



Office of the Chief Inspector

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	Merlin Park Community Nursing Unit 5&6
Name of provider:	Health Service Executive
Address of centre:	Merlin Park, Galway
Type of inspection:	Unannounced
Date of inspection:	25 June 2019
Centre ID:	OSV-0000635
Fieldwork ID:	MON-0026599

About the designated centre

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

Merlin Park Community Nursing Unit is a designated centre operated by the Health Service Executive (HSE). It is located within the grounds of Merlin Park Hospital. The centre is made up of two single storey adjacent buildings referred to as Unit 5 and Unit 6, they can accommodate up to 52 residents. It is located to the East of the City of Galway with easy access to local amenities. The service provides 24-hour nursing care to both male and female residents. Long-term care, respite and palliative care is provided, mainly to older adults. Bedroom accommodation in Unit 5 is provided in four single bedrooms and six multi-occupancy rooms, bedroom accommodation in Unit 6 is provided in 11 single bedrooms and four multi-occupancy rooms. Multi-occupancy bedrooms accommodate three to four residents and have shower and toilet facilities en suite. One single bedroom has en suite bathroom facilities. There are a number of toilets and one assisted shower room in each unit available to other residents occupying single bedrooms. There is a variety of communal day spaces provided in each unit including day rooms, dining rooms and conservatories.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	44
--	----

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 June 2019	09:00hrs to 19:00hrs	Mary Costelloe	Lead
25 June 2019	09:00hrs to 19:00hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Inspectors spoke briefly with eight residents. The overall feedback from the residents was one of satisfaction with the service provided.

Residents commented that they were well cared for, comfortable and had no complaints.

Residents spoken with stated that they enjoyed the variety of activities taking place.

One resident commented that he would like his own television that he could see from his bed.

Some residents commented that they could not remember the meal choices for lunch and would have to 'wait and see'.

Capacity and capability

This inspection was a follow up to the poor findings of previous inspections. Following the last inspection, meetings were held with the Chief Operating Officer and the Head of Social Care of the HSE's Community Health organisation Area 2(CHO 2) to discuss concerns about regulatory non-compliances in CHO2 designated centres for older people and regulatory knowledge demonstrated by senior HSE managers with responsibilities for these centres.

The findings from this inspection showed a number of initiatives were in process to address the deficits in governance and management previously identified, however, there were still repeated non-compliances with the regulations in many areas. Issues identified; during the last inspection in relation to the lack of sufficient showering facilities, inconsistent water temperature in showers and fire safety management issues had been addressed or were in progress.

The nursing management team advised inspectors that the water supply was still unfit for drinking, brushing teeth and face washing as laboratory test results had still not confirmed safe levels of Legionella bacteria in the supply. However, there was

still a lack of clarity regarding the suitability of the supply despite the risk to residents who were using water. Some staff spoken with were still unclear regarding the current status of the fitness of the water supply and signage at wash hand basins regarding the use of the water was still inconsistent.

Measures to ensure the service was safe, appropriate, consistent and effectively monitored noted on this inspection included:

- Arrangements and systems in place to address issues in relation to maintenance of equipment and building services had improved. The maintenance manager met with the person in charge bi-weekly and a computerised maintenance log was in place. All staff spoken with confirmed that this system had led to improvements and maintenance issues were now being resolved in a more timely manner.
- There was a plan in place for the segregation of house-hold and health care roles. Resources had been allocated to provide a dedicated contract cleaning team and cleaning supervisor. The manager of older peoples services advised inspectors that these arrangements were due to commence two weeks following the inspection.
- Redecoration and refurbishment of the premises had commenced.
- Additional administrative support had been provided to assist the person in charge fulfill her role.
- The person in charge and two clinical nurse managers were currently undertaking a level 6 management leadership training course.
- Monthly meetings with directors of nursing in CHO2 were taking place to ensure shared learning and improvements to practice.
- A fire safety audit was carried out by an external fire consultant following the last inspection. An action plan was put in place and there was an ongoing schedule of fire safety remedial works in progress.
- An infection control audit had been completed by an external auditor.
- The annual review on the quality and safety of care in the centre had been completed.
- Funding had been approved for personal assistants (PAs) to support some residents attend events and activities of their choice in the community. The implementation of this service should commence to ensure that residents are supported to lead purposeful lives.

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

- Repeated regulatory non-compliances from previous inspections.
- Failure to ensure and uphold residents' rights.
- Failure to ensure that all records as required by the regulations were maintained and available.
- Failure to ensure that the assessed needs of residents were updated and reflected in the care planning documentation.
- Failure to ensure that all residents had timely access to allied health care services.
- Failure to ensure that findings from audits are reported, implemented and

monitored effectively.

- Failure to submit notifications in respect of changes to persons involved in the management of the centre.
- Failure to notify the Chief Inspector that the post of the person in charge was not full-time in the centre.
- Failure to ensure that adequate deputising arrangements were in place in the absence of the person in charge.
- Failure to submit requested information in relation to action plan in place to address infection control audit findings.
- Failure to submit requested information in relation to action plan updates in relation to fire safety audit and annual review.

Governance arrangements required further review. The person in charge of this centre was not full-time in the post as she was also involved in the management of and, deputised for the person in charge, in another HSE designated centre. These arrangements had not been advised to the Chief Inspector and were not reflected in the centre's statement of purpose. Effective governance, operational management and administration arrangements were not in place in the absence of the person in charge. The person nominated to deputise in the absence of the person in charge did not work full-time (.5 WTE whole time equivalent) and therefore consistent cover was not provided.

A planned and actual staff rota was in place for both units of the designated centre; however, the rota did not reflect the days when the person in charge was involved in the management of another designated centre.

The service was not adequately resourced regarding residents' access to speech and language therapy, tissue viability and audiology services as set out in the centre's Statement of Purpose. This had a negative impact on residents and did not ensure their health and well being was optimised.

Staff levels were adequate to the size and layout of the centre and the dependency care needs of residents. Garda (police) vetting disclosures, in accordance with the National Vetting Bureau, were available in respect of staff in the centre to ensure the protection of residents. The person in charge advised inspectors that all staff had completed mandatory training; however, the staff training matrix was still not up to date and training certificates were not available in staff files.

Nursing management staff in the centre continued to regularly review areas such as medication management, incidents and falls, malnutrition prevention, wound care, restraint use and activities. While findings were set out and action plans put in place to address areas for improvement, there was limited evidence of improvement to practice and that action plans were implemented.

There was evidence that residents continued to be consulted with. Residents' committee meetings continued to take place on a regular basis and were facilitated by a SAGE advocate. Issues raised by residents such as requests for day trips, alternative activities and catering options were acted upon.

Regulation 14: Persons in charge

The person in charge was a registered nurse. She had the required experience in the area of nursing the older adult and was currently undertaking a management and leadership qualification. The person in charge of this centre was not full-time in the post as she also was involved in the management of and deputised in the absence of the person in charge in another HSE designated centre. These arrangements had not been advised to the Chief Inspector.

The deputising arrangements required review as when the person in charge was on leave or away from the centre attending another designated centre, the arrangements were not robust. Consistent cover was not provided.

Judgment: Not compliant

Regulation 15: Staffing

During the hours of inspection, the inspectors noted that staffing levels and skill-mix were sufficient to meet the assessed needs of residents. A review of staffing rosters showed there was a nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge was unable to provide evidence of all training provided to staff. The training matrix had not been updated to include all training completed in 2019 and training certificates were not available in staff files.

There was still inadequate guidance, training and education provided to staff in areas such as management of laundry and use of laundry equipment.

While staff were aware that copies of the regulations and National standards for infection prevention and control in community services were available in the nurses' office, staff spoken with were not knowledgeable regarding these documents.

A copy of the care and welfare regulations was not available on one of the units.

Further oversight and supervision was required to monitor nursing documentation

for accuracy and completeness. For example, a wound assessment was not accurately assessed or recorded.

The meal time experience required monitoring and supervision to ensure that a person- centred, quality service was provided to all residents.

Staff appraisals were not carried out to inform the training needs of staff.

Judgment: Not compliant

Regulation 21: Records

Records as required by the regulations were not available.

- Inspectors reviewed a sample of staff files and noted that evidence of full employment history and commencement dates of employment were not available for all staff.
- Staff training records were not kept up to date.
- While staff promoted a restraint free environment, records of safety checks carried out by staff of residents using bedrails were not recorded consistently in line with recommendations set out in their care plans.
- Cleaning checklists were not completed consistently and gaps of several days were noted to the cleaning checklists in some areas.
- The temperature of the refrigerated unit used to store some medicines was not recorded consistently on a daily basis in line with best practice and the medication management policy.
- There were gaps noted in the administration of medicines records, no codes had been used to indicate the rationale for the non administration of same.
- There were gaps noted in the administration of nutritional supplements as prescribed for a resident who had lost weight.
- There were no records of fluid intake and output for a resident to provide evidence that fluid intake was provided as recommended in their care plan.
- A planned and actual staff rota was in place for both units of the designated centre, however, the rota did not reflect the days when the person in charge was involved in the management of another designated centre.

Judgment: Not compliant

Regulation 23: Governance and management

The HSE is required to address deficits in governance and management as evidenced by:

- Repeated regulatory non-compliance's from previous inspections.
- Failure to ensure and uphold residents' rights.
- Failure to ensure that all records as required by the regulations were available.
- Failure to ensure that the assessed needs of residents were updated and reflected in the care planning documentation.
- Failure to ensure that all residents had timely access to allied healthcare services.
- Failure to submit notifications in respect of changes to persons involved in the management of the centre.
- Failure to ensure that findings from audits are reported, implemented and monitored effectively.
- Failure to notify the Chief Inspector that the post of the person in charge was not full-time in the centre.
- Failure to ensure that adequate deputising arrangements were in place in the absence of the person in charge.
- Failure to submit requested information in relation to action plan in place to address infection control audit findings.
- Failure to submit requested information in relation to action plan updates in relation to fire safety audit and annual review.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The contracts of care reviewed did not specify the type of room occupied and some were not signed by the person in charge.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The Statement of Purpose required updating to reflect recent changes to the persons participating in the management of the centre and to management of complaints. The arrangements in place for the management of the centre were not accurately reflected.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints procedure displayed and complaints policy required updating to reflect the names of the nominated person to deal with complaints and the nominated person to oversee that complaints have been appropriately responded to and that records are maintained in line with the regulations.

Judgment: Not compliant

Quality and safety

Deficits in the governance arrangements impacted on the quality and safety of care for residents, particularly in relation to cleaning, decontamination, infection control, nursing documentation, access to allied healthcare, risk management and residents' rights.

The centre comprised of two distinct units and was originally designed as a hospital. The general layout had not changed and the centre still resembled a hospital-type setting. The inspectors acknowledge that there have been efforts to improve the decoration of the premises, in particular the entrance areas and main corridor areas. However, many parts of the building and garden areas were still maintained in poor repair and showed an obvious lack of regular and routine maintenance. Issues relating to the premises requiring attention are discussed further under Regulation 17.

Residents continued to be supported and encouraged to have a good quality of life which was respectful of their wishes and choices. They had opportunities to participate in meaningful activities, appropriate to their interests and preferences. A meaningful activities assessment was completed for all residents. A varied programme of recreational and stimulating activities was offered. Two full-time activities coordinators were employed, they had received training to support the activities programme; for example Sonas, a therapeutic programme specifically for residents with Alzheimer's or dementia, and 'fit for life' physical exercise programme.

During the inspection residents were observed to be up and about and partaking in a variety of activities. The weekly and monthly activity schedule was displayed in each unit. During the inspection, inspectors observed residents partaking and enjoying a variety of activities, including trips to the coffee shop, quiz, imagination gym and Sonas. Other activities that took place regularly included weekly baking, arts and crafts, dog therapy, hand massage and weekly exercise programme. Residents had recently been on a number of outings and day trips to places of local interest including a fund raising event in Salthill and the aquarium. A representative of the local men's shed visited and held weekly workshops and activities with a group of male residents. The person in charge informed inspectors that funding had been recently approved for personal assistants (PAs) to support younger residents attend events and activities of their choice in the community and she was in the

process of arranging this.

Residents had access to appropriate medical services. A local general practitioner (GP) practice comprising five GPs visited the centre routinely three days each week. Residents could choose to retain their own GP if they wished. There was an out-of-hours service also provided.

Nursing staff spoken with confirmed that there was improved access to some allied health services including physiotherapy and dietitian, however, improvements were still required to ensure all residents had timely access to other allied health services. Inspectors identified a number of residents who required review by speech and language therapy (SALT), tissue viability nurse and audiologist. The local management team had identified these gaps on the risk register from October 2018. The HSE had not made alternative arrangements to ensure that these services were accessed by residents when required.

There was a pre-assessment process for potential residents to ensure that their needs could be met. Care delivered was based on a comprehensive nursing assessment completed on admission, involving a variety of validated tools. A range of risk assessments were completed for residents including risk of developing pressure ulcers, falls risk, nutritional assessment, dependency, moving and handling, oral health, pain and meaningful activities. However, inconsistencies were still noted in the nursing documentation. Improvements were required to ensure that care plans were in place for all identified issues, that all care plans were person centred, reflected the current needs of residents and guided staff in the care of the resident.

There was evidence of generally good medicines management practices and sufficient policies and procedures to support and guide practice. Medicines were regularly reviewed by the general practitioners (GPs) and good supports were available from the local pharmacist.

Staff continued to promote a restraint-free environment. There was evidence of risk assessment and care plans in place to support the use of bedrails. However, records of safety checks carried out by staff were not consistently recorded.

Staff promoted non-restrictive and non-pharmacological interventions as the preferred method of providing support to residents experiencing behavioural and psychological signs of dementia. Residents also had access to support and advice from the community psychiatric team who visited the centre. Nursing staff stated that no chemical restraints were in use.

A fire safety audit was carried out by an external fire consultant following the last inspection. An action plan was put in place and a schedule of fire safety remedial works had been taking place. Works completed included replacement of missing intumescent strips, smoke seals, overhead door closers and adjustment to door hinges on fire doors. There was evidence of regular fire safety checks being carried out and all staff had received on-going fire safety training which included evacuation and use of equipment. The servicing of the fire alarm and fire equipment was up to date. All fire exits were observed to be free of any obstructions. The fire evacuation

plans had been updated and were displayed adjacent to the fire panel and in each bedroom. Records reviewed showed that fire drills, including simulated full compartment evacuation fire drills had been conducted to take account of night time staffing levels and residents evacuation requirements. Aspects of fire safety management requiring further review are discussed under regulation 28: Fire precautions.

Painting, redecorating and replacement of floor coverings had commenced. The corridors to both units and a small number of bedrooms had been repainted, window sills had been replaced in some rooms and the floor covering had been repaired in a small number of bedrooms since the last inspection. The management team acknowledged that the progress on the refurbishment works was slow and advised that it had been hindered by the fire safety remedial works that had been taking place.

Meals were prepared in the main kitchen of the hospital located within the grounds of the centre. They were served to residents from heated trolleys in the dining rooms in both units. The meal time experience required oversight to ensure that all residents were offered a quality service and choice at mealtimes. This is discussed further under regulation 18: Food and nutrition.

The arrangements in place at the time of inspection for cleaning and decontamination of the centre were still unsatisfactory. Some staff spoken with did not demonstrate a knowledge of infection prevention and control guidance with regard to the management of soiled or infected laundry and the use of laundry equipment. There was no dedicated cleaning team; as a result cleaning duties were fragmented and carried out by catering, laundry and care staff, with some cleaning duties completed by the porter. Cleaning checklists were not completed consistently and gaps of several days were noted to the cleaning checklists in some areas.

Risk management and assessment of risk required further review and oversight to ensure that all hazards were identified, assessed and measures and actions put in place to address the risks identified. A number of hazards which posed a risk to residents were noted by inspectors during the inspection. These were brought to the attention of the management team and discussed further under regulation 26: Risk management. While PEEPs(personal emergency evacuation plans) were in place, the inspectors noted that there was no PEEP for a resident whose file was reviewed.

Regulation 17: Premises

The premises still did not conform to other matters set out in schedule 6 of the

regulations. For example

- The plasterwork and paintwork to the walls of many bedrooms and communal day rooms were still defective, stained and chipped.
- The wooden skirting boards to some bedrooms were still defective and required repair and repainting.
- The floor covering and wall floor coving to many bedrooms were still defective and unsafe.
- The rain water gutters to the rear of the unit required cleaning as weeds were noted in same.
- There was inadequate storage space for equipment.
- The enclosed garden area was not well maintained, walkways and footpaths were not regularly cleaned, accumulations of builders waste including metal and wooden objects was noted and cigarette ends were strewn on the ground outside the conservatory doors.

Judgment: Not compliant

Regulation 18: Food and nutrition

There was no menu displayed in one dining area and the menu was not clearly written and difficult to read in the other unit. Staff or residents did not know what was on offer for lunch. Residents who could eat a regular diet were offered a choice of meal the previous day but residents spoken with were unable to remember what they had ordered. Residents who required modified diets did not have a choice of main meal and were served the modified option on the day. 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; however, some staff practices observed remained task-orientated with little or no meaningful engagement.

An inspector observed soup being served to residents in plastic type glasses and plastic milk cartons were placed directly on the tables, this was not indicative of a quality service.

Judgment: Not compliant

Regulation 26: Risk management

A number of hazards which posed a risk to residents were noted by inspectors during the inspection. These were brought to the attention of the management

team.

- Objects including a knife, scissors, empty paint cans, sharp metal strips and discarded wooden boards were left unsecured in the enclosed garden area.
- The clinical waste bin stored externally was not secure and could be accessed from the enclosed garden area.
- Cleaning agents were left unattended on an open cleaning trolley.
- PEEPs (personal emergency evacuation plans) were not in place for all residents
- A long blue metal handle was left in a communal bathroom.

Judgment: Not compliant

Regulation 27: Infection control

Inspectors were not assured that procedures and practices consistent with good practice standards for the prevention and control of healthcare-associated infections were implemented by staff.

Inspectors were informed that legionella readings were still high in some bedroom areas and a resident was moved from Room 14 in Unit 6 to other accommodation due to high readings. The management team advise inspectors that a meeting was to take place later in the week to review the situation. Other findings included:

- There was no dedicated cleaning team.
- Cleaning duties were fragmented and carried out by catering, laundry and care staff, with some cleaning duties completed by the porter.
- There was no signage at some wash hand basins advising that the water supply was unfit to drink.
- Catering staff completed both catering and cleaning duties intermittently throughout the day.
- Some hand sanitising agents stored in the sluice room were dated 2014 and had expired their date of effectiveness.
- There was still inadequate guidance, training and education provided to staff for the management of laundry and use of laundry room equipment.
- Storage racks for urinals and bedpans were not wall mounted in the sluice room.

Judgment: Not compliant

Regulation 28: Fire precautions

Some aspects of fire safety management required further review. Further fire

drills were required to ensure all staff were involved in a simulated full compartment evacuation. Some staff spoken with did not demonstrate a knowledge or understanding of the individual fire compartments and the number of residents accommodated within the compartments. Wooden door wedges were noted on the floor behind some doors. Many doors were not fitted with self-closing devices. This posed a risk as doors could not close automatically in the event of fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Improvements were still required to ensure that all medicines were administered as prescribed. While medicine charts were generally found to be completed in line with the medication policy, inspectors noted some gaps in the medicine administration charts where no codes had been used. One prescription did not have the frequency of administration recorded.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care records were maintained in a computerised format. Staff used a variety of accredited assessment tools to assess each resident's needs.

Improvements were still required to ensure that care plans were in place for all identified issues, to ensure all care plans reflected the current needs of residents and guided staff in the care of the resident. There was poor evidence available to show that care plans reviewed had been revised in consultation with the resident concerned, and where appropriate, the resident's family.

Some care plans reviewed were not person-centred and did not always describe care interventions that reflected residents' preferences and wishes regarding their care, other care plans had not been reviewed and updated to reflect residents current needs.

Some residents assessed as requiring hydration monitoring did not have an intake and output chart completed to determine if the plan was effective or if it required review.

Judgment: Not compliant

Regulation 6: Health care

Improvements were still required to ensure all residents had timely access to some allied health services. Inspectors identified a number of residents who required review by speech and language therapy (SALT), tissue viability nurse and audiologist. Inspectors saw documentation for requests for some of these services extending from May 2018 to present.

Judgment: Not compliant

Regulation 8: Protection

Garda (police) vetting disclosures, in accordance with the National Vetting Bureau, were available in respect of staff in the centre to ensure the protection of residents.

Judgment: Compliant

Regulation 9: Residents' rights

While improvements had been made to ensure additional televisions were provided in shared bedrooms, some residents still did not have a television positioned in a way that they could easily view.

Residents who required modified diets did not have a choice of main meal at lunch time.

There was no menu displayed to inform and remind residents what was on offer for each mealtime.

Systems in place to ensure that residents' personal clothing was returned to them following the laundry service required improvement. There was several items of personal clothing in both laundry rooms that did not have an identifiable label. Staff did not know who the clothing belonged to.

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
Capacity and capability	
Regulation 14: Persons in charge	Not 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 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
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	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Merlin Park Community Nursing Unit 5&6 OSV-0000635

Inspection ID: MON-0026599

Date of inspection: 25/06/2019

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 14: Persons in charge	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 14: Persons in charge:</p> <ul style="list-style-type: none"> • The PIC is now responsible for the Designated Centre Merlin Park CNU and is not involved in the Management of any other Designated Centre. • The HR process to enhance the Governance in Merlin Park has commenced, to provide additional Clinical Governance and consistent cover to Deputise in the absence of the PIC. • CNM2 Deputises for the PIC in her absence. 	
Regulation 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>Training and staff development:</p> <ul style="list-style-type: none"> • An administrative support has been assigned to oversee and manage required training and staff development records a briefing took place on the 18.07.2019 with training expected to be completed by 31.10.2019 for all relevant staff. • The training matrix is being updated to include all mandatory training completed in 2019 and training records will be available for all staff 30.09.2019. 	

- Training and Education was completed with all laundry staff on the management of laundry and use of equipment. Another HSE CNU runs a fully compliant Laundry Service. A site visit is to take place to see what learning can be obtained to ensure full compliance in the Merlin Park CNU.
- An infection control re-audit is taking place by an independent external facilitator on the 20.08.2019. A corrective action plan will be put in place. Following this audit. The auditor here will also provide an information session in August Infection control, laundry handling and hand hygiene.
- Information has been provided to all staff on the Regulations and the National Standards for Infection Prevention and Control. A series of presentations are being scheduled for staff the first of which will be held on the 30.07.2019.
- Care and Welfare Regulations are available for all staff on duty and they will be provided with an individual hard copy by 31.08.2019.
- Oversight and supervision is now in place to monitor nursing documentation. This is done through monthly nursing metrics with feedback and action plans given to staff through the fortnightly staff engagement meetings. Concurrent reviews of care plans are conducted by the PIC on a weekly basis with individual feedback given to nurses.
- The PIC has met with the Catering Manager to discuss menu options and flexible mealtimes are available to residents. Residents have access to the meal options available in the onsite Canteen menu. Residents if they so wish can go to the Canteen or campus coffee shop with family and staff members. Wheelchair access and parking is available if required.
- A nurse is allocated to monitor and supervise all mealtimes. Tables are being set in a more homely manner using appropriate crockery and utensils. Menus from the main kitchen are being developed by the Catering Manager in conjunction with the PIC, SALT and residents and will be available on each table in the dining room for the residents. A customer satisfaction survey has commenced with residents which includes the dining experience. The outcomes from this survey will be reviewed and actions taken to form a more person centered dining experience.
- Staff are aware of the daily menu options and are in a position to advise residents of their choices.
- Staff engagement will take place to discuss their training needs and this is due to commence on 01.09.2019 and aim to have it completed by the 31.10.2019.

Regulation 21: Records	Not Compliant
------------------------	---------------

Outline how you are going to come into compliance with Regulation 21: Records:

- A work history template will be distributed to all staff to provide evidence of full employment history and commencement dates with a completion date of 30.09.2019.
- An administrative support has been assigned to oversee and manage required training and staff development records a briefing took place on the 18.07.2019 with training expected to be completed by the 31.10.2019 for all relevant staff.
- The PIC has completed a restraint audit and gaps in documentation have been identified and corrected. The findings and actions of this audit were shared with staff at the daily Safety Pause. Staff have been reminded of the requirement to consistently record safety checks on bedrails and the CNMs have been advised to monitor that this is being complied with.
- A new external cleaning team has been appointed commencing 27.07.2019 Cleaning checklists are displayed and will be checked by a cleaning supervisor daily. The PIC will oversee the cleaning schedule adhered to.
- An audit schedule by the cleaning contractor will be completed and findings discussed with the PIC.
- A review of the current cleaning schedule will take place as part of the new cleaning contract to incorporate all cleaning tasks and to align cleaning tasks with the findings of the infection control audit.
- The refrigerated unit used to store medicines now has an accurate daily record of temperatures. All Nursing Staff have received communication to advise on the importance of completing this task. This is checked weekly by PIC. A new structured template has been devised for daily completion by the CNM2.
- A letter was issued to each staff nurse on the 27.06.2019 outlining their responsibilities in Medication Management which includes recording nutritional supplements. The PIC and CNM2 are completing Medication Audits monthly. Learning and actions identified are shared with the staff on duty and errors rectified within set timeframes.
- Audits of care plans with regard to fluid intake are in progress to ensure residents identified as requiring monitoring of fluid intake have appropriate records of this and nursing staff have been reminded of the importance of adhering to the care plan for the resident.
- The staff roster identifies the Deputy for the PIC during times when the PIC is away from the centre and she is no longer responsible for another regulated centre.

Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ul style="list-style-type: none"> • The deficits in Governance and Management and repeated non-compliance are currently being addressed through completing the actions identified in this action plan. • A weekly oversight teleconference is taking place led by the Head of Social Care with her Social Care Team including the PIC, GM, Manager of OPS, a member of Quality, Risk and Safety and other HSE services i.e. maintenance as required to address any actions. The 1st one was held on the 18.07.2019. • Residents have access to an advocacy service and are treated with Dignity and Respect. Staff deal with all residents equally. Varying levels of support are provided in accordance with the resident's needs. Additional information on their rights in an accessible format has been made available to the residents such as their menus. • A review has commenced of all the records as required under schedule 1 and 2 to ensure regulation compliance with a completion date of 30.11.2019. • The care plan audit now shows that the assessed needs of residents have been updated and reflected in the care planning documentation. The CNM2 has taken responsibility for this process. All staff have received communication and were advised of the deficits found in the report. • A referral pathway has been established for timely access to Health and Social Care Therapies to include Physio, Speech and Language Therapy (SALT), Audiology, Vascular and a Tissue Viability Nurse (TVN) as identified when required in residents individual care plans. 2 staff have completed a TVN wound care module course in the CNME in GUH to send referrals to the TVN. The Vascular Team have now reviewed a client in Merlin Park CNU. • An audit schedule has been developed. A process has now been put in place that will ensure findings from audits are now reported, implemented and monitored effectively to improve the quality of service. • Currently the infection control audit is in the process of being completed and a re-audit is scheduled for the 20.08.2019 by an external auditor. • The HR process to enhance the Governance in Merlin Park has commenced. • All requested information in relation to action plan in place to address Infection Control audit findings, Fire Safety audit and Annual Review have been submitted to HIQA on 10.07.2019. The PIC – CNM2 is currently overseeing completion of actions. • All actions have been completed and we are awaiting sign off by the external Fire 	

Consultants. This re audit was requested on the 15.07.2019 and we expect this to be completed by the 30.09.2019.

Regulation 24: Contract for the provision of services	Substantially Compliant
---	-------------------------

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:

- Contracts have been reviewed and room occupancy included.
- Relevant contracts are now signed by the PIC. There are two outstanding contracts pending legal process.
- An audit of Contract of Care has been completed by the PIC.

Regulation 3: Statement of purpose	Substantially Compliant
------------------------------------	-------------------------

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

- The SOP has been updated to reflect the recent the RPR, PPIM and the PIC's Deputy.
- The complaints process has been updated in the SOP and submitted to HIQA.

Regulation 34: Complaints procedure	Not Compliant
-------------------------------------	---------------

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

- The complaints procedure and complaints policy is being updated to reflect the names of the nominated person to deal with complaints and the nominated person to oversee the complaints and to ensure they are appropriately responded to and that records are maintained in line with the Regulations. The nominated person to deal with complaints is the PIC and the CNM2. The Manager of OPS Residential will conduct monthly review to ensure all complaints are appropriately responded to and all records specified under Regulation 34 are adhered to. An external Manager will have responsibility for any

appeals processed.

- Complaints and compliments will be an agenda item on the Monthly Social Care Quality and Patient Safety Committee Chaired by the Head of Service from Quarter 3 2019. Trends will be reviewed and actioned.

Regulation 17: Premises

Not Compliant

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

- The current painting programme has been escalated as an urgent service requirement and has been discussed with the Maintenance Team on the 12.07.2019. The painting programme is advancing. The outstanding repairs in Merlin Park CNU have progressed.
- In consultation with the Residents and an interior designer, a project to enhance the homely environment in the CNU commenced as of 16.07.2019 and work to be completed by 31.10.2019.
- Maintenance inspected all skirting boards and defective boards will be made good as required. Maintenance work has commenced since 15.07.2019 and aim to be completed by 30.09.2019.
- Floor and wall covering has been assessed following the Infection Control Audit. Any follow up works were identified during a further assessment of the CNU with the Maintenance Manager, PIC and MOPs on the 12.07.2019.
- Floor repairs on defective flooring in the Units are currently at tender stage scheduled to be completed 31.10.2019.
- A schedule of seasonal gutter monitoring and management by the Maintenance Team is now in place.
- A deep clean is planned for 27.07.2019 and in advance of same a review of all equipment is taking place. Equipment which is not required will be disposed of. A review of storage space will then be progressed and this may require more input from Maintenance if deemed needed.
- The garden was immediately made safe and cleaned up. There is a maintenance programme in place whereby two staff members have taken ownership with maintaining the garden on a daily basis which includes tending to plant beds, hanging baskets, potted plants and the chicken coup. They have completed the painting of the garden furniture with input from the Residents in vibrant colours and to celebrate a garden party took place for residents and families on the 21.07.2019
- A member of staff has set up 'A Men's Shed' for Residents and this takes place every

Wednesday and gardening forms part of the residents activity programme. 2 Residents involved in the gardening project in 2018 won a Galway County Council Award for their hanging baskets and attended an awards ceremony in the Connacht Hotel.

- The Designated Smoking Area for Residents has been enhanced and additional fire safe bins have been installed.
- A member of staff has set up 'A Men's Shed' for Residents and this takes place every Wednesday and gardening forms part of the residents activity programme. 2 Residents involved in the gardening project in 2018 won a Galway County Council Award for their hanging baskets and attended an awards ceremony in the Connacht Hotel.
- All storage space is being reviewed and evaluated. Shelving will be installed as required.

Regulation 18: Food and nutrition

Not Compliant

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

- The dining room is now supervised by a nurse at all meal times and this is clearly identified on the daily allocation with a clear role to improve the dining experience.
- A customer satisfaction survey has commenced with residents which includes the dining experience. The findings from this survey as reviewed by the PIC and PPIM will inform an action plan to implement a more person centred, quality dining experience.
- The dining experience for residents is being reviewed in line with the provision of a more person centred approach to mealtimes "with increased staff to resident engagement".
- An initial audit of the current meal time experience will be carried out.
- Since the inspection the PIC has since attended a Person Centred Care Information Session. 27.06.2019
- The PIC has met with the Catering Manager 17.07.2019 and advised her of the findings of this inspection. An improvement plan has been discussed and agreed.
- The menus are currently being designed to ensure that residents have a choice and the menus are in an easy read format and laminated for each resident and are available on each table in the dining room.

- Residents on a modified diet are offered a choice of meals.
- Residents will now order their meals on the same day.
- The PIC has met with the Catering Manager to discuss menu options and flexible mealtimes are available to residents. Residents have access to the meal options available in the onsite Canteen menu. Residents if they so wish can go to the Canteen or campus coffee shop with family and staff members. Wheelchair access and parking is available if required.
- The practice of using plastic type glasses and cups has ceased and the catering department has provided appropriate home like Delph.

Regulation 26: Risk management	Not Compliant
--------------------------------	---------------

Outline how you are going to come into compliance with Regulation 26: Risk management:

- A number of hazards were immediately removed from the garden and the garden made safe and a maintenance plan is now in place following discussions with the Maintenance Manager. The garden was immediately made safe and cleaned up. There is a maintenance programme in place whereby staff members have taken ownership with maintaining the garden on a daily basis which includes tending to plant beds, hanging baskets, potted plants, and the chicken coup.
- Staff members have now taken ownership for checking the garden area daily to ensure it's safe and that there are no hazards. The garden is significantly improved since the inspection.
- There is a new clinical waste bin which has been purchased and put in place, stored externally and has a new secured lock in place on the gated enclosure. This action was completed on the 05.07.2019
- A new external cleaning team (who supply their own enclosed cleaning trolley during the cleaning process) has been appointed commencing July 27th 2019. As part of the Service Arrangement cleaning checklists are required to be displayed and to be checked daily for compliance by the cleaning supervisor.
- A review of the current cleaning schedule will take place as part of the new cleaning contract to incorporate all cleaning tasks and to align cleaning tasks with the findings of the Infection Control Audit.

- Staff walkabouts take place to ensure that all hazards are identified, assessed and measured with actions put in place to address the identified risks.
- One of the short stay residents on the day of inspection did not have a PEEP in place and this was subsequently completed on the same evening of Inspection. An audit of all care plans has been completed and all residents have a PEEP in place.
- All storage space is being reviewed and evaluated.

Regulation 27: Infection control

Not Compliant

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

- There is a dedicated external cleaning team commencing in the 27.07.2019.
- The PIC and OPS Manager Residential have met with the Managers of the new cleaning team and a cleaning schedule has been developed.
- Consistent signage based on the advice of the Public Health Department has been put in place at all wash hand basins.
- The Public Health Department is providing supporting advice regarding the Management of Legionella. Routine sampling is taking place and this is organised by the Maintenance Department. Precautionary measures are put in place if there are any adverse results. All water samples are currently clear the last one being the 10.07.2019. Oversight in relation to Legionella prevention is provided by the Social Care Management Team Meetings.
- The practice of catering staff being involved in cleaning duties will cease as of the 27.07.2019.
- Out of date Cleaning Agents have been removed from the Sluice Room and storage room.
- The Laundry staff received additional training and education has been provided with regard to the Laundry Policy. An independent audit of the Laundry is scheduled for the 20.08.2019 as part of the Infection Control re-audit.
- Bed pans and urinal storage racks in the Sluice Room have now been wall mounted

Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <ul style="list-style-type: none"> • 2 additional Fire training sessions has been organised for 13.08.2019 to include compartment evacuation and night time fire drills. • A schedule of further annual Fire Training Sessions, dates have been made available to staff. All staff are currently compliant with Fire Training however following findings of the HIQA report additional training has been put in place. All staff on the roster will have completed this additional training by 31.10.2019. • The CNU has an onsite Fire Marshall who has conducted an internal staff education session. Additional signage has been developed to inform staff, residents and visitors. • All wooden door wedges have been removed and staff have been advised that they are not to be used in any circumstances. Action completed 12.07.2019. • The Fire Safety Consultancy Agency have been requested on the 15.07.2019 to re audit the site. • Self-closing devices have been completed as per the Fire Safety Consultant's report. 	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:</p> <ul style="list-style-type: none"> • The PIC is now completing monthly Medication Audits. Any actions identified are and will be shared with the staff on duty and any errors rectified within the set timeframes. • The PIC issued a letter to each staff nurse outlining 27.06.2019 their responsibilities in Medication Management, which includes nutritional supplements. • Engagement with GPs has taken place regarding prescribing practices following a medication audit and the importance of prescribing in line with medication policy. 22.07.2019 	

Regulation 5: Individual assessment and care plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</p> <ul style="list-style-type: none"> • A referral pathway has been established for timely access to Health and Social Care Therapies to include Physio, Speech and Language Therapy (SALT), Audiology, Vascular and a Tissue Viability Nurse (TVN) as identified when required in residents individual care plans. 2 staff have completed a TVN wound care module course in the CNME in GUH to send referrals to the TVN. The Vascular Team have now reviewed a client in Merlin Park CNU. • Evidence is now available to demonstrate that the care plans have been reviewed and revised. A Person Centered approach describing care interventions that reflect the resident's preferences and wishes and this is now documented. There is evidence of consultation with the residents and where appropriate their families. A hard copy of the residents own care plan are shared with the resident themselves and if the resident has consented or where the PIC considers it appropriate be made available to his or her families. Following this if the resident is in agreement with their care plan they sign it. • Concurrent reviews of care plans are conducted by the PIC / CNM2 on a weekly basis with individual feedback given to nurses. • Audits of care plans with regard to fluid intake are in progress to ensure residents identified as requiring monitoring of fluid intake have appropriate records of this. 	
Regulation 6: Health care	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 6: Health care:</p> <ul style="list-style-type: none"> • A referral pathway has been established for timely access to Health and Social Care Therapies to include Physio, Speech and Language Therapy (SALT), Audiology, Vascular and a Tissue Viability Nurse (TVN) as identified when required in residents individual care plans. 2 staff have completed a TVN wound care module course in the CNME in GUH to send referrals to the TVN. The Vascular Team have now reviewed a client in Merlin Park CNU. 	
Regulation 9: Residents' rights	Not Compliant

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

- The positioning of all televisions has been reviewed. Identified modifications have been completed on the 26.07.2019.

- Modified diets are provided from the Main Kitchen in Merlin Park with the input from Catering, Speech and Language Therapist, PIC, Residents and a Dietician to optimize meals and choices being provided.

- There are now menus available on every table in the dining room to inform the residents of the choices for each mealtime.

- All clothing now has identifiable labels. All residents have labelled mesh bags for their smaller personal items. All clothing is now returned to residents directly after laundering. All excess clothing has now been removed. The current Laundry policy will be updated to reflect this change.

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 14(4)	The person in charge may be a person in charge of more than one designated centre if the Chief Inspector is satisfied that he or she is engaged in the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	26/07/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Yellow	30/10/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	26/07/2019
Regulation 16(2)(a)	The person in charge shall ensure that copies	Not Compliant	Orange	31/08/2019

	of the Act and any regulations made under it are available to staff.			
Regulation 16(2)(b)	The person in charge shall ensure that copies of any relevant standards set and published by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act are available to staff.	Substantially Compliant	Yellow	31/08/2019
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	31/12/2019
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	31/12/2019
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Yellow	26/07/2019

Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Orange	26/07/2019
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/11/2019
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/12/2019
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management	Substantially Compliant	Yellow	31/10/2019

	structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	26/07/2019
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	26/07/2019
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard	Not Compliant	Orange	26/07/2019

	identification and assessment of risks throughout the designated centre.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/08/2019
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	Orange	30/09/2019
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2019
Regulation 29(4)	The person in charge shall ensure that all medicinal products	Substantially Compliant	Yellow	26/07/2019

	dispensed or supplied to a resident are stored securely at the centre.			
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	26/07/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	26/07/2019
Regulation 34(1)(c)	The registered provider shall provide an accessible and effective 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.	Substantially Compliant	Yellow	30/09/2019

Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to.	Substantially Compliant	Yellow	26/07/2019
Regulation 34(3)(b)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that the person nominated under paragraph (1)(c) maintains the records specified under in paragraph (1)(f).	Substantially Compliant	Yellow	26/07/2019
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	31/08/2019
Regulation 6(1)	The registered provider shall, having regard to	Not Compliant	Orange	31/08/2019

	the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	26/07/2019
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.	Substantially Compliant	Yellow	26/07/2019
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure	Substantially Compliant	Yellow	26/07/2019

	that a resident radio, television, newspapers and other media.			
--	---	--	--	--