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:	Kanturk Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Kanturk, Cork
Type of inspection:	Unannounced
Date of inspection:	20 February 2019
Centre ID:	OSV-0000572
Fieldwork ID:	MON-0025908

About the designated centre

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

Kanturk Community Hospital is a designated centre located on the outskirts of Kanturk town. It is operated by the Health Service Executive (HSE) and registered to accommodate a maximum of 33 residents. It is a single-storey building set on a large mature site which also accommodates the Ambulance base and the Duhallow community services. The layout of the centre comprises a long corridor with multi-occupancy wards on either side of the corridor. Residents' bedroom accommodation is provided in six single rooms and five wards where occupancy levels range from four to six residents. All bedrooms have wash-hand basins and there are shower, bath and toilet facilities available. Communal spaces comprise a large conservatory and dining room; both have comfortable seating and dining tables. There is a small visitors room with coffee dock, and a chapel. There is a secure garden area as well as walkways, seating area with shrubbery that can be viewed from the conservatory. Kanturk Community Hospital provides 24-hours 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, mainly to older adults.

The following information outlines some additional data on this centre.

Current registration end date:	27/06/2018
Number of residents on the date of inspection:	27

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
20 February 2019	09:30hrs to 18:20hrs	Breeda Desmond	Lead
20 February 2019	09:30hrs to 18:20hrs	Noel Sheehan	Support

Views of people who use the service

Inspectors met with several residents and three family members during the inspection. Feedback was positive; people said that the new person in charge was always around asking how they were; they highlighted all the upgrades to the building and that they were involved in choosing the paint colours for bedrooms and fabric for curtains for bedrooms and the conservatory. They said that the activities programme had greatly improved and they were much happier with all that was going on.

Capacity and capability

This inspection was a follow up to the poor findings of previous four inspections. The findings from this inspection showed a number of initiatives were in process to address the deficits in governance and management previously identified. Measures to ensure the service was safe, appropriate, consistent and effectively monitored noted on this inspection included:

- the appointment of a person in charge
- set up and establishment of the Quality Patient Safety committee monthly meetings as part of senior management strategy
- set up and establishment of the local weekly governance and management meetings as part of the service quality improvement oversight
- annual review of the service completed based on the National Standards in accordance with Regulation 23(d)
- completion of fire safety remedial works
- review and establishment of a staff training matrix with several training sessions completed at the time of inspection
- appointment of the practice development nurse specialist to support the service
- vetting disclosures were in place for all staff, in compliance with legislation to protect vulnerable people
- segregation of house-hold and healthcare roles.

There was evidence to show that concerns previously raised regarding overall governance, support and safety were in the process of being addressed. The registered provider was required to demonstrate that improvements can be sustained and the quality of life of residents further improved.The general manager was appointed to the role in November 2018 and was on site at least once a week to support local management; the Head of Social Care had attended the centre several times to support management, including following a fire incident. The quality

safety and risk management monthly meetings attendees comprised the general manager, quality safety and risk adviser, practice development, person in charge, CNM2, and clinical projects manager; agenda items included the annual review, quality indicators, feedback from residents and relative surveys, complaints, staff training, policies, risk register, and incidents. The local management 'compliance working group' met once a week and reviewed quality indicators cognisant of internal audits and inspection findings, and these fed into the monthly quality safety and risk senior management meetings. Minutes from these meetings were insightful.

However, the findings from this inspection demonstrated deficits in the overall governance and management of the service as evidenced by:

- findings of repeated non-compliance
- long-term residents continued to be accommodated in situations which adversely impacted their daily quality of life, privacy and dignity
- a failure to address identified fire risks in a timely manner
- a comprehensive review of occupancy levels was not undertaken to inform the profile and numbers of residents who could be accommodated in the centre. Following the reduction in the number of residents accommodated in the centre, the registered provider had failed to ensure that the space created by the reduced number of residents was adequate to enhance the quality of life, privacy and dignity of the remaining residents.

Significant fire safety works were completed or in the process of completion. Nonetheless, assurances were sought following notification of a recent fire in the centre, and documentation returned did not provide the necessary assurances that all electrical appliances were safe. Floor plans submitted did not reflect the compartmentation and fire safety works completed. Cognisant that several reports from different departments have been submitted to the Office of the Chief Inspector regarding fire safety, they did not provide assurances that a coherent approach to fire safety was being taken.

The annual review for 2018 was completed. It was based on the national standards and contained actions with responsibilities assigned and time lines for completion. The person in charge had good oversight of the clinical data gathered and this data was trended and analysed and work practices were changed accordingly which resulted in improved outcomes for residents, for example, there was a reduction in use of bed rail restraint; bed tables were no longer used to restrict a person's movement; medication administration rounds were changed to enable residents have a better quality mealtime experience; staff supervision was in place to promote a social model of care.The statement of purpose was updated to reflect the current organisational structure, bed occupancy lay out and conditions of registration.

The person in charge and clinical nurse manager (CNM2) demonstrated good knowledge of their roles and responsibilities, including insight into the significant issues identified in the previous inspection findings. They demonstrated commitment to driving a person-centred approach to care to improve the quality of

life and quality of care for residents.

Upon taking up her post, the new person in charge had completed a training needs analysis of all staff and had commenced a programme of training including fire safety, drills and evacuations, adult protection, manual handling and lifting, hand hygiene and infection prevention and control, and dysphagia for example. The newly appointed practice development co-ordinator for H.S.E. Area 4 formed part of the support mechanism for training and ongoing professional development for the service. She discussed her role and responsibility with the inspectors. She had commenced individual and small group coaching and teaching sessions with staff; and developed action plans with time-lines for staff to review progress and provide additional supports when necessary.

Staff levels were adequate to the size and layout of the centre and the dependency care needs of residents. Following from the last inspection and residents' feedback, the activities programme was developed in line with residents' preferences and interests. Vetting in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 was in place for staff to ensure the protection of residents. Notifications were timely submitted to the office of the Chief Inspector and these correlated with the incident and accident log examined.

In conclusion, the findings of this inspection were that, while substantial improvement was noted, the Health Services Executive (HSE) were required to take further action to strengthen the governance and management of this centre for the purpose of improving the quality of life for residents. Areas for improvement that had been identified on previous inspections persisted in relation to personal accommodation, storage of personal possessions, accessibility to shower and toilet facilities, end of life care, premises; food and nutrition, infection prevention and control, fire precautions, individual assessment and care planning, and residents' rights.

Regulation 14: Persons in charge

The person in charge took up post in January 2019. She had the necessary experience and qualification as required by the regulations. She actively engaged and facilitated the inspection. She was knowledgeable and forthright regarding the service, previous inspection findings and her role, responsibility and accountability for improving the service to ensure it was safe, person-centred and effectively monitored.

Judgment: Compliant

Regulation 16: Training and staff development

Staff supervision had significantly improved. The person in charge and the clinical nurse manager (CNM2) attended the morning handover from night duty staff and then walked around to greet all the residents. They attended other staff meetings, observed mealtimes and delivery of personal care activities, and walked about throughout the day. They visited the centre at weekends and evening times to ensure practice was in accordance with best practice and their statement of purpose, and to promote a social model of care.

The person in charge had identified deficits in staff training and had put in place a schedule of training. Dates for training were available for example, most staff had completed training on safeguarding and there were 2 additional dates allocated - 26 February and 19 March for the remaining staff. The person in charge advised that training groups were small to ensure discussion and interaction was facilitated to ensure staff understood the concepts being taught.

Staff appraisals had commenced and were well underway at the time if inspection. The person in charge had envisaged that these would be completed by now but there were delays due to industrial action and staff on leave.

Staff gave positive feedback to inspectors regarding the support they were receiving, and the accessibility of the person in charge.

Judgment: Compliant

Regulation 21: Records

Vetting disclosures in accordance with the National Bureau (Children and Vulnerable Persons) Act 2012 were in place for all staff and these were securely maintained.

The sample of drug administration records examined were comprehensively maintained in accordance with professional best practice guidelines.

Medication errors were recorded as part of the H.S.E. incident records. Issues identified were discussed at hand-over meetings and staff meetings to raise awareness and mitigate the possibility of recurrences

Judgment: Compliant

Regulation 23: Governance and management

The appointment of key personnel as part of the governance and management structure enabled the setting up of critical supports such as the quality safety and risk committee with monthly meetings held in the centre and the 'compliance working group' with weekly meetings. A programme of audits was established; these

were completed by the person in charge and the CNM2 and these informed the weekly meetings which in turn fed into the monthly quality safety and risk management meetings. Minutes from these meetings showed that audits were thorough and their associated action plans were forthright, time-bound with review dates to ensure good oversight of proposed actions. Inspectors observed increased staff supervision throughout the day and staff and residents highlighted their ease of accessibility to the person in charge.

The annual review for 2018 demonstrated good oversight of the clinical and quality of life data gathered; this data was trended and analysed and work practices were changed accordingly which resulted in improved outcomes for residents.

While fire safety remedial works were either completed or in the process of completion, floor plans submitted did not reflect the compartmentation described on inspection. Following receipt of an notification related to a fire, a provider assurance report was requested. Information included in that report did not provide assurances regarding electrical equipment throughout the centre. Cognisant that several reports from different departments have been submitted to the Office of the Chief Inspector regarding electrical equipment, they did not provide assurances that a coherent approach to fire safety was being taken.

However, overall, the HSE is required to address deficits in governance and management as evidenced by:

- a failure to take all the necessary actions to improve the quality of life, privacy and dignity of residents
- a comprehensive review of occupancy levels was not undertaken to inform the profile and numbers of residents who could be accommodated in the centre
- a failure to address identified fire risks in a timely manner
- long-term residents continued to be accommodated in situations which adversely impacted their quality of life, privacy and dignity.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was updated to ensure compliance with the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications were timely submitted in accordance with regulatory requirements.

Judgment: Compliant

Quality and safety

The findings from this inspection showed significant improvement in the prevailing culture from one of institutional practices to a social model of care. Observations showed that most staff understood and delivered a person-centred approach to care and interaction with residents. Most staff delivered care that was calm, relaxed and sociable, and staff actively engaged with residents to seek out their choices and preferences throughout the day or to allay concerns or anxieties, however, some staff practices remained task-orientated with little or no meaningful engagement.

Residents and relatives surveys were completed. The person in charge reviewed these and themes for improvement were identified, for example, more activities and specifically one-to-one sessions, televisions in bedrooms, and requests to stay up longer in the evening times. These were discussed with staff and several new initiatives were in place for example, specific times were allocated for one-to-one sessions including hand and foot massage; life story books and local history books being developed. New televisions were in place for most residents bedrooms. Approximately half the residents had their tea in the dining room on the day of inspection and this was a significant improvement on previous inspection findings.

Following a reduction in beds, space was re-allocated to enhance the living space of individuals. Residents had access to bedside lockers and wardrobes, however, very few residents had access to a bedside chair. While all residents had bed screens, the location of some screens meant that residents' wardrobes were outside their personal bed space area. The inspectors were advised that new wardrobes were on order, however, some resident's had access to only a single wardrobe for all their clothes.

Restrictive practice relating to bed rails significantly reduced; the front door was open; lap belts were reduced to one resident and theirs was assessed by the occupational therapist to enable better positioning; one resident had a soft table to support his hand. An activities person was appointed and had completed life stories to support person-centred care. Following research relating to where residents came from, staff were in the process of developing local histories with old photographs for residents to browse; individualised story books were being developed with residents' interests, past times and work, for example, one resident with farming background had a large book with coloured photographs with livestock; another resident had donkeys when he was younger and staff had created a book for him.

The risk register was available to inspectors and had been updated since the last inspection and it included specified risks. New signage was in place to alert people to the change in incline of two ramps along the main corridor. Paint colours,

orientation signage and new non-slip floor covering renovations were done cognisant of dementia care strategy.

As identified on each inspection report thus far, the premises was not fit for it's stated purpose, that is, to provide a homely environment for each resident that would maximise their independence and ensure their quality of life, privacy and dignity. There was no storage facilities for assistive equipment, so equipment was seen in the main bathroom, the church and bedrooms.

The sample of care plans reviewed and while there was some improvement and the appointment of the practice development co-ordinator to support and coach staff regarding assessments and care planning, significant work was necessary to reach compliance.

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

There was an improvement to storage facilities for residents. Residents outlined that bespoke wardrobes and bedside lockers were designed to meet their individual needs; receipted evidence showed that these were being delivered on 5 March 2019. Nonetheless, some wardrobes were located outside the floor/wall mounted privacy curtains which meant that residents did not have free access to their wardrobes. Other wardrobes were single, and these provided very limited space for residents.

St. Patrick's ward was a five-bedded room, where the middle bed on the right had a bedside locker, but it could not accommodate a wardrobe.

While effort was made to personalise bed areas in multi-occupancy rooms with drawings and pictures and flowers, the layout of multi-occupancy accommodation was not conducive to truly implementing a homely model.

Judgment: Not compliant

Regulation 13: End of life

Some care plans had person-centred information regarding end of life care wishes, while others totally lacked detail of any wishes the resident may have regarding their spiritual and end of life care. One staff member spoken with did not have training in end of life care and was unable to complete an end of life care plan.

Judgment: Not compliant

Regulation 17: Premises

Refurbishment of the centre was ongoing at the time of inspection:

- corridors, doors, architraves, wards and communal areas were being painted
- new non-slip flooring was in place on the main corridor
- the shower room by Edel Quinn ward was being refurbished and converted into a wet room with toilet and wash-and basin facilities
- a coffee dock was under construction to enhance the visitors room.

However, it was not possible to have bedside chairs in several bed areas.
Some overhead hoists were not in an optimum position in relation to bed location to provide assistance when moving residents.

There was no storage facilities for assistive equipment in the centre. As a result, one bathroom with specialist bath facilities and one shower room was not used as they were inaccessible due to the amount of equipment stored.

Judgment: Not compliant

Regulation 18: Food and nutrition

There was improvement observed at meal times. Most residents were in the day room and conservatory for lunch time. Interactions and assistance were mostly person centred with active engagement. For example, one resident's independence varied throughout the day and the healthcare assistant providing assistance realised that the resident was able to feed herself at that time, so she brought over a table, adjusted the height of the table to suit and this enabled the resident to enjoy their meal independently. However, this person-centred approach was not always observed. Approximately half the residents were in the dining room at tea time and this was an improvement from previous inspection findings. Nonetheless, residents had little choice regarding the time they had their breakfast of where to have it.

Meal times were now protected, that is, medication rounds were no longer undertaken at meal times. These were completed following meals; this afforded

residents the opportunity to have a pleasant normal dining experience.

Judgment: Not compliant

Regulation 26: Risk management

The floor surface on the main corridor was upgraded to non-slip flooring. The ramp along the main corridor where there was a change in floor level was clearly marked, to highlight the change in incline to minimise the risk of falls. This was added to the risk register following the last inspection.

Judgment: Compliant

Regulation 27: Infection control

Household and care staff roles were now separated to ensure and enable suitable and safe practices. Clinical waste bins were no longer in place in unrestricted areas. While the sluice room was now in operation, it could not accommodate a sluice sink, in line with best practice guidelines.

Judgment: Not compliant

Regulation 28: Fire precautions

Significant fire safety work and fire safety training was completed and assurances were provided regarding some remedial works completed. For example, replacement of internal fire doors, upgrading fire barriers in attic spaces, an updating of the fire safety and fire evacuation procedures to be followed in the event of a fire. Staff demonstrated a fire evacuation relating to night duty staff levels and the evacuation was completed within two minutes. Further assurances were provided following discussions with staff as well as review of the fire evacuation reports that highlighted issues, and actions taken to mitigate those issue.

Effective horizontal evacuation was demonstrated by staff, with resident involvement, to reflect the staff numbers on night duty. Staff were very knowledgeable regarding evacuation procedures and residents' dependency and evacuation plans. Staff relayed that fire safety training, including drills and evacuations, were completed weekly.

Inspectors identified gaps in fire door smoke sealants and these were remedied

during the inspection.

Non compliance relating to fire were reported under governance and management.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The annual review had identified that significant work was needed regarding assessments and care planning to ensure they were person centred and that the information contained in assessments and care plans correlated. A practice development co-ordinator for H.S.E. area 4 was appointed in January 2019. At the time of inspection she had been in the centre 10 days to coach and support staff regarding all aspects of care documentation. Action plans were developed for each staff member regarding supports needed and timelines for follow up meetings.

The practice co-ordinator identified other quality issues, for example, lack of continence promotion to enable a better quality of life for residents; ease of access to information such as people who are a high falls risk and resuscitation status. She was in the process of addressing these to enhance timely access to services and information.

Of the sample of care plans reviewed, there were incomplete and not timely updated, for example, one resident's care plan showed that it was last updated on 28 July 2018. Nonetheless, this care plan had lots of valuable information regarding the resident's interests and activities that were meaningful to them. Residents had 'missing persons profiles', however, a photographic identification was not always attached to this document in line with best practice. While consent was sought from residents for photographs as part of their care documentation, when a resident was unable to sign consent their next of kin was asked to sign consent on behalf of the resident. This was a repeat finding.

Judgment: Not compliant

Regulation 6: Health care

Residents had good and timely access to medical services, occupational therapy, physiotherapy, mental heath occupational therapy to support and advise staff regarding promoting health and wellbeing of residents.

Judgment: Compliant

Regulation 8: Protection

Further training was undertaken by the person in charge regarding protection. It was reported to inspectors that training groups were small to enable better discussions regarding peoples' understanding of institutional practices. Observations on inspection showed improvement where routines were much less rigid; most staff positively engaged in a social manner, and residents gave positive feedback regarding improvement in their life in the centre.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Significant improvements were noted regarding respecting residents' human rights. A activities programme was updated and meaningful activities were available to residents, for example, gardening, hand and foot massage, baking, card playing, music sessions, movie afternoons, sonas, and imagination gym. In addition, the local voluntary community groups were invited into the centre and their activities enhanced the in-house activities programme, for example, the mens' shed, red cross organisation and musicians. Residents had access to independent advocacy services and there were notices on display in the centre advising residents of this.

Clear visor solar guards were in place on residents' bedroom windows; this inhibited people from looking in windows and residents could look out without a reduction in visibility or light.

While improvement was noted regarding the number of people in the day room and dining room for tea at 16:30hrs, many residents were observed to be either in bed or their bedrooms at this time.

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 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	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	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Kanturk Community Hospital OSV-0000572

Inspection ID: MON-0025908

Date of inspection: 20/02/2019

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Governance and management: A comprehensive review of occupancy levels and dependencies has taken place with an emphasis on providing enhanced private space for the residents, this review has taken in to consideration assessed needs and personal choice of the resident cohort. The fire officer and fire consultant has visited the centre and all remedial work has been completed and reports have been submitted to H.I.Q.A	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: Personal possessions: There is currently a review taking place of all ward environments in conjunction with the Occupational Therapist to maximize all space available to benefit the residents. Occasional chairs have been sourced for the bed rooms which will improve both the living and visiting experience. Privacy screens have been reviewed and some changes in location of screens has been identified which will maximize personal space and will ensure each resident will have their personal possessions within their space. New wardrobes and lockers have been provided to all the residents which allows for enhanced independent management of personal possessions by all the residents.	
Regulation 13: End of life	Not Compliant
Outline how you are going to come into compliance with Regulation 13: End of life: End of life:	

This compliance plan response from the registered provider did not adequately assure The Office of the Chief Inspector that the actions will result in compliance with the regulations.

All staff have been provided with coaching and support to enable them complete end of life care plans in conjunction with the residents ,there is a plan to develop an end of life committee within the centre, this committee will support and promote quality end of life care within the centre through peer review, audit, review and feedback to staff following a person within the centre passing.it is anticipated this committee will be in place by end May 19,

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Premises: a review of all areas is currently being undertaken with a plan to optimize personal space. All equipment has been reviewed and all excess is currently being moved to a storage area identified within the grounds.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

This compliance plan response from the registered provider did not adequately assure The Office of the Chief Inspector that the actions will result in compliance with the regulations.

Food and nutrition: All residents are offered choice of refreshments and snacks, they are available throughout the day/night. New menu request cards have been developed which further enhance the dining experience and increases resident choice of both nutrition and choice of dining times.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

Infection control:
A recent audit of infection control was carried out within the centre and a number of extra hand sanitisers have been installed, a new sink for the sluice area in St Teresa's is currently awaited with a proposed installation in 4 weeks.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The fire consultant and fire Officer have visited the centre and all remedial work has been addressed and reports have been issued to H.I.Q.A. including fire walls in the attics

increased exit egress from the wards and new fire doors. All staff have received fire training in the new evacuation procedures and regular fire drills are being carried out on site on a bi weekly basis to ensure all staff are aware of the procedures to follow.

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:

Individual assessment and care plan: Coaching and training is being provided to all staff to ensure care plans are person centred and reflect the needs of the individual. Continence assessments have been added to all care plans and staff have been advised how to complete same as a deficit in continence promotion and management was identified within the centre. A programme of auditing has commenced to identify any outstanding deficits and these deficits will be addressed on an individual basis. The audit tools to be used will include the DML Data set and metrics will be introduced in Kanturk in May 2019. Where a deficit is noted, the staff member will be offered support from the Director of Nursing and the services of Practice Development will also be sought. Any risk in relation to care planning will also be added to the risk register and advised to the General Managers office.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8:

Protection:
further training has been provided to a number of staff and all staff will be trained in safe guarding by 19/03/19

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

This compliance plan response from the registered provider did not adequately assure The Office of the Chief Inspector that the actions will result in compliance with the regulations.

Residents' rights: A mobile phone is available for residents' personal use, residents can also access the landline to make or receive a private call if they wish. The activity programme is currently being reviewed, activities provided will be based on the identified needs and requests of the resident group, all residents have recently has a PAL assessment completed and this assessment will be used to guide activities.

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(a)	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 a resident uses and retains control over his or her clothes.	Not Compliant	Yellow	31/05/2019
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	Not Compliant	Orange	31/05/2019

	his or her clothes and other personal possessions.			
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 the resident concerned are provided.	Not Compliant	Orange	31/05/2019
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	30/04/2019
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	30/04/2019
Regulation 18(2)	The person in charge shall provide meals, refreshments and	Not Compliant	Orange	30/04/2019

	snacks at all reasonable times.			
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	31/03/2019
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/06/2019
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant		30/04/2019
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant		28/03/2019

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		28/03/2019
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant		28/03/2019
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant		28/03/2019
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		28/03/2019

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 practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant		28/03/2019
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant		28/03/2019
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		28/03/2019
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.	Substantially Compliant		28/03/2019
Regulation 5(4)	The person in charge shall	Not Compliant	Orange	28/03/2019

	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.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	28/03/2019
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant		28/03/2019
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant		31/05/2019
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant		31/05/2019

Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant		30/04/2019
Regulation 9(3)(c)(iii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident telephone facilities, which may be accessed privately.	Not Compliant		31/05/2019