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:	Carlow District Hospital
Name of provider:	Health Service Executive
Address of centre:	Athy Road, Carlow
Type of inspection:	Unannounced
Date of inspection:	22 March 2019
Centre ID:	OSV-0000553
Fieldwork ID:	MON-0026697

About the designated centre

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

Carlow District Hospital is located on a large health campus on the Athy road in Carlow town. The centre provides short-term accommodation for 17 male and female residents in six single bedrooms, one three bedded bedroom and two four bedded bedrooms at ground floor level throughout. All bedrooms have full en suite facilities. The centre provides care and support for residents with respite, transitional/convalescence and general palliative care needs. Beds are allocated on a needs basis. The centre currently employs nursing staff, care staff, catering and household staff. A discharge plan is initiated with each resident and their family either prior to or on admission and is reviewed and updated on an on-going basis to discharge. If a resident requires long term nursing care, the Common Summary Assessment Report (CSAR's) form is completed and submitted following consultation with the resident/representative. Following discharge by the Medical Officer, the resident is placed appropriately and the necessary services are informed.

The following information outlines some additional data on this centre.

Current registration end date:	22/11/2020
Number of residents on the date of inspection:	12

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
22 March 2019	09:00hrs to 17:00hrs	Catherine Rose Connolly Gargan	Lead

Views of people who use the service

Residents who spoke with the inspector expressed high levels of satisfaction with the service provided. They said the availability of a place for short term term care was an invaluable to them. Residents expressed the importance of the service in the context of convalescing and respite as being hugely important in maintaining their independence and relieving carers at home. Residents told the inspector that the palliative care service provided was of a high standard and the centre was renowned throughout the local community for this valuable service. Residents said they loved coming to stay in the centre and some said that the service they received was better than any holiday they had been on. Residents said they felt happy and safe in the centre and staff were exceptionally caring towards them.

Residents knew the person in charge and stressed they had no complaints but were aware they could make a complaint if they wished to do so. Residents knew they had a care plan and said staff discussed with them any changes to their health and social care needs. All residents spoken to informed the inspector that they were staying in the centre for short periods and confirmed their overall satisfaction with this arrangement. Residents spoke positively about the activities provided and how they were able to exercise choice with all aspects of living in the centre.

Capacity and capability

This was an unannounced inspection to monitor ongoing compliance with the Regulations. The provider was not in compliance with six regulations on the last inspection in August 2018 and submitted a compliance plan to address each area of non compliance. The inspector found on this inspection that the provider had progressed but not sufficiently completed the actions proposed to bring the centre into compliance in relation to fire safety, risk management and premises. These ongoing non-compliances continued to have a negative impact on the safety and comfort of residents.

The overall governance, management and oversight of the service by the provider was weak. There was failure by the provider to sustain compliance and to bring the centre into compliance with the Regulations since the last inspection.

The local clinical management team, overseen and led by the person in charge ensured residents received a good standard of health and social care. Procedures for monitoring the quality and safety of the service and residents' quality of life were in place but required improvement to ensure these systems informed a continuous quality improvement agenda.

The person in charge worked on a full time basis and was supported on a day to day basis by an assistant director of nursing. The person in charge and assistant director of nursing had responsibility for two designated centres, Carlow District Hospital and Sacred Heart Hospital. Both designated centres are located on the same site. The provider representative did not regularly attend the centre. This arrangement did not ensure issues that arose were addressed by the provider in a timely manner or that required actions to bring the centre into compliance with the Regulations were progressed. While all complaints were satisfactorily addressed to the satisfaction of complainants, the complaints process required clarification.

There were sufficient staffing resources provided to ensure the delivery of safe and good quality care to the residents. All staff were facilitated to attend mandatory training such as safeguarding, fire safety and moving and handling training in addition to professional development training.

Assurances that each staff member working in the centre were appropriately vetted in accordance with the National Vetting bureau (Children and Vulnerable Persons) Act 2012 were available in the centre.

An annual review of the quality and safety of care delivered to residents had taken place for 2018. A satisfaction survey with a small number of residents had been completed, the results of which indicated good satisfaction levels with the service provided.

Regulation 15: Staffing

There was sufficient staff with appropriate skills to meet the assessed individual and collective needs of residents in the centre. The inspector observed that residents were appropriately supervised and staff attended to their needs without delay.

A planned and actual staff duty rota was available.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge maintained a record of staff training which was made available to the inspector. Staff were facilitated to attend mandatory and a range of professional development training to support their skills and knowledge with caring for residents in the centre.

The person in charge completed annual appraisal with all staff. Staff were appropriately supervised according to their role.

Staff who spoke with the inspector confirmed that they were well supported by senior staff.

Judgment: Compliant

Regulation 21: Records

A sample of staff files were examined by the inspector and were found to meet the requirements of the Regulations. An Garda Siochana vetting disclosures were available in the staff files examined. The provider representative gave assurances to the inspector that all staff had completed satisfactory vetting in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and their staff files on-site contained the necessary disclosure documentation.

Records of simulated day-time emergency evacuation drills and testing of fire equipment were maintained.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management structure was clearly defined. The person in charge of the centre was also the person in charge of another designated centre, located on the same site. The inspector found that local governance and management of the service was good, however oversight by the provider was not satisfactory. There was limited evidence of the provider representative attending the centre and no evidence of a formal meeting structure with the local management team. The inspector was told that this was already identified as an area for improvement and appropriate arrangements were put in place going forward.

Local management meetings were held at regular intervals by the person in charge with the centre's local clinical management team. Agenda items for discussion included audits, risk management, complaints and staffing among other items regarding the quality and safety of the service and quality of life for residents.

Systems were in place to monitor the quality and safety of the service and the quality of life for residents in the centre. Key care performance indicators were monitored and details of incidents of responsive behaviours, falls by residents, infections, complaints, pressure ulcer development, weight loss among others were collated by the person in charge every 24 hours. For the most part, data collated through auditing was analysed and action plans were developed. However some improvement was necessary to ensure auditing procedures informed continuous quality improvement. For example, completion of identified

improvements was not assured as timescales, persons responsible and completion dates were not consistently identified as part of this process. There was also limited evidence that the improvements identified were reviewed or progressed by the provider. For example, areas identified on previous inspections in relation to residents' safety, which had been escalated by the local management team to the maintenance department were not yet progressed.

A report detailing an annual review of the quality and safety of the service and quality of life for residents was done in consultation with residents and was available for 2018.

Judgment: Not compliant

Regulation 3: Statement of purpose

The centre's statement of purpose contained the information required under Schedule 1 of the Health Act (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The statement of purpose clearly described the management structure, the facilities and the service provided.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a low number of complaints made regarding the service provided. A record of all complaints was maintained. The records evidenced that complaints were documented, investigated and the outcomes were recorded. Complainants were notified of the outcome of their complaint and the complaint log recorded whether or not they were satisfied. Residents who spoke with the inspector confirmed that were aware they could make a complaint regarding any dissatisfaction they experienced with the service.

A policy was available to inform the complaints' process. While the person in charge confirmed that she received all complaints that could not be resolved locally, this key role was not identified. The procedure for making a complaint including the procedure for appeals if dissatisfied with the outcome of investigation of complaints was not clearly displayed.

Judgment: Substantially compliant

Quality and safety

The centre premises is at ground floor level throughout. The centre is located on a large health care complex. An out-of-hours GP service and an out-patient physiotherapy department are located separate to residents' accommodation but within the same building. The centre premises was well maintained, visibly clean, spacious and bright. Residents' accommodation in the centre comprised of seven single bedrooms, two bedrooms with four beds and one bedroom with three beds. All bedrooms had full en-suite toilet and washing facilities. The design and layout of the premises generally met residents needs, as the average length of their residency in the centre was short. However, windows in residents' bedroom doors required review to ensure their privacy was protected. The absence of a bath for residents' use and hand washing sinks in the clinical/medicine room and the cleaner's room were found on the last inspection in August 2018. As staff were involved in administering chemotherapy medication, the absence of a hand washing sink in the clinical/medicines room was not in line with best practice. There was a number of areas and rooms for residents to spend time or meet visitors. For example, there was a well designed peaceful oratory, a sitting room, a quiet room and a family area/kitchenette room available for residents use. Not all rooms used by residents had emergency call bell fitted, as required by regulations. This was identified at the last inspection and posed a risk to residents' safety.

While there was evidence that risk in the centre was appropriately managed in most areas, proactive management of risk posed by a number of unidentified hazards was necessary. Measures were in place to protect residents from risk of fire but some areas of fire safety management by the provider were not comprehensive.

The inspector was informed by nurse management that admissions to the centre were carefully managed to ensure compliance with the centres' statement of purpose. Each resident had a clear discharge plan in place initiated either prior to or on admission. The inspector was satisfied that residents’ health and social care needs were met to a good standard. The provider had arrangements in place to ensure timely access to allied health professional services. This arrangement optimised residents’ good health and promoted their independence. There were effective systems in place for the assessment, planning, implementation and review of health and social care needs of residents. Residents' care documentation demonstrated that while their nursing and healthcare needs were appropriately assessed and reviewed on a regular basis, improvements were necessary in the standard of person centred detail in some care plans viewed. Residents supervision needs were met in all areas of the centre to ensure any risks to their wellbeing were mitigated.

Residents' medicines were safely managed, stored appropriately, reviewed and administered as prescribed.

All staff interactions with residents were courteous and kind. Residents confirmed they felt safe in the centre. In response to findings on the day of inspection, the inspector received confirmation that potential unauthorised access into the centre was urgently addressed by the provider. Otherwise procedures were in place to

ensure that residents were safeguarded from abuse and that any incidents, suspicions or disclosures of abuse were appropriately investigated and addressed.

Management and staff within the centre respected residents' rights, choices and wishes, and supported them to maintain their independence, where possible. Residents' access to a meaningful activity programme that met their interests and capabilities was an area of care that was focused on by the local management team to enhance residents' quality of life. Increased activity staffing resources, staff training and broadening of the variety of activities available was seen to positively impact on residents' social interaction and quality of life in the centre. Residents had access to local newspapers and their civil and religious rights were respected. An enclosed safe, attractive outdoor area was provided for residents. There was evidence of good consultation with residents and or relatives in relation to service provision. As this was a small centre, management were able to regularly speak to each resident in the centre. However, due to the short length of time that many residents stayed in the centre there were few structured residents' meetings to ascertain residents views. The inspector requested management to review these arrangements to improve the opportunities for residents to give ongoing feedback. This was also requested by the inspector during the last inspection in August 2018.

Regulation 11: Visits

Residents' visitors were welcomed into the centre and visitors were observed visiting residents throughout the day of inspection. A record of all visitors was maintained. Several comfortable alternative areas to residents' bedrooms were available for residents to meet their visitors in private if they wished.

Judgment: Compliant

Regulation 13: End of life

Staff provided end-of-life care to residents with the support of their general practitioner and the community palliative care team. Detailed information was in place for each resident describing their individual wishes regarding advanced decision making. This information was regularly reviewed in consultation with each resident where possible, or with their family on their behalf, as appropriate. Care plans describing residents’ preferences and wishes regarding their end-of-life physical, psychological and spiritual care preferences were not routinely developed. The inspector was told that end-of-life care plans were developed when a resident’s health deteriorated. This arrangement required review as residents may not be provided with sufficient opportunity to express their individual wishes and preferences regarding their end-of life care.

Good support was given to residents to meet their spiritual needs from local clergy. A small oratory was available in the centre. Families are facilitated to be with residents overnight when they become very ill. A family room with kitchenette facilities was provided.

Measures are taken to ensure residents do not experience pain. Residents' level of pain and the effectiveness of pain management medicines administered is closely monitored by staff using an appropriate assessment tool.

Judgment: Compliant

Regulation 17: Premises

The centre premises was maintained to a good standard and appropriate assistive equipment and aids to support residents' safe mobility needs was provided.

Signage throughout the centre and storage and lighting in the dry store room were improved since the last inspection in August 2018.

The following areas were identified on the last inspection and have not been progressed to completion.

- a bath was not available for residents' use. The inspector was told that a bath was purchased and awaiting installation.

- not every room used by residents in the centre had an emergency call facility, including the oratory, the quiet room or the family room.

- a hand wash basin was not available in the clinical/medication room. The inspector also found on this inspection that a hand wash basin was not available in the cleaner's room.

- a number of bedroom doors required review as they were seen to be very heavy and difficult for frail residents to open.

There were insufficient storage facilities for residents' assistive equipment. Residents' equipment was stored in a room with a toilet. The inspector was told that the toilet was not in use, but this room was the area designated for installation of a bath for residents.

A road into the health campus ran along the front of the centre and traffic entering and leaving the centre was busy. Car parking around the front entrance of the centre was occupied by out-of-hours GP transport vehicles until after 17:00hrs. This arrangement resulted in this car parking not been available for residents or residents' visitors. Safe pedestrian crossing arrangements to the centre's car park or designated disabled vehicle parking was not available.

Judgment: Not compliant

Regulation 26: Risk management

Procedures and arrangements were in place to promote and protect the health and safety of residents, visitors and others. The centre's risk management policy included a register of most identified hazards that posed a risk to residents, visitors and others. Concomitant controls were described to mitigate the level of assessed risk posed by the hazards identified. The inspector found that the controls specified in the centre's risk register to control the risk of unauthorised access into the centre through the back doors had not been implemented. Correspondence was forwarded to the Office of the Chief Inspector confirming that unrestricted access through the back and front doors into the centre was urgently addressed to completion in the days following the inspection.

Since the last inspection in August 2018, appropriate controls were implemented to prevent unrestricted access to the kitchen/pantry area, staff changing facilities and to cleaning liquids stored on the cleaning trolley. However, the following hazards were not identified or risk assessed in the centre's risk register;

- unrestricted access to a kettle in the family room.

- risk posed to frail elderly residents with negotiating heavy doors to some bedrooms

- risk posed by inadequate appropriate storage for residents' assistive equipment

- risk posed by the absence of a hand-wash sink in the clinical room and the cleaner's room.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were measures in place to ensure residents and others were protected from risk of fire. Each resident's emergency evacuation needs were assessed and a personal emergency evacuation plan (PEEP) was developed to inform their evacuation needs. Fire safety checking procedures were completed daily and at weekly intervals to ensure all exits were clear of obstruction and the fire alarm system was operational. The fire alarm and the emergency lighting system were serviced regularly by an appropriately qualified external contractor. Although frequency of servicing was increased since the last inspection, servicing was not consistently done on a quarterly basis as required.

Staff fire safety training and participation in simulated emergency evacuation drills

was facilitated. Records of staff training made available to the inspector confirmed that all staff had attended annual fire safety training and further training was scheduled in the weeks following the inspection. A simulated emergency evacuation drill to test night time conditions was not available. Completion of simulated night time emergency evacuation drills to ensure the staffing levels at night were sufficient was a required action from the last inspection in August 2018. The inspector was informed that a simulated night time emergency evacuation drill was scheduled to occur in the days following the inspection. The record of the simulated evacuation drills made available to the inspector reflected testing of the day-time staffing levels, the procedure followed, timescales and learning. However, the records examined referenced simulated emergency evacuation of a room only and not a compartment which contained a number of rooms. There was also no reference to the supervision arrangements of residents with cognitive impairment who may be at risk of returning following evacuation. Staff who spoke with the inspector were knowledgeable regarding the emergency evacuation procedures in the centre.

There were no residents in the centre who smoked on the day of inspection. Arrangements were in place for completion of risk assessments in relation to residents who smoked to include assessment of the level of risk associated with smoking, the arrangements for the safe storage of cigarette lighters and supervision when smoking.

Clear signage was displayed over emergency exits. The actions that should be taken to activate the alarm in the event of discovering a fire were located by break glass units adjacent to emergency exit doors. However, instructions to take in the event of an emergency were not displayed elsewhere in the centre. A centre specific floor map of the centre clearly identifying the emergency exit routes was also not displayed.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Residents were protected by safe medicines management procedures and practices in the centre. Practices in relation to prescribing, medication reviews and storage met with regulatory requirements. Administration practices by nursing staff reflected professional guidelines. Residents had access to the pharmacist responsible for dispensing their medicines. The pharmacist was facilitated to meet their obligations and completed regular medicine audits.

The person in charge was implementing a revised residents’ medicine prescription and administration record into the centre to ensure safe medicine management procedures.

Medicines controlled by misuse of drugs legislation were stored securely and the

balances were checked by two staff at each staff changeover. Medicines that required refrigerated storage were stored appropriately and storage temperatures were checked daily. Appropriate procedures were in place for return of unused or out-of-date medicines to the pharmacy. Multidose medicine preparations were not dated on opening to ensure use did not exceed efficacy timescales recommended by the manufacturers.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Staff used a variety of accredited assessment tools to complete a comprehensive assessment of each resident's needs on admission and regularly thereafter. This process included assessment of each resident's risk of falling, malnutrition, pressure related skin damage, depression and their mobility support needs among others. These assessments informed the development of care plans. The inspector found that improvement in the detail of care plan documentation was necessary to clearly reflect each resident's individual care preferences and wishes. For example, staff knew residents well and were aware of residents' personal care and end-of-life care preferences. However, this detailed person-centred information was not reflected in some residents' care plan documentation. Interventions to ensure the welbeing of residents with unintentional weight loss, swallowing difficulties, diabetes or at risk of developing pressure related skin damage was clearly described in associated care plans.

Where possible, residents were consulted with regarding their care plan development and subsequent reviews. The families of residents unable to be involved in this process were consulted on behalf of individual residents. Records were maintained of this consultation process.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were met to a good standard. Residents were provided with timely access to medical and allied health professional services. Residents in the centre were cared for by general practitioners from a local practice as they wished. Physiotherapy, occupational therapy, speech and language therapy, tissue viability, chiropody, dental, optical and dietician services were available to residents as needed. Psychiatry and palliative care services were also available to residents as appropriate.

Residents were given opportunity and supported to access national health screening

programmes.

Judgment: Compliant

Regulation 8: Protection

Measures and procedures were in place to protect and safeguard residents from abuse. The inspector found that intermittent unrestricted access into the centre posed a potential risk to vulnerable residents. The provider urgently addressed this finding in the days immediately following the inspection. Confirmation was received by the Office of the Chief Inspector from the provider representative that access to the centre was controlled to ensure residents' safety.

Residents who spoke with the inspector confirmed that they felt safe in the centre. All interactions observed by the inspector between staff and residents were respectful, courteous and kind. Staff were facilitated to attend training on safeguarding residents from abuse. Staff who spoke with the inspector confirmed that they had attended safeguarding training and clearly articulated their responsibility to report any disclosures received or incidents they may suspect or witness.

Judgment: Compliant

Regulation 9: Residents' rights

A residents' meeting forum arrangement was not in place. The inspector was told that this was because all residents in the centre were admitted on a short-stay basis not exceeding eight weeks. The inspector asked that this arrangement be reviewed to give residents opportunity to express their views in a structured forum. Use of alternative means to enable residents to participate in the running of the centre were in place. Residents' feedback on the service provided was valued and used to enhance life and the service provided in the centre.

Residents feedback was used to improve in opportunities for residents to participate in meaningful activities that interested them and met their capabilities. Activity staffing resources has been increased and a varied schedule of activities was provided. The day-to-day activities in the centre were organised around residents' wishes and preferences. A variety of meaningful scheduled activities each day complimented one-to-one activities. Residents were encouraged and supported to continue to enjoy the activities they engaged in prior to their admission such as reading books, meeting up with family and friends from the community who came to visit them in the centre or watch favourite television programmes. Individual televisions and discreet listening equipment were provided for each resident in the

multiple occupancy bedrooms. This arrangement provided residents with choice of television viewing.

Staff respected residents' privacy and dignity by closing bedroom doors and displaying notices that care was in progress in the bedroom. Privacy screens were closed during care and were fitted to provide sufficient space for residents to transfer in and out of bed as necessary. Most residents in the multiple occupancy bedrooms used the en-suite facilities however, the curtain screening provided around beds did not contain noise or malodours. Small windows were fitted in each bedroom door and screening to prevent views into residents' bedrooms was not available.

Advocacy services were available and referrals were made on behalf of residents as necessary. However the contact details for this service was not displayed if residents wished to make contact with this service independently.

Judgment: 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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Carlow District Hospital OSV-0000553

Inspection ID: MON-0026697

Date of inspection: 22/03/2019

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A formal meeting structure has been set up by the Provider Representative with the local management team.
All audits going forward will be SMART, identifying timescales, person responsible and completion dates.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The HSE procedure for making complaints "Your service, your say" is clearly displayed in the centre. The name and contact number of the complaints officer, together with the appeals process if dissatisfied with the outcome of the investigation is also now clearly displayed at various points in the centre.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
- A Parker bath was purchased and will be installed by May 31st 2019.

- Emergency call facilities are been installed in the oratory, quiet room & family room
- A wash hand basin is been installed in the clinical/medication room & the cleaners room
- All fire doors have been audited and in working order
- An area is been sought for storage space
- Privacy to identified bedroom doors through the windows in their doors is now implemented.
- Work has commenced on the car park to ensure disability parking and identified spaces for unit for visitors

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
All risks have been identified and are now on local risk register with action for completion by the appropriate person

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A plan has been devised to ensure that simulated emergency evacuation drill is carried out and these drill and recorded and feedback given to staff on any issues raised
A centre specific floor map identifying exit routes was displayed in each room and is now also displayed in public areas.

All fire equipment is under maintenance by registered fire company

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
We are currently involved in a project in the south east region to ensure holistic, individual assessment and care planning to reflect each residents individual care preferences and wishes. The 4 domains of care planning are now introduced at

admission of each Resident. Training and development of all staff involved in the care planning process is continuing on an ongoing basis.

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 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	31/05/2019
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 responsibilities for all areas of care provision.	Not Compliant	Orange	01/05/2019
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service	Substantially Compliant	Yellow	01/05/2019

	provided is safe, appropriate, consistent and effectively monitored.			
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.	Substantially Compliant	Yellow	16/04/2019
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	16/04/2019
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.	Substantially Compliant	Yellow	15/04/2019
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably	Not Compliant		15/04/2019

	practicable, residents, are aware of the procedure to be followed in the case of fire.			
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	15/04/2019
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	15/04/2019
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Substantially Compliant	Yellow	15/04/2019
Regulation 34(1)(c)	The registered provider shall provide an accessible and effective	Substantially Compliant	Yellow	15/04/2019

	complaints procedure which includes an appeals procedure, and shall nominate a person who is not involved in the matter the subject of the complaint to deal with complaints.			
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.	Substantially Compliant	Yellow	15/04/2019