Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Tralee Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Teile Carraig, Killerisk Road, Tralee, Kerry
Type of inspection:	Unannounced
Date of inspection:	25 February 2019
Centre ID:	OSV-0000566
Fieldwork ID:	MON-0024476

About the designated centre

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

Tralee Community Nursing Unit is a designated centre located in the urban setting of the town of Tralee. It is registered to accommodate a maximum of 43 residents. It is a single-storey facility set on a large site. Residents' bedroom accommodation is set out in two units, Lohar unit with 22 beds and Dinish unit with 21 beds. Each unit is self-contained with a dining room, kitchenette, day room and comfortable seating throughout the units; each unit has an enclosed courtyard with garden furniture seating and tables, raised flower beds and shrubbery and paved walkways. Bedroom accommodation comprised single, twin and multi-occupancy wards, all with wash-hand basins, some had shower, toilet and wash-hand basin en suite facilities. There were additional shower and toilets and a bath room in each unit. The Rose Café is located at the entrance to the centre with café style seating and a seasonal life-size display as decoration; calligraphy adorned the pillars of the café. The atrium was a large communal space located between the two units with comfortable seating, where the group activities were held. The activities room with situated off the atrium. The ladies and gents 'Finishing Touches' hair salon, 'Oifig and Phoist' and 'Treasure Trove' had shop frontage of a bygone era as decoration. The quiet visitors room was located between both units. The oratory was situated on the corridor by the main entrance. Tralee Community Nursing Unit provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Current registration end date:	19/06/2021
Number of residents on the date of inspection:	42

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:

Date	Times of Inspection	Inspector	Role
25 February 2019	09:20hrs to 18:30hrs	Breeda Desmond	Lead
26 February 2019	08:20hrs to 16:00hrs	Breeda Desmond	Lead

Views of people who use the service

The inspector met with several residents and three relatives throughout the inspection. One resident said that due to the care, attention and love, she walked again following a significant injury. She gets up in her own time in the morning and makes a cup of tea in the dining room. She highlighted the encouragement that the activities co-ordinator gave her and all the residents. Satisfaction questionnaires were completed and feedback was positive regarding food and meal times and staff.

Capacity and capability

There were several areas of non compliance identified in the previous inspection, and while there were some improvements noted on this inspection, overall, the service required better oversight to ensure that the care delivered reflected the person-centred approach described in the statement of purpose. The non compliance noted on the inspection findings of January 2018, resulted in this service being registered with an additional restrictive condition, Condition 8 - The provider shall address the regulatory non compliance as outlined in the action plan dated 15 March 2018 to the satisfaction of the Office of the Chief Inspector no later than 30 June 2018. The purpose of this condition was to ensure that the registered provider at all times operated the designated centre in compliance with the regulations.The findings of non compliance noted on this inspection indicate that the provider was operating the designated centre in breach of this condition.

There was a clearly defined management structure with defined lines of accountability and responsibility for the service. The newly appointed clinical nurse manager (CNM2) took up post on the day of inspection. She formed part of the management team that supported the person in charge. The general manager attended the centre on a monthly basis; the project officer in clinical development supported the service in areas such as policy review, dementia awareness programme, resident care documentation, and person-centred support programmes.

Improvements noted included:

- additional staff on duty on both units in the afternoon and twilight hours
- a full time rehabilitation activities co-ordinator
- development of an activities programme that reflected the choices and interests of residents
- appointment of a CNM2

However, the findings from this inspection demonstrated deficits in the overall

governance and management of the service as evidenced by:

- inadequate resources to ensure the effective delivery of care in accordance with the statement of purpose, for example, lack of a catering supervisor to support catering staff
- poor staff supervision to ensure the service provided was safe, appropriate and consistent and these are discussed in detail in regulations relating to meals and mealtimes, residents' rights, assessment and care planning documentation, infection prevention and control
- the annual review for 2018 was not in place
- poor understanding of the audit process; practice did not form part of audits such as medication management; mealtimes were deemed as protected even though medication rounds were completed during meals
- necessity to request vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for all staff to be on site
- records and documents, as required in Schedules 1, 2, 3, 4 and 5 were not comprehensive, current or maintained in line with professional best practice guidelines
- poor understanding of the power differential between vulnerable adults and their dependent relationship with care givers.

In conclusion the findings of this inspection were that the HSE had failed to take the necessary action to strengthen the governance and management of this centre for the purpose of improving the quality of life for residents and supporting the staff on the ground in striving to achieve greater regulatory compliance.

Regulation 14: Persons in charge

The person in charge was a qualified nurse and had the necessary experience of nursing older people. She was full time in post.

Judgment: Compliant

Regulation 15: Staffing

Staff levels had increased on both units in the afternoon and evening times to facilitate better choice for residents to stay up for longer as per their feedback in satisfaction surveys completed.

While there were catering staff on site to assist with meals and mealtimes, catering was outsourced and this is discussed under regulation 18 Food and Nutrition. Catering staff spoken with were very knowledgeable regarding their roles,

responsibilities, residents' dietary requirements and textured diets.

Judgment: Compliant

Regulation 16: Training and staff development

Overall, there was a lack of staff supervision as identified in several regulations throughout this report, for example, residents' rights, food and nutrition, and infection prevention and control.

While staff had received training regarding behavioural communication documentation, this was not being used by staff to help establish causes and possible interventions to prevent or alleviate stressful situations for residents. Staff had completed end of life care, 'let me decided' and advanced care directives but care documentation reviewed suggested that some staff did not understood what was being taught; audits of care documentation did not identify these issues.

Judgment: Not compliant

Regulation 21: Records

Medication administration records were not maintained in line with professional guidelines best practice. Review of medication audits highlighted that documentation was audited, but practice was not.

While a record of PRN psychotropic usage was put in place, these records were not resident specific, that is, there were several entries on a single page; these records were not maintained appropriately in accordance with Schedule 3.

A sample of staff files reviewed showed that employment histories were not comprehensive for the files reviewed. Nursing certification was not in place for one staff member, two written references including a reference from a person's most recent employer was not in place.

Vetting disclosures for all staff in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were not on site at the start of the inspection. These were requested and were on site for all staff before the end of the inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The annual review for 2018 was not available at the time of inspection. The statement of purpose had not been updated following the last registration inspection to reflect the new conditions of registration including the restrictive condition and the registration date.

Audits undertaken included clinical, non clinical and social questionnaires. There were six types of quality of life questionnaires, for example, meal times, work culture observation, and social and recreational satisfaction surveys. One of the questions in the meals and mealtimes survey queried whether there was any inappropriate activities such as cleaning or ward rounds during residents meal time and a second asked whether meal times were protected. These were answered 'no' and 'yes' respectively. The inspector observed that medication rounds were all undertaken during mealtimes of breakfast, lunch and tea, indicating that meal times were not protected and staff did not consider completing a drug round at meal time as inappropriate. Practice did not always form part of the audit process, for example, medication management reviewed documentation and not medication administration rounds. It was proposed to commence the work culture observational tool, this had not commenced.

Many residents had just a single wardrobe for their clothes; it was reported to the inspector that residents could ask for additional wardrobe space if they wished, indicating that there was poor insight into the essence of person-centred care.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose had not been updated or maintained in compliance with the regulations. It was updated on inspection to reflect the actual accommodation available to residents, the registration details including the current date of registration, expiration date and the conditions of registration (1 -8).

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications were timely submitted in compliance with the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Complaints were recorded in line with the requirements set out in the regulations. Residents and relatives gave feedback indicating they could raise issues and that they would be addressed in a timely manner. The complaints procedure was displayed throughout the centre.

Judgment: Compliant

Quality and safety

Some practices observed showed that staff were attentive, kind and gentle, while other staff practices were task-orientated institutionalised behaviour with little or no positive meaningful engagement. This was evidenced when a member of staff insisted (at 08:30hrs) on waking up a resident to have their breakfast even though the staff had been told that the resident was cosily tucked up in bed asleep. Several issues identified, and practice observed, did not respect residents' human rights, for example, one resident was left uncovered when a staff member left their bedroom; several more examples were given in Regulation 9, Residents' rights.

Residents gave positive feedback regarding the improvement in their activities programme and encouragement to participate in activities.The rehabilitation activities co-ordinator discussed the activities programme and highlighted the importance of getting to know each individual in order to develop an activities programme to suit their needs. She outlined that she incorporated activities with rehabilitation to maximise the benefit to residents. She worked with the physiotherapist and occupational therapist and was involved with residents' assessments to develop a rehabilitation or activities programme tailored to their individual needs. She was full time in the centre and this enabled her to continue the rehabilitation programme throughout the week. She visited each resident in their bedrooms and encouraged activities such as hair brushing, oral hygiene, putting on cardigan or shoes as part of maintaining independence and rehabilitation. She encouraged residents to use the recently acquired terra bikes, to join the group activities in the morning and afternoons. Observation on inspection showed that residents enjoyed the one-to-one sessions and the group sessions and actively participated. Daily national news papers were provided as well as local papers and

magazines and news paper reading was part of the one-to-one and group sessions.

At the time of inspection the atrium was decorated for the six nations rugby tournament and St Patrick's day. The Rose Café had decorations from St. Valentine's day. Photographs of residents participation were displayed following each event.

Activities included music sessions which were facilitated by staff, residents, family members and volunteers; other activities included painting, baking, knitting, crochet, dog therapy, sonas and imagination gym. Photographs were displayed by the atrium of residents mixing their Christmas puddings, painting and enjoying pet therapy. One resident was playing the accordion in one day room, a staff member playing the guitar and singing on the first day of inspection, and a staff member played the concertina on the second day of inspection. Residents sang their favourite songs and it was clear that this was a regular session, and the session ended with a rousing rendition of Amhran na bhFiann, the national anthem.

Residents forum was held every two months and minutes showed that lots of issues were discussed. The relatives forum met quarterly. However, these minutes showed a paternalistic approach to decision making with decisions taken by management rather than discussing concerns with residents.

While the premises was warm and bright, multi-occupancy bedrooms did not afford adequate space for residents to have a bed-side chair to relax and maybe watch TV; personal storage space was inadequate to meet the needs of residents. The community physiotherapy clinic continued to be facilitated within the Lohar unit which impacted peoples' privacy and confidentiality.

A sample of residents care plans and assessments reviewed showed some had person-centred information to inform individualised care and support, however, others had generic information with little or no insight into the person's wishes. This also pertained to residents' end of life care plan documentation. There were no behavioural support plans to trend and identify issues that may have triggered a resident's behaviour. Records of PRN psychotropic were not maintained in line with legislation; this was a repeat finding.

While fire drills and evacuation training was conducted on a regular basis, records maintained did not reflect the practice described. While there was guidance regarding fire evacuations it was not centre-specific and contained little detail to inform staff in the event of a fire. Many rooms with chemicals, sharps and clinical waste were not secured to protect residents and prevent unauthorised entry. Infection prevention and control practices observed were not in keeping with best practice guidelines. The safety statement was not updated on an annual basis in line with best practice guidelines.

Residents gave positive feedback regarding their meals and the quality of meals and choice. However, residents' requiring textured diets were not afforded any choice. The presentation of textured diets required attention to make them visually appealing.

Overall the quality and safety of care in this centre required significant review to

improve the quality of life of residents living there.

Regulation 11: Visits

There was an open visiting policy and visitors seen throughout the day and evening. Visitors were made welcome and were known to staff.

Judgment: Compliant

Regulation 12: Personal possessions

The inspector was informed that additional surplus wardrobes were re-distributed so that each resident had access to more than a single wardrobe. However, many single occupancy and some twin bedrooms had a single wardrobe for each residents. Some staff understood this to be adequate space to store and maintain a resident's clothes and other personal possessions even though residents' incontinence wear was also stored in this meagre space. Staff advised that residents could ask for additional wardrobes if they wished.

Judgment: Not compliant

Regulation 13: End of life

A sample of care plans reviewed showed there appeared to be very little understanding of spirituality and end of life care, and the importance of seeking peoples' wishes. Staff spoken with did not appear to understand the significance of trying to elicit this information while residents' were well enough. Information recorded was generic and while there was some narrative it did not reflect the possible spiritual needs of the resident; the information included was more relevant to social and recreational support.

Judgment: Not compliant

Regulation 17: Premises

The premises was warm and bright. There were several occasional seating areas throughout and residents and visitors were observed enjoying these areas. Residents had access to two enclosed courtyards. Residents' survey identified that one entrance to the courtyard was difficult to access with a wheelchair and this issue was referred to maintenance department.

Residents' bedroom accommodation comprised single (19), twin (two) and multi-occupancy rooms (five x four-bedded). While single rooms were adequate to meet the needs of residents, bedside chairs could not be facilitated beside all beds in multi-occupancy rooms. This was a repeat finding. While effort was made to display photographs and art work, there was very limited space in these rooms to truly personalise them. Feedback given in residents surveys highlighted that people would like more space, that areas were cluttered, and they would like space for their pictures.

The community physiotherapy clinic continued to be facilitated in Lohar unit. While the waiting area for the physiotherapy clinic was outside the unit, people had to come into Lohar unit to access the clinic, impacting residents' privacy and confidentiality.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents had good access to speech and language therapy and dietician specialist. Residents gave positive feedback regarding their meals and variety of choice. All meals came from the acute care hospital's main kitchen. While choice was available for specialist diets, they could not provide choice with textured diets. This was a repeat finding. Presentation of textured meals required review to ensure they were more visually appealing. While menus were available they were not in an accessible format or accessible to residents.

Judgment: Not compliant

Regulation 26: Risk management

Several rooms such as the equipment room, sluice room and the cleaner's room were either unlocked or the locks were broken enabling unauthorised access to items such as sharps, clinical waste and chemicals. The lock to the sluice room was repaired following the inspector reporting it, however, it was not repaired effectively

as some staff fobs did not work.

While residents had personal emergency evacuation plans, a photographic identification was not always present in these plans, in line with best practice guidelines.

Implementing the Safety Statement should be an integral part of everyday operations and so it must be relevant at all times. Therefore, it should be revised periodically, at least annually, and whenever significant changes take place, or when risk assessments were carried out and improvements were made that have an impact on safety and health. The safety statement viewed was dated 2018 and for review in 2020.

Judgment: Not compliant

Regulation 27: Infection control

While infection prevention and control audits were completed these dd not identify several infection prevention and control practice issues highlighted on inspection, for example, inappropriate storage of items over the hand wash sink in the sluice room such as urinalysis stick and apparatus for testing stool samples. The hand wash sink in one sluice was inaccessible due to placement of a large box of bedpan inserts and large plastic bag underneath the sink. The sink surround was visibly unclean. Communal toiletries were seen in several areas. There was a large bottle of chlorohexidine disinfectant freely accessible on one bathroom window sill.

Staff were observed carrying uncovered used urinals through the unit to the sluice room, some were not wearing protective gloves.

Staff were observed walking between rooms without removing their protective gloves. While some good hand hygiene was observed, all staff did not complete hand hygiene in line with the World Health Organisation guidelines.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire drills and evacuations were undertaken routinely. New on-line records for fire safety training was in place and this was being updated on inspection as several of the entries had dates of 2017 even though the inspector was assured that all fire safety training was up to date. The fire training officer was on site on second day of the inspection giving a scheduled fire safety training. He advised that all drills and

evacuations simulated night duty staff numbers. While there were four staff on night duty, two on each unit, the evacuations were undertaken with four staff rather than three, as one staff member stayed in the unaffected unit. This protocol was unclear as it was not detailed either in the fire safety instruction guidance document or when talking with staff. The fire training officer agreed to complete all training with three staff rather than four to ensure competencies. While records were maintained of fire drills and evacuations, and times of evacuations, they reflected the number of staff attendees and residents involved in the evacuation, but did not reflect the number of staff involved in each evacuation.

Monthly hydrant flushing records showed that the last check was completed 06/04/2018. The inspector was advised that there were up-to-date records as part of fire safety precautions; while these records were requested they were not seen.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was a new pharmacy supplying the centre. Stock was provided per resident and delivers were made on a daily basis when necessary. Residents had choice if they wished to stay with their own pharmacist supplying their medication. Medication was securely stored in the centre in line with professional guidelines.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Healthcare assistants recorded the activities of daily living, daily narrative regarding resident's status, and appropriate risk assessments to inform care.

Some assessments and care plans had person-centred information to guide individualised care, however, others had incomplete baseline assessments conducted on admission and subsequently. For example, one resident with significant co-morbidities did not have recorded how many people were required to assist them; the records showed that they had a cough but notes did not identify the type of cough; they did not indicate the type of medication or whether the resident had oedema (swelling of the ankles); their personal care plan was generic and gave no indication what the resident would like.

Weights were due to be completed on a monthly basis but records in the sample of care documents reviewed showed these were not comprehensive, and some had recorded that the weighing scales was broken in October 2018. It was reported to the inspector that records of residents' weights were maintained in another folder

which were requested, but these records were not seen by the inspector.

Judgment: Not compliant

Regulation 6: Health care

Residents had timely access to medical services, specialist consultant, dietician, speech and language. Records showed effective oversight of residents' condition, medication management and responses to medications.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The inspector reviewed PRN psychotropic medication records. As records were not maintained per resident and behavioural support accounts were not recorded, there was no association made between the frequency of use of PRN psychotrophic medications and behaviours that challenge to help establish a pattern that may help identify possible causes to the anxiety and improve outcomes for residents.

Judgment: Not compliant

Regulation 8: Protection

The inspector observed lots of positive engagement, positive interaction and encouragement between staff and residents. Nonetheless, the inspector observed breakfast time where all residents had breakfast in bed at 8:20hrs. One resident was asleep and the carer left her tucked up in bed, and the healthcare assistant informed the nurse that the resident was asleep. The nurse went to the resident and insisted that they woke up to have their breakfast. This was reflective of rigid institutional practice that bared no consideration for the resident in bed.

The community physiotherapy clinic continued to be accommodated in the middle of Lohar unit, which impacted their privacy and confidentiality.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents forum was held every two months and minutes showed that lots of issues were discussed. The relatives forum met quarterly. Minutes of these meeting demonstrated that information was relayed regarding many aspects of life and care in the centre. One of the issues recorded was the rationale for cancelling the well organised day trip to Muckross House for residents which included a two-course meal and residents said they were so looking forward to it, was due to lime disease. While a different outing was arranged, it was unbelievable that this event was cancelled for this reason.

Some residents had double wardrobes while many others had a single wardrobe for all their clothes. While there was a surplus of single wardrobes following a delivery of double wardrobes, these were not automatically re-distributed to residents. The inspector was informed that residents' could ask for additional wardrobes if they wished; this demonstrated a fundamental lack of understanding of person-centred care, dementia care, or the vulnerability and power differential of resident and nurse.

There was a lovely small seating area in front of the nurses' station in Dinish unit, however, there were two blood pressure monitors charging here and a third with a 'broken' sign displayed. A large seated weighing scales with big signage 'do not move' was located in a lovely seating area on Loher unit, which took from the setting. This was discussed with staff who showed little insight that communal space was for residents, for their social activities.

Several issues were observed that did not have regard for respecting residents' human rights, privacy and dignity, for example:

- one staff member giving personal care left the resident exposed in bed while leaving the room to get some piece of equipment
- communal toiletries and specialist shampoos on bathroom windows and stored in the equipment room
- cleaning off dining tables while residents were still eating
- there were long delays noted when answering call bells in the morning in both units
- lots of signage on wardrobes regarding residents' laundry arrangements.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: End of life	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Tralee Community Nursing Unit OSV-0000566

Inspection ID: MON-0024476

Date of inspection: 25/02/2019

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. **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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training and development on medication management has been provided by practice development on a weekly basis; March and April 2019. Staff nurses have been reminded of their obligation to maintain comprehensive and accurate records. All nurses will complete HSEland medication management A staff meeting was held on the 26/03/2019 and expectations were outlined as per draft Inspection Report. A Quality Improvement Group has been convened 01/04/2019; this Quality Improvement Group will meet weekly thereafter. A local Action Plan was implemented on the 02/04/2019; directing and facilitating Staff in a number of areas; supervision, rights of residents, meals and mealtimes to incorporate their training and skills in practice; this has been disseminated through daily one to one meetings. Management undertake unscheduled walk-a rounds on a daily basis to address any Quality, Safety and Risk issues as per February 2019 Report. Management will ensure staff have access to their job description, outlining reporting relationships and roles and responsibilities. Management will take measures to support staff. Utilizing HR policies as appropriate.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Management will immediately address any inconsistencies that exist within staff personnel files by undertaking a thorough review of same. Management will write to individual staff members outlining any discrepancies', additional or missing information ensuring each personnel file is in keeping with the Health Act and Regulations. Management will monitor same and maintain Personnel Files as an agenda item at local	

QPS staff meetings.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The completion of the Annual Review 2018 (22/03/2019) Practice Development provided training to 2 additional staff on Work Culture Observations on the 06/03/2019; Management has met with staff in relation to supporting them undertake WCCAT and commencement of same. Work Culture Observations (commenced 29/03/2019) and will continue to take place on a regular basis; (weekly initially) suggestions will form part of an action plan to assist in improving the quality of life and safety for residents. Management will assist staff in applying recommendations and changes in practice. Furthermore overseeing the implementation of suggestions via an action plan; resources; training and development; information sessions for residents and staff as appropriate; action plans will be kept active until completed and signed by relevant people. A Protected Mealtimes and Guidance for Assistance with Meals is in place in Tralee Community Nursing Unit; Staff will be asked to read and sign the PPPG. Item on Agenda at Staff Meetings 26/03/2019 and thereafter. Staff informed Quality, Safety and Risk management policy and procedures; outlining their role and responsibility. Incident reporting process and investigation. These measures will initially be communicated to staff as part of a Quality Improvement Initiative and Action Plan. Additional wardrobes have been distributed to residents 09/04/2019 Action Plan to be completed by 15/04/2019 Time scale 16/04/2019	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: Additional wardrobes distributed to residents by 09/04/2019 Excessive storage of incontinence wear has been removed from the wardrobes. Daily requirements are replenished daily 29/03/2019. Staff has been informed at a staff meeting that this practice of placing large amounts of continence wear in a resident's wardrobe must stop. 26/03/2019	
Regulation 13: End of life	Not Compliant
Outline how you are going to come into compliance with Regulation 13: End of life: Training and Development for documentation has been provided by Practice Development in 2018; this will continue in 2019.	

It will be mandatory for each nurse to attend. This training facilitates nurses in ensuring that nurses have an understanding of each of the Activities of Daily Living.
The CNM2 and PIC is available to assist and support nurses with documentation.
PPPG available for Staff Nurses to read and sign the declaration of understanding.
Information sessions in person centered care to incorporate End of Life Care

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The PIC will maintain and update the Statement of Purpose periodically and at least annually, 25/02/2019.

The 4 bed environment will be reviewed with a view to placing a chair at each bedside.

This has been referred to the Physiotherapy Manager and a plan for relocation is in place date to be confirmed.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The issues highlighted with Food and Nutrition; meals and mealtimes will be addressed through a working group. The existing menus will be updated to reflect the food options / choice provided by UHK.
An action plan will be put in place and overseen by Management.

Work Culture Observation completed 29/03/2019; suggestions will be put in place 12/04/2019. Food and Nutrition; Meals and Mealtimes practices will continue to be monitored.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Staff have been reminded of reporting procedures; outlining broken equipment, locks etc in the safety pause. Responsibility to ensure maintenance issues are immediately addressed to CNM2 / PIC and in their absence to Maintenance Department.
Staff have been told that under no circumstances are doors leading to restricted access or high risk environments to be left open or unlocked. This practice is NOT acceptable.
Nurses have been reminded of the importance to supervise daily care, address local issues and report same to management.

Management will enforce quality, safety and risk policies and procedures and take necessary actions to prevent re-occurrence.

Staff have been asked to report any restrictions or ineffective fobs – immediately

26/03/2019.

The doors and fob access controls have been reported to maintenance; and reviewed by maintenance on the 02/04/2017. A service of all fobs and fob access doors has been conducted by ADA security on 04/04/2019.

All residents' emergency evacuation plans will have a photographic identification. The responsible person for updating each resident's PEEP is identified on each unit.

The Safety Statement was last updated on 10th January 2019; this was a typo error and has been corrected. The PIC has reviewed and replaced the Safety Statement 19/03/2019.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Infection Prevention and Control Guidelines are in place in each Unit. Staff have been asked to read and sign the declaration of understanding.
All staff have been asked to complete infection prevention and control training – Hand Hygiene HSE-Land. Breaking down the barriers to Infection HSE-Land to submit certificate for personnel file 17/05/2019.
The 2 onsite Hand Hygiene Assessors will reassess all staff members and submit assessment for personnel file 07/05/2019.

Staff have been reminded of quality housekeeping standards of practice; communal use toiletries are under no circumstances acceptable and toiletries MUST be returned to the residents bedside locker immediately after use. This is an expected safe standard of practice 26/03/2019; and will be included in inspection by Management as part of a quality walk around.

A complete review of domestic / cleaning staff duties and responsibilities has been put in place on 25/03/2019

The domestic supervisor is present on the unit at least 2 times weekly; an environmental audit will be undertaken by the supervisor on a weekly basis commencing on 08/04/2019; feedback will be provided to management and staff. Issues arising will be reported and resolved within a timely manner.

The uniform for Noonan's catering staff member has been changed (as it can lead to confusion for the resident, staff and visitors) 10/04/2019 in place.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A review of the records will take place to ensure the number of staff involved in each fire drill (evacuation) is recorded and the activity of the drill is recorded. This will be clearly

communicated and emphasized to each staff member during fire drill (evacuation) training 30/04/19.
The number of staff that attended a fire drill (evacuation) session will be clearly outlined on a separate record sheet 30/04/19.
The location of monthly fire flushing records will be communicated to all relevant staff 12/04/2019.

The Fire Safety Strategy will be reviewed and updated by 30/04/2019.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Staff nurses informed of the issues outlined under Regulation 5 Individual assessment and care plan; within 48hrs of admission.
The CNM2 will provide support and assistance to nurses; and monitor and review healthcare records. Issues will be highlighted with individual nurses and reported to the PIC.
Practice Development; support structure available and accessible for nurses
Protected Time is facilitated; nurses have been asked to utilise and ensure fulfilment when recording healthcare records.
Record keeping is incorporated in the local action plan; identifying responsibility and accountability for managing each resident's individual assessment and care plan.
Audit of the Individual assessment and care plan and reassessment to ensure record keeping relates to practice.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The CNM2 will monitor and audit psychotropic medication management and ensure that documentation of same is maintained per individual residents
The ABC charts, behavioural support and care plans will be completed in accordance with policy.
The PIC will conduct a monthly trend analysis of behavior supports, psychotropic medication usage and incidents or episodes to commence 01/04/2019.
Staff nurses will be involved in team discussions, across relevant multidisciplinary team members to ensure a full plan of care and supports are in place reviewed during 3 monthly reassessment or if otherwise indicated 30/04/2019.
Staff to read Restrictive Practices Policy (Restraint National Policy) and sign the declaration of understanding

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Staff have been directed to ensure that residents are facilitated to allow a natural awakening as part of person centred care 01/04/2019.
There is a system in place for facilitating resident's wishes or needs to have meals at different times of the day; staff have been reminded of this and informed that this must be adhered to same 26/03/2019.
Staff to read Safeguarding Vulnerable Adults Policy and Information Sessions provided to staff as part of Quality Improvement;
Measures will be employed invoking HR policy to ensure the rights of residents are protected.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Staff have been directed to ensure that residents are facilitated to allow a natural awakening 26/03/2019.
There is a system in place for facilitating resident's wishes or needs to have meals at different times of the day; staff has been reminded of this and informed that this must be adhered to same 26/03/2019.
Significant work undertaken in 2018 through the Cultured transformational club addressed issues (activities) this will be revisited as part of the action plan 01/04/2019.
Environmental workplace observation to be carried out 12/04/2019
The issues outlined specific to respecting residents rights, privacy and dignity highlighted at staff meeting 26/03/2019.
Safeguarding vulnerable adults policy – information sessions and HSE-Land training.
The PIC to conduct walk-around to address any real-time practice issues with staff 01/04/2019.
Issues outlined pertaining to storage of toiletries, communal toiletries are not permitted each resident has their own in accordance with policy (to be enforced 01/04/2019).

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 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Not Compliant	Yellow	09/04/2019
Regulation 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of	Not Compliant	Orange	03/05/2019

	the resident concerned are provided.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	15/04/2019
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 the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	28/02/2019
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	31/10/2019
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Yellow	24/05/2019
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	Not Compliant	Orange	26/04/2019

	the Chief Inspector.			
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	16/04/2019
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.	Not Compliant	Orange	22/03/2019
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	03/05/2019
Regulation 27	The registered provider shall ensure that	Not Compliant	Orange	17/05/2019

	procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	12/04/2019
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	Yellow	30/04/2019
Regulation 5(2)	The person in	Not Compliant	Orange	30/04/2019

	charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	30/04/2019
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/04/2019
Regulation 7(1)	The person in charge shall	Not Compliant	Orange	01/05/2019

	ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	01/05/2019
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	17/05/2019
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Not Compliant	Orange	30/04/2019