the fire detection and alarm system were not being carried out, the alarm log book was incomplete.

Staff in the premises did not receive suitable training in fire prevention and emergency procedures.

- Fire training was not up to date for all staff. Assurances were given that fire training will be provided for the remaining staff on 17 December 2018 bringing training for all staff up to date.
- It was observed that there was a high degree of staff uncertainty regarding the operation and interpretation of the recently installed fire alarm panel.

Inspectors were not assured that people working in the centre were adequately prepared for the procedure to be followed in the case of fire.

- The scenarios documented in fire drill reports did not provide assurance that all staff were adequately prepared or resourced for the most demanding evacuation procedures that are likely to be required in the centre.
- It was confirmed to inspectors that a simulated full evacuation of the centre

has not been carried out using only night time staffing levels (two staff) and procedures.

Adequate arrangements had not been made for detecting and containing fires.

- The certification for the fire detection and alarm system contained a discrepancy regarding the classification of the installed fire detection and alarm system. On some documents it is referred to as an L1 system, and on other documents it is referred to as an L2 system;, an L1 system is required.
- The inspectors were not assured of the likely fire performance of all door sets (door leaf, frame, brush seals, intumescent strips, hinges, closers and ironmongery), including the recently fitted door leafs and door frames that have been retro fitted with brush seals. The doors intended to perform as fire doors were not fitted with plates or tags confirming their fire performance. In some cases there were considerable gaps between the bottom edge of the door leafs and the frames and floor.
- The inspector was not assured that the doors to the sluice room and the hot press or \store located along bedroom escape corridors or the door to the staff changing room would achieve their required fire performance.
- The bedroom accommodation was not compartmented and did not facilitate the phased horizontal evacuation of the centre. In the event of a fire, the centre must be completely evacuated.
- Due to the considerable number of ceiling mounted extractor fans, attic access hatches and numerous unsealed service penetrations, the inspector was concerned about the effectiveness of the ceiling in restricting fire spread through the roof space of the premises.
- It was observed that some high risk-areas have not been adequately protected from the risk of fire that is to say, ELCB and electrical distribution boards in the office, the linen press in the escape corridor, the kitchen, and the hot press area.
- Four non fire-rated tall storage presses containing bed linen, towels, and supplies were located along the bedroom escape corridor, presenting an increased fire risk to the only escape route in the bedroom part of the building.

The registered provider did not make adequate arrangements for giving warning of fire.

- A zone floor plan was not displayed next to the fire alarm panel so there was no means of quickly identifying the location of the alarm activation. Furthermore, the written description of alarm zones that was displayed next to the alarm panel was out of date and did not reflect the alarm zoning applicable since the upgrading of the fire alarm panel

Staff spoken with were unsure about the arrangements to be followed for calling the fire service; staff thought that an automatic dialler and external monitoring station support was to have been incorporated into the fire detection and alarm system and were unsure if this was active or not. This matter needs immediate clarification to all

staff.

Adequate arrangements had not been made for the safe placement of residents and for their evacuation where necessary.

- From a review of the Personal Emergency Evacuation Plans (PEEPs) there were two high dependency residents in the centre which is not in accordance with the Statement of Purpose for the centre.
- The bedroom accommodation has not been compartmented and does not facilitate the phased horizontal evacuation of the centre. All residents were to be evacuated to a designated area in the car park of the centre. This evacuation strategy considerably increases staff and equipment resources and delays the evacuation of the centre. The inspectors were not assured of the safety of residents in the event of an evacuation.
- A recommendation of the fire risk report prepared for the provider in October 2018 was to review the evacuation needs of the residents and provide all necessary equipment. The provision of all necessary equipment has not been completed.
- The Personal Emergency Evacuation Plans (PEEPs) identify that wheel chairs are required for the evacuation of six residents; however, only three wheelchairs are provided in the centre. No other evacuation aids have been provided.
- The summarised schedule of PEEPs presented to inspectors did not reflect the needs identified in the individually documented PEEPs.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
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	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for St Eithne's Rest Care Centre OSV-0000699

Inspection ID: MON-0025884

Date of inspection: 10/12/2018

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

Outline how you are going to come into compliance with Regulation 15: Staffing:
FOLLOWING DISCUSSION WITH OUR RESIDENTS A SCHEDULE IS IN PLACE TO FACILITATE RESIDENTS SOCIAL NEEDS, THIS IS MANAGED BY OUR MULTI DISCIPLINARY TEAM.

WE HAVE A COMPETENT NURSE MANAGER ON SITE WHO HAS AN ALLOCATION OF RING FENCED HOURS FOR NURSING MANAGEMENT DUTIES. THE FULL TIME MANAGER OF TULSK PARISH SERVICES IS NOW COMPLETING NON NURSING ADMINISTRATION DUTIES FOR ST. EITHNES. THIS WILL STRENGTHEN THE GOVERNANCE AND MANAGEMENT OF ST. EITHNES.

CONTINUITY OF CARE IS OUR PRIORITY, AT ALL SHIFT CHANGES A HANDOVER IS COMPLETED AND STAFF ARE UPDATED OF ANY CHANGES WHICH HAVE TAKEN PLACE. THE SMALL NUMBER OF RESIDENTS ALLOWS FOR STAFF TO HAVE A THOROUGH KNOWLEDGE OF RESIDENTS CARE AND NEEDS

ALL OUR LAUNDRY IS OUTSOURCED.

DEDICATED CLEANING HOURS HAVE BEEN RESOURCED AND CLEANING SCHEDULES ARE IN PLACE.

ADDITIONAL HOURS HAVE BEEN ALLOCATED TO THE COOK TO FACILITATE THE NUTRITIONAL NEEDS AND DINING EXPERIENCE OF OUR RESIDENTS. ALL CHEFS HAVE COMPLETED HACCP TRAINING.

OUR RECORDS HAVE ALL BEEN UPDATED IN LINE WITH REGULATIONS.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
FIRE SAFETY TRAINING – COMPLETED ON 24TH JANUARY 2019. ALL STAFF WILL HAVE COMPLETED TRAINING AND ONGOING TRAINING WILL BE PROVIDED WHERE APPROPRIATE.

MOVING & HANDLING TRAINING WILL BE COMPLETED BY 28TH FEBRUARY 2019.

INFECTION CONTROL & PREVENTION TRAINING SCHEDULED FOR 7TH FEBRUARY 2019.

FOOD HYGIENE EDUCATION – CHEF'S HAVE COMPLETED HACCP TRAINING

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
PHYSIOTHERAPIST HAS REVIEWED AND COMPLETED INDIVIDUAL CARE ASSESSMENTS FOR ALL RESIDENTS, THESE ARE NOW ON THE FILES.

WEEKLY CHECKS ON FIRE DETECTION AND FIRE ALARM SYSTEM ARE COMPLETED AND RECORDED IN FIRE REGISTER.

FIRE ALARM TEST LOG NOW COMPLETED.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
WE HAVE A COMPETENT NURSE MANAGER ON SITE WHO HAS AN ALLOCATION OF RING FENCED HOURS FOR NURSING MANAGEMENT DUTIES. THE FULL TIME MANAGER OF TULSK PARISH SERVICES IS NOW COMPLETING NON NURSING ADMINISTRATION DUTIES FOR ST. EITHNES. THIS WILL STRENGTHEN THE GOVERNANCE AND MANAGEMENT OF ST. EITHNES.

THE BOARD OF TSP ARE COMMITTED TO PROVIDING A CONSISTENT HIGH QUALITY SERVICE TO OUR RESIDENTS AND ARE PROUD OF THEIR TRACK RECORD IN THIS REGARD. THE BOARD WILL CONTINUE TO REVIEW ITS POLICIES AND PROCEDURES IN ALL AREAS TO ENSURE BEST OUTCOME FOR THE RESIDENTS OF ST. EITHNES.

SUITABLE EQUIPMENT FOR THE SAFE MOVING AND HANDLING OF RESIDENTS HAS BEEN PURCHASED.

CONTINUITY OF CARE IS OUR PRIORITY, AT ALL SHIFT CHANGES A HANDOVER IS COMPLETED AND STAFF ARE UPDATED OF ANY CHANGES WHICH HAVE TAKEN PLACE. THE SMALL NUMBER OF RESIDENTS ALLOWS FOR STAFF TO HAVE A THOROUGH KNOWLEDGE OF RESIDENTS CARE AND NEEDS. STAFFING IS UNDER CONSTANT REVIEW.

THERE IS A CLEARLY DEFINED MANAGEMENT STRUCTURE IN PLACE AND ROLES HAVE BEEN CLEARLY SPECIFIED. THERE ARE JOB DESCRIPTIONS ONSITE FOR ALL MEMBERS OF STAFF WHICH CLEARLY DEFINE THEIR ROLES. ARRANGEMENTS ARE IN PLACE TO ENSURE AN EFFECTIVE AND REGULAR CLEANING ROUTINE AND ADDITIONAL ADMINISTRATION, CHEF AND CLEANING HOURS HAVE BEEN ALLOCATED. TRAINING HAS ALSO BEEN SOURCED.

ALL OUR LAUNDRY IS OUTSOURCED.

THERE IS A WASTE MANAGEMENT SYSTEM IN PLACE WHICH COMPLIES WITH THE POLICY OF EXTERNAL CONTRACTOR (BARNA WASTE).

REFURBISHMENT HAS BEEN ONGOING SINCE OCTOBER 2018 AND CONTINUES IN THE NURSING HOME.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
THE FLOOR PLAN HAS BEEN ADDED TO THE STATEMENT OF PURPOSE. A DESCRIPTION OF THE ROOMS IN ALL PARTS OF THE CENTRE INCLUDING SIZE AND PRIMARY FUNCTION IS OUTLINED.

ADMISSION PROCEDURES ARE OUTLINED IN THE STATEMENT OF PURPOSE. WE DO NOT TAKE EMERGENCY ADMISSIONS.

WHOLE TIME EQUIVALENTS FOR STAFF HAVE BEEN ADDED.

EMERGENCY PROCEDURES FOR THE DESIGNATED CENTRE HAVE BEEN ADDED.

THERE ARE ARRANGEMENTS IN PLACE FOR CONSULTATION AND PARTICIPATION OF RESIDENTS IN THE OPERATION OF THE CENTRE AND RECORDS OF THESE MEETINGS ARE ON SITE.

COMPLAINTS MANAGEMENT HAS BEEN REVISED AND IS IN PLACE.

PEEPS IDENTIFIED THE NEED FOR 7 WHEELCHAIRS AND THESE ARE NOW IN PLACE.

ALARM ZONING AND FIRE PROCEDURE NOTICES HAVE BEEN UPDATED AND ARE IN PLACE.

FIRE RATED GLASS HAS BEEN ORDERED FOR THE GLAZED PANEL AND THIS WILL BE REPLACED BY 31ST JANUARY 2019.

CARE PLANS HAVE BEEN UPDATED AND WILL BE REVIEWED ON A FOUR MONTHLY BASIS OR EARLIER IF ANY ACUTE CHANGES TAKE PLACE.

CLEANING SCHEDULES ARE NOW IN PLACE. INFECTION CONTROL TRAINING HAS BEEN SCHEDULED FOR 7TH FEBRUARY 2019. ALL LAUNDRY IS OUTSOURCED.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
SIGNAGE HAS BEEN ACTIONED AND ONCE DOORS HAVE BEEN PAINTED THESE WILL BE PUT IN PLACE. SIGNAGE FOR TOILETS ARE IN PLACE. COMPLETION DATE 31ST JANUARY 2019

DESIGNATED CLEANING HOURS HAVE BEEN APPOINTED WITH IMMEDIATE EFFECT.

THERE ARE GRAB RAILS IN PLACE IN ALL TOILET AREAS.

THE HAND RAILS REQUIRED HAVE BEEN ORDERED AND WILL BE MOUNTED AS SOON AS DELIVERED, COMPLETION DATE 31ST JANUARY 2019.

THERE ARE CURTAIN SCREENINGS IN ALL SHARED ROOMS TO ENSURE PRIVACY.

STORAGE HAS BEEN REVIEWED IN THE KITCHEN AREA AND ONLY DRY LIQUIDS ARE USED FOR CLEANING.

THERE IS ADEQUATE STORAGE FOR LINEN, RECORDS AND EQUIPMENT IN THE CENTRE.

EXTRA WHEELCHAIRS HAVE BEEN PURCHASED.

THERE IS A SLUICE FACILITY AVAILABLE.

LAUNDRY FACILITES ARE NOT REQUIRED AS ALL OUR LAUNDRY IS.

TEN NEW PRESSURE RELIEVING MATTRESSES HAVE BEEN PURCHASED.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
RESIDENT PHYSIOTHERAPIST HAS UPDATED RISK ASSESSMENTS. NEW DINING ROOM CHAIRS HAVE BEEN ORDERED, EXPECTED DELIVERY 22ND FEBRUARY 2019.

FOUR EXTRA WHEELCHAIRS HAVE BEEN PURCHASED.

HAND SANITISERS HAVE NOW BEEN MOUNTED ON WALLS.

SHARPS CONTAINER IS KEPT IN A SECURED AREA OUT OF SIGHT OF RESIDENTS.

ALL LEADS IN USE HAVE BEEN RISK ASSESSED.

ELECTRICAL INSPECTION HAD BEEN CARRIED OUT ON 5TH NOVEMBER 2018 AND ALL ELECTRICAL WORKS IDENTIFIED IN THE REPORT HAVE BEEN COMPLETED.
SERVICE CONTRACTS HAVE BEEN IMPLEMENTED FOR THE BEDS.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
DAILY, WEEKLY AND MONTHLY CLEANING SCHEDULES ARE NOW IN PLACE AND AVAILABLE FOR INSPECTION.

DESIGNATED CLEANING HOURS HAVE BEEN APPOINTED WITH IMMEDIATE EFFECT. CLEANING SCHEDULES ARE IN PLACE AND COMPLETED.

SEGREGATION OF LINEN IS IN PLACE. ALL OUR LAUNDRY IS OUTSOURCED.

EXCESS LINEN IS STORED IN OUR LAUNDRY PREMISES AS PER FIRE SAFETY

RECOMMENDATION.

THERE IS A WASTE MANAGEMENT SYSTEM IN PLACE WHICH COMPLIES WITH THE POLICY OF AN EXTERNAL CONTRACTOR (BARNA WASTE)

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: ALL ESCAPE ROUTES HAVE BEEN CLEARED OF FURNITURE. EGRESS AND ACCESS HAS BEEN REVIEWED AND IS COMPLIANT WITH REGULATION 28.

INSPECTION CERTS FOR ELECTRICIAL INSTALLATION ARE AVAILABLE

RESOURCES HAVE BEEN PUT IN PLACE FOR EVACUATION PROCEDURES REQUIRED BY THE CENTRE

THE LOCATION OF COMPARTMENTATION WITH THE APPROPRIATE FIRE RESISTING DOORS HAS BEEN IDENTIFIED AND WILL BE PROVIDED BY 31ST MARCH 2019. THE REQUIRED FIRE RESISTING DOORS TO THE PROTECTED CORRIDOR HAVE BEEN PROVIDED AND WE ARE PREPARING A WORKABLE PLAN IN CONJUNCTION WITH THE ADVICE AND GUIDANCE OF OUR EXPERT FIRE CONSULTANT.

MARTSON LIMITED FIRE SAFETY ENGINEERING AND TRAINING HAVE BEEN RETAINED AS TECHNICAL FIRE SAFETY ADVISOR TO REVIEW THE PREMISES IN RELATION TO FIRE SAFETY PRECAUTIONS.

TRAINING PROGRAMME IS IN HAND AND ADDITIONAL FIRE TRAINING WILL BE COMPLETED BY 24TH JANUARY 2019. SUITABLE TRAINING WILL BE PROVIDED EVERY YEAR AS REQUIRED.

ALL STAFF HAVE BEEN TRAINED AND THE RESOURCES PUT IN PLACE FOR EVACUATION PROCEDURES REQUIRED BY THE CENTRE.

WEEKLY CHECKS ON FIRE DETECTION AND FIRE ALARM SYSTEM ARE COMPLETED AND RECORDED. TESTING OF FIRE EQUIPMENT WILL BE CARRIED OUT BY STAFF OR BY SPECIALIST CONTRACTORS AS APPROPRIATE.

FIRE ALARM TEST LOG NOW COMPLETED.

SIMULATED NIGHT DRILL WAS CARRIED OUT ON 10TH NOVEMBER 2018 AND 18TH JANUARY 2019 AND RECORDED IN FIRE REGISTERS

ALARM SYSTEM IS AN L1 SYSTEM.

LINEN PRESS HAS BEEN DECOMMISSIONED. ALL EXCESS LINEN IS STORED IN OUR LAUNDRY PREMISES.

ZONED FLOOR PLAN IS NOW IN PLACE AT THE FIRE PANEL.

WE INSTALLED AN AUTOMATIC DIALLER ON 3RD JANUARY 2019 WHICH IS CONNECTED TO AN EXTERNAL MONITORING STATION, THE PREMISES IS PROTECTED BY AN L1 APOLLO ADDRESSABLE FIRE ALARM SYSTEM. ALL STAFF HAVE BEEN INFORMED OF THIS AND THE SYSTEM HAS BEEN DEMONSTRATED TO THEM.
ARRANGEMENTS HAVE BEEN PUT IN PLACE FOR THE SAFE PLACEMENT OF RESIDENTS AND FOR THEIR EVACUATION WHERE NECESSARY. ALL STAFF ARE AWARE OF THESE ARRANGEMENTS.
PEEPS PLANS AND STATEMENT OF PURPOSE HAVE BEEN UPDATED.
A SYSTEM OF HORIZONTAL EVACUATION BEST SUITS OUR NEEDS, THERE ARE STILL SOME ISSUES TO BE RESOLVED. AS PREVIOUSLY MENTIONED WE ARE CURRENTLY DEVISING A SUITABLE AND WORKABLE PLAN. MANY MEASURES HAVE ALREADY BEEN UNDERTAKEN SUCH AS STAFFING LEVELS, EQUIPMENT, EMERGENCY LIGHTING, AUTOMATIC FIRE DETECTION, PROTECTED CORRIDOR, ASSEMBLY POINT, DOOR OPENING AND STAFF TRAINING. OUTSTANDING MEASURES SUCH AS COMPARTMENTATION ARE IN HAND. IT IS ACKNOWLEDGED THAT FURTHER STAFF TRAINING WILL BE NEEDED WHEN THE COMPARTMENTATION FOR EVACUATION PURPOSES HAVE BEEN IMPLEMENTED.
FOUR EXTRA WHEELCHAIRS HAVE BEEN PURCHASED AND THERE ARE NOW SEVEN WHEELCHAIRS ONSITE.
SUMMARISED SCHEDULE OF PEEPS HAS BEEN AMENDED TO REFLECT THE INDIVIDUAL PEEPS DOCUMENTS.

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	21/01/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	28/02/2019
Regulation 17(1)	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	Not Compliant	Orange	31/01/2019

	the statement of purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/01/2019
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/01/2019
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	31/01/2019
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details	Not Compliant	Orange	05/01/2019

	responsibilities for all areas of care provision.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	05/01/2019
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.	Substantially Compliant	Yellow	31/01/2019
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	31/01/2019
Regulation 26(1)(b)	The registered provider shall	Not Compliant	Orange	28/02/2019

	ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.			
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	31/01/2019
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Substantially Compliant	Yellow	31/01/2019
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	31/01/2019
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in	Substantially Compliant	Yellow	31/01/2019

	Schedule 5 includes the measures and actions in place to control aggression and violence.			
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Substantially Compliant	Yellow	31/01/2019
Regulation 26(1)(d)	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.	Substantially Compliant	Yellow	31/01/2019
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/01/2019
Regulation 28(1)(c)(i)	The registered provider shall make adequate	Not Compliant	Orange	18/12/2018

	arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	18/12/2018
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	18/12/2018
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Red	24/01/2019
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety	Not Compliant	Orange	24/01/2019

	management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	18/12/2018
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Orange	18/12/2018
Regulation 28(2)(iii)	The registered provider shall make adequate arrangements for calling the fire service.	Not Compliant	Red	18/12/2018
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	18/12/2018
Regulation 03(1)	The registered provider shall prepare in writing a statement of	Not Compliant	Orange	31/01/2019

	purpose relating to the designated centre concerned and containing the information set out in Schedule 1.			
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	31/01/2019