Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Report of an inspection of a Designated Centre for Older People

| | |
|---|---|
| Name of designated centre: | St Joseph's Home |
| Name of provider: | Sisters of St. Joseph of Annecy |
| Address of centre: | Killorglin,<br>Kerry |
| Type of inspection: | Announced |
| Date of inspection: | 18 and 19 July 2018 |
| Centre ID: | OSV-0000287 |
| Fieldwork ID: | MON-0023475 |

## About the designated centre

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

St. Joseph's Home is a 40 bedded nursing home that was purpose built in the 1970s. The centre is currently in the process of being renovated. New extensions and refurbishment of the existing premises has resulted in 21 new single bedrooms and seven new twin bedrooms, all of which are en suite with shower and toilet. The centre is accessed via a long driveway and situated approximately one kilometre from Killorglin town. It is divided into three sections, St. Bridget's, St. Patrick's and St. Mary's. The centre offers 24-hour nursing care to long-term and short-term residents, predominantly over the age of 65 years.

**The following information outlines some additional data on this centre.**

| | |
|---|---|
| Current registration end date: | 14/11/2021 |
| Number of residents on the date of inspection: | 39 |

## How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

**1. Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

**2. Quality and safety of the service:**

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| 18 July 2018 | 10:00hrs to 18:00hrs | John Greaney | Lead |
| 19 July 2018 | 08:30hrs to 17:45hrs | John Greaney | Lead |

## Views of people who use the service

The inspector spoke with a number of residents over the two days of the inspection. All expressed satisfaction with the standard of care provided to them. All residents said that they felt safe in the centre. Many said that staff were very obliging and would go out of their way to help them.

Residents said that the food was very tasty and they always got good sized portions at meal times. Drinks and snack were also provided outside of mealtimes. Residents were happy with the programme of activities and there was enough activities to keep them occupied throughout the day.

## Capacity and capability

Improvements were noted in aspects of governance and management since the last inspection, which took place in August 2017. Significant improvements, however, were still required to ensure that governance and management arrangements supported positive outcomes for residents.

Improvements were seen in the monitoring of the quality and safety of care delivered to residents. There was a comprehensive programme of audits on topics such as care planning, medication management, restraint, hand hygiene and the care environment. There was an action plan associated with each each audit clearly identifying who was responsible for implementing any required improvements and a time frame within which they should be completed. There was an annual review of the quality and safety of care with an associated action plan.

There was a governance and management structure set out in the Statement of Purpose. However, clarity was required in relation to the reporting relationship within this structure. There was a management committee that was made up of a variety of professionals from the local community. The committee met approximately every three to four months and at those meetings the agenda included a report from the person in charge, staffing, finances, and building renovations. The inspector was informed during the inspection that this was an advisory committee, but documentation submitted to HIQA identified the committee as the unincorporated body responsible for the management of the centre. The registered provider representative was requested to provide clarity around the management committee and to ensure that each member of the committee were clear on their responsibilities. Discussions with members of management indicated that some staff members reported to the registered provider representative and others reported to the person in charge. This had been a recent change in reporting arrangements and the inspector was not satisfied that this change in reporting arrangements enhanced oversight of care delivery or provided adequate supervision of staff on a day-today basis. This change in reporting arrangements did not

correlate with the management structure outlined in the Statement of Purpose.

Governance and management team meetings had commenced since the last inspection. These meetings were initially held monthly and the agenda for the meetings indicated that the day to day operation of the centre was discussed. More recently these meetings had become ineffective due to a breakdown in communication between members of the management team.

Communication systems were in place to support staff in providing safe and appropriate care. Handover meetings took place at the start of each shift to ensure good communication and continuity of care from one shift to the next. Regular staff meetings took place. The inspector found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories.

Mandatory training was completed and up to date in fire safety, and most staff had completed training in safe moving and handling, safeguarding vulnerable persons and responsive behaviours. Other training provided included cardiopulmonary resuscitation, food hygiene, dementia-specific training, end of life care and infection control. Nursing staff confirmed they had attended clinical training in areas such as wound care and medication management.

Duty rosters were maintained for all staff, and during the two days of inspection, the number and skill-mix of staff working during the day, evening and night time was observed to be appropriate to meet the needs of the current residents.

A review of a sample of staff files included all the information required under Schedule 2 of the regulations. Registration details with An Bord Altranais for 2018 was seen for nursing staff. Garda Síochána (police) vetting was in place for all staff and no staff commenced employment until all aspects of vetting were in place. A file was kept for volunteers who worked in the centre.

Improvements were required in relation to the supervision of staff when it was identified that there was a requirement for improvement in performance. Arrangements for increased supervision were not adequately addressed when it was identified through both the disciplinary process and the performance appraisal process, that staff members would benefit from a performance improvement plan. An urgent compliance plan was issued to the provider on the day following the inspection to address this issue.

Improvements were also required in relation to safeguarding arrangements and the investigatory process following allegations of abuse. There was not always an investigation conducted in accordance with the centre's own safeguarding policy and adequate safeguarding arrangements were not always put in place following allegations of abuse. In addition, the requirement to notify HIQA following suspicions or allegations of abuse was not adhered to.

## Regulation 15: Staffing

A review of the roster indicated that there were adequate numbers and skill mix of staff to meet the needs of residents, both day and night. The person in charge and clinical nurse manager were usually present in the centre each day from Monday to Friday. There were two staff nurses and six healthcare assistants on duty each day from 08:00hrs to 14:00hrs and two staff nurses and five healthcare assistants until 20:00hrs. There were two staff nurse and two healthcare assistants on night duty.

Judgment: Compliant

## Regulation 16: Training and staff development

When increased supervision of staff was indicated, this was not put in place.

A number of staff were overdue attendance at training in recognising and responding to abuse, manual and people handling, and responsive behaviour.

Judgment: Not compliant

## Regulation 21: Records

Personnel records were maintained in accordance with the requirements of Schedule 2 of the regulations.

Judgment: Compliant

## Regulation 23: Governance and management

Significant improvements were required in relation to governance and management:

- there was lack of clarity around the role of the management committee as to whether it was an advisory committee or the unincorporated body responsible for the management of the centre. Documentation submitted to HIQA indicated that it was the unincorporated body but it was not clear that each member of the management committee were aware of their responsibilities
- some staff members reported to the registered provider representative and others reported to the person in charge. This recent change in reporting arrangements did not correlate with the management structure outlined in the Statement of Purpose. The inspector was not satisfied that this change in reporting relationship enhanced oversight of care delivery or provided

adequate supervision of staff on a day-to-day basis

- governance and management team meetings had become ineffective due to a breakdown in communication between members of the management team
- staff were not always adequately supervised when performance was not always at the desired level
- the investigatory process following allegations of abuse were not always managed in line with the centre's own safeguarding policy. Adequate safeguarding arrangements were not always put in place following allegations of abuse
- the requirement to notify HIQA following suspicions or allegations of abuse was not always adhered to.

Judgment: Not compliant

## Regulation 24: Contract for the provision of services

The contract of care included terms in relation to the number of occupants in each bedroom and also included fees for additional services.

Judgment: Compliant

## Regulation 3: Statement of purpose

There statement of purpose required review to ensure it reflected the management of the centre and the reporting relationship with the management structure.

Judgment: Substantially compliant

## Regulation 30: Volunteers

There were a number of volunteers involved in the provision of activities to residents. Each volunteer had their roles and responsibilities set out in writing and had a vetting disclosure in accordance with the National Vetting Bureau Act 2012.

Judgment: Compliant

## Regulation 31: Notification of incidents

A review of records indicated that most incidents occurring in the centre were notified to HIQA within the required time frame. However, not all incidents of suspicions or allegations of abuse were notified as required.

Judgment: Not compliant

## Regulation 34: Complaints procedure

The complaints policy did not identify who was responsible for ensuring that all complaints were responded to and that adequate records were maintained. The complaints log contained three complaints since the last inspection in August 2017. The person in charge was advised to record all complaints and not only those that were deemed to be significant complaints.

Judgment: Substantially compliant

## Quality and safety

Overall, residents were supported and encouraged to have a good quality of life which was respectful of their wishes and choices. Improvements were required in safeguarding practices to ensure that suspicions or allegations of abuse were investigated according to the centre's own policy and that adequate safeguarding arrangements were put in place. The centre generally ensured that the rights and diversity of residents were respected and promoted. There was evidence of consultation with residents informally on a daily basis by the person in charge and staff and formally through residents' meetings. There was a named advocate to support residents should the need arise.

Visitors were seen to come and go throughout the days of inspection and there was a visitors' room available where residents could receive visitors in private if they wished. Residents were facilitated to exercise their civil, political and religious rights. Staff confirmed that residents can vote in the centre if they wish. Residents' religious preferences were ascertained and facilitated. There was a large church in the centre and there was a daily mass. The preferences of non-catholic residents were also supported and facilitated.

The centre was purpose built in the 1970s, however, it had become dated and is now in the process of undergoing major renovations. A new wing, comprising 20 single en suite bedrooms, was registered with HIQA in July 2017. Another new wing and renovations of the existing premises provides en suite bedroom accommodation for 15 residents in seven twin and one single bedroom. This inspection was scheduled in response to an application to register the centre following the

construction of these new bedrooms.

All of the new bedrooms are large, bright and spacious and were furnished with wardrobes, chest of drawers, bedside locker with lockable storage, comfortable armchair and bedside table. The en suites were also large and contained a shower, toilet and wash hand basin. There was a large, bright reception area with seating for residents with a view to the outside through large windows and glass paned doors. While this is currently accessible and used by residents, it is not currently in use as a reception area until all renovations are complete. All of the new bedrooms have overhead hoists. Some work remains outstanding, such as the provision of screening between beds in shared rooms and the installation of hand sanitizers, soap dispensers and paper towel dispensers.

Plans are in place for the renovation of St. Bridget's and St. Patrick's wings but this has not yet commenced. St. Patrick's and St. Bridget's appeared to be clean throughout, however, some work was required in relation to the décor as there was significant amount of chipped paintwork. The corridors were narrow and there was limited natural light in comparison to the new wings. It is acknowledged that this will be addressed in the proposed renovations.

Residents had access to appropriate equipment such as hoists, wheelchairs and speciality beds and mattresses. There were ceiling hoists in all of the new bedrooms and also in the bedroom designated as the palliative care room. Maintenance records were available demonstrating a programme of preventive maintenance for equipment such as beds, baths, hoists, hoist slings, wheelchairs, and weighing scales. Handrails were provided in bath, shower and toilet areas and handrails were provided on corridors. There was a large chapel that was easily accessible.

There was an activities coordinator for the purpose of meeting residents' social care needs. There were a large number of volunteers facilitating the programme of activities, which included Sonas, art and crafts, bingo, sing-songs and religious activities. Residents told the inspector how much they enjoyed the activities. The inspector was informed that there were no organised excursions and residents were usually taken out on trips by their families. The programme of activities could be enhanced by the facilitation of residents to participate in activities within the local community and the provision of excursion to local attractions. In addition, the inspector observed that there was a large secure outdoor space. However, over the two days of the inspection the inspector did not any residents being taken outside even though the weather on both days was very amenable to spending time outside.

Staff supported residents to maintain their independence where possible and residents' healthcare needs were met. Residents had good access to general practitioner (GP) services and to a range of allied health professionals and out-patient services. Overall, residents and relatives expressed satisfaction with the healthcare service provided.

Since the previous inspection, significant improvements were seen in the assessment and care planning process. The assessment process involved the use of

a variety of validated tools and care plans were found to be more person-centred and provided good guidance on the care to be delivered on an individual basis. Systems were in place to make sure that care plans were reviewed and updated on a regular basis to ensure that residents' up-to-date care needs were met.

Improvements were required in relation to the measures in place to protect residents from being harmed or suffering abuse. Most staff had completed training in adult protection and demonstrated their knowledge of protecting residents in their care and the actions to be taken if there were suspicions of abuse. In instances where there were suspicions or allegations of abuse, the centre's own policy was not adhered to in relation to investigating the allegation or safeguarding residents while the investigation was underway. In addition to this, there were not adequate records detailing the investigation conducted or the outcome of the investigation.

There was a centre-specific restraint policy, which promoted a restraint-free environment and included a direction for staff to consider all other options prior to its use. The inspector saw that the centre had reduced its bedrails use to five residents at the time of the inspection, and there was evidence that other alternatives such as low-profiling beds were in use to prevent restraint. Two residents had lap belts in place for postural support purposes and there was an occupational therapy assessment completed identifying the need for the lap belts.

Systems were in place to promote safety and effectively manage risks. Policies and procedures were in place for health and safety, risk management, fire safety, and infection control. There were contingency plans in the event of an emergency or the centre having to be evacuated. Fire fighting equipment, alarms and emergency lighting were all provided and serviced at appropriate intervals. All staff had attended up-to-date fire safety training. There were daily checks of means of escape to ensure that emergency exits remained unobstructed. All safety checks, however, were not conducted in accordance with fire safety guidance issued by HIQA. For example, the fire alarm was not sounded weekly to assess if it was functioning appropriately and that all fire doors would close when the fire alarm sounded. There was fire safety signage on display at intervals along the corridor identifying the evacuation process in St. Mary's wing, however, this had not yet been put in place in the new wing. The fire safety signage identified where you were in the centre in relation to the nearest emergency exit. It did not, however, clearly identify fire compartments within the centre so that staff could identify places of relative safety within the centre in the event of a requirement for horizontal evacuation. While staff members spoken with were knowledgeable of what to do in the event of a fire, they were not clear on which fire doors formed the perimeter of each fire compartment. Fire drills were conducted at frequent intervals. The record of fire drills required review, as it did not provide adequate detail of scenario simulated, the time it would take to evacuate all residents from a compartment and any learning from the drill.

## Regulation 11: Visits

There were adequate arrangements in place for residents to receive visitors. There was open visiting and visitors were seen to come and go throughout the two days of

the inspection. There were adequate facilities for residents to receive visitors in a suitable private area, separate from the resident's bedroom.

Judgment: Compliant

## Regulation 12: Personal possessions

The centre was in the process of being renovated. There was ample space in the new bedrooms for residents to store clothing and other personal possessions in their bedrooms. Each resident had access to a bedside locked, a chest of drawers and a double wardrobe.

Judgment: Compliant

## Regulation 17: Premises

The centre was purpose built in the 1970s, however, it had become dated and is now in the process of undergoing major renovations. A new wing, comprising 20 single en suite bedrooms, was registered with HIQA in July 2017. Another wing has been built since then comprising six twin en suite bedrooms and renovations of the existing centre has resulted in one new twin and one new single bedroom. Some work remains outstanding, such as the provision of screening between beds in shared rooms and the installation of hand sanitizers, soap dispensers and paper towel dispensers.

Plans are in place for the renovation of St. Bridget's and St. Patrick's wings but this has not yet commenced. St. Patrick's and St. Bridget's appeared to be clean throughout, however, some work was required in relation to the décor as there was a significant amount of chipped paintwork. The corridors were narrow and there was limited natural light in comparison to the new wings. It is acknowledged that this will be addressed in the proposed renovations.

Judgment: Not compliant

## Regulation 26: Risk management

There was a risk management policy that complied with the requirements of the regulations. There was a risk registered that addressed risks throughout the centre. A small number of residents smoked and there was an assessment completed of the level of supervision required by each resident while smoking and their level of

access to cigarettes and lighters.

Judgment: Compliant

## Regulation 28: Fire precautions

Improvements were required in relation to fire safety. For example:

- All safety checks were not conducted in accordance with fire safety guidance issued by HIQA. For example, the fire alarm was not sounded weekly to assess if it was functioning appropriately and that all fire doors would close when the fire alarm sounded
- there was fire safety signage on display at intervals along the corridor identifying the evacuation process in St. Mary's wing, however, this had not yet been put in place in the new wing
- fire safety signage identified where you were in the centre in relation to the nearest emergency exit. It did not, however, clearly identify fire compartments within the centre so that staff could identify places of relative safety within the centre in the event of a requirement for horizontal evacuation
- while staff members were knowledgeable of what to do in the event of a fire, they were not clear about which fire doors formed the perimeter of each fire compartment
- fire drills were conducted at frequent intervals. The record of fire drills required review, as it did not provide adequate detail of scenario simulated, the time it would take to evacuate a compartment and any learning from the drill.

Judgment: Not compliant

## Regulation 29: Medicines and pharmaceutical services

Medication administration practices observed by the inspector were in compliance with relevant guidance. Residents prescriptions were review regularly by each resident's GP. Medication was stored and disposed of in compliance with professional guidelines and national legislation. All staff nurses had completed a medication management training module.

Judgment: Compliant

## Regulation 5: Individual assessment and care plan

Comprehensive assessments were completed and updated appropriately by the attending nurse in consultation with residents. Care plans were individualised to residents' wishes and needs and provided good guidance on the care to be delivered on an individual basis to each resident. This facilitated positive outcomes for residents. A personal evacuation plan was available for each resident and contained an adequate level of detail.

Judgment: Compliant

## Regulation 6: Health care

Residents had timely access to medical services. Records demonstrated residents were regularly reviewed by their general practitioner. Residents had access to allied health professionals such as speech and language therapy and occupational therapy and were reviewed whenever assessments indicated that a review was required. A chiropodist visited the centre approximately every six weeks.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

The inspector observed kind and respectful interactions by staff. care plans identified the various communication needs of residents in adequate detail. Assessment and care plans were comprehensive and directed care. There was minimal uses of restraint and the only form of restraint in use were bedrails and lap belts. Where restraint was in place, it was only used following an assessment and following the exploration of alternatives to restraint. Two residents had lap belts in place for postural support purposes and there was an occupational therapy assessment completed identifying the need for the lap belts.

Judgment: Compliant

## Regulation 8: Protection

Residents spoken with by the inspector stated that they felt safe in the centre and staff treated them kindly. Staff spoken with demonstrated adequate knowledge of what to do in the event of suspicions or allegations of abuse. Training records indicated that all nursing staff had attended training in recognising and responding to abuse. Most care staff had attending this training and a number of housekeeping

and catering staff were overdue attendance at this training.

In instances where there were suspicions or allegations of abuse, the centre's own policy was not adhered to in relation to investigating the allegation or safeguarding residents while the investigation was underway. In addition to this, there were not adequate records detailing the investigation conducted or the outcome of the investigation.

Judgment: Not compliant

## Regulation 9: Residents' rights

There was an activities coordinator who was supported by a large number of volunteers. The inspector was informed that there were no organised excursions and residents were usually taken out on trips by their families. The programme of activities could be enhanced by the facilitation of residents to participate in activities within the local community and the provision of excursion to local attractions. In addition, the inspector observed that there was a large secure outdoor space. However, over the two days of the inspection the inspector did not see staff taking residents outside even though the weather on both days was very amenable to spending time outside.

Judgment: Substantially compliant

## Appendix 1 - Full list of regulations considered under each dimension

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Not compliant |
| Regulation 21: Records | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Contract for the provision of services | Compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Regulation 30: Volunteers | Compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Substantially compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 12: Personal possessions | Compliant |
| Regulation 17: Premises | Not compliant |
| Regulation 26: Risk management | Compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 29: Medicines and pharmaceutical services | Compliant |
| Regulation 5: Individual assessment and care plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Managing behaviour that is challenging | Compliant |
| Regulation 8: Protection | Not compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for St Joseph's Home OSV-0000287

## Inspection ID: MON-0023475

## Date of inspection: 18 and 19/07/2018

**Introduction and instruction**
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

## Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

### Compliance plan provider's response:

| Regulation Heading | Judgment |
|---|---|
| Regulation 16: Training and staff development | Not Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br><br>Staff Training is being reviewed quarterly and we will continue to do so and all staff will be booked in for training as required. Safeguarding Training is booked on the 18th September 2018 and Manual Handling Training scheduled for the 21st September 2018.<br><br>In the future, any staff who may have received a disciplinary warning will need to have a Performance Improvement Plan put into place. | |
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br><br>The Organization Structure Algorithm for St. Josephs Nursing Home has been reviewed and is attached. A notification will be sent in to HIQA re same. This Structure has been updated in the Statement of Purpose.<br>Governance and Management meetings with the Registered Provider, Director Of Nursing and CNM2 are to occur fortnightly and the larger Governance and Management Meetings with all heads of Department will occur on alternate months.<br>All Staff who receive a disciplinary warning will have a performance Improvement Plan Implemented.<br>At the fortnightly Management meeting, notifications to HIQA will be discussed ensuring all management personnel are familiar with the notifications and any safeguarding concerns will also be discussed. These both will be ongoing items on the agenda.<br>A mediation process is ongoing with members of the Management Team. | |
| Regulation 3: Statement of purpose | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 3: Statement of purpose: | |

The statement of Purpose has been reviewed again and changes made accordingly.
The statement of Purpose will be reviewed every 6 months or more frequently if needed and this will be discussed at our fortnightly governance and management meetings.

| Regulation 31: Notification of incidents | Not Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

This will also become an item on the agenda for our fortnightly governance and management meeting in order to ensure that no notification is omitted. It also then is a point of discussion with all management personnel so that all are equally familiar with the notifications.

In the event of a serious incident arising an emergency Governance and Management Meeting will be scheduled.

| Regulation 34: Complaints procedure | Substantially Compliant |
|---|---|

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

All complaints now are logged. It has been communicated to all Staff that all complaints are to be logged and submitted to the Director of Nursing where they are either investigated if appropriate, or utilized for Quality Improvement. This will be done in a clear and detailed manner.
The appointment of a HR Administrative role is currently being addressed and when the appointment is made before the 31st December this person will then oversee all complaints.
Our Complaints policy is being amended to incorporate these changes

| Regulation 17: Premises | Not Compliant |
|---|---|

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

There are ongoing renovations in St. Josephs where the current build will be totally revamped and updated in accordance with the regulations. This work is due for Completion by the end of March 2019.

The majority of outstanding work which was remaining on the day of the Inspection has been completed. The hand sanitizers, soap dispensers and paper towel dispensers are in place. The fire place in the dayroom has been connected.
Please see photos attached.
The installation of screening between beds is ongoing and has not been completed as yet so for now all these rooms will a have single occupancy until the screens are in place.

| Regulation 28: Fire precautions | Not Compliant |
|---|---|

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

The guidelines from HIQA on Fire Precautions in designated Centre's were reviewed by Director of Nursing and Registered Provider.

Weekly sounding of the fire alarm and checking the closing of all doors when the alarm sounded was commenced on the 3rd August 2018. A weekly checklist has been put in place for same and is kept in the Fire Register.

The fire compartments have now been labeled on the fire plans on the walls of the building Evacuation training will be taking place on Horizontal phased Evacuation.

The documentation for fire drills is to be reviewed post training.

The fire policy will need to be reviewed and updated to reflect these changes made.

| Regulation 8: Protection | Not Compliant |
|---|---|

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

Further training has been scheduled for all staff on Safeguarding the Vulnerable Adult.
A review and updating of the centre's own policy will be completed.

The Action Plan previously detailed under regulation 16 will be adhered to as already mentioned.

| Regulation 9: Residents' rights | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Days excursions to be planned??

Use of our outside facilities will be incorporated into the activities timetable each week. We will be offering twice weekly walks outside accommodated by staff and volunteers as weather permits.
An Excursion is being arranged for the residents. A mini bus is being sourced and destination being decided on for the excursion and this will occur before the 31st October 2018. A minimum of quarterly outings will be arranged in the future.

## 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 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training. | Substantially Compliant | Yellow | 30th September 2018 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Not Compliant | Red | 20 July 2018 |
| 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 | Yellow | 10th August 2018 for New Build and March 2019 when refurbishment completed. |
| Regulation 23(b) | The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision. | Not Compliant | Orange | 10th August 2018 |
| 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 | 10th August 2018 |
| Regulation 28(1)(c)(iii) | The registered provider shall make adequate | Not Compliant | Yellow | 3rd August 2018 |

| | | | | |
|---|---|---|---|---|
| | arrangements for testing fire equipment. | | | |
| 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 | Yellow | November 2018 |
| Regulation 28(2)(iv) | The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents. | Not Compliant | Yellow | 31st August 2018 |
| Regulation 28(3) | The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre. | Not Compliant | Yellow | 10th August 2018 |
| 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 | 17th August 2018 |
| Regulation 31(1) | Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence. | Not Compliant | Yellow | 10th August 2018 |
| Regulation 34(1)(f) | The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of | Substantially Compliant | Yellow | 30th September 2018 |

| | | | | |
|---|---|---|---|---|
| | all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied. | | | |
| 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 | 10th August 2018 |
| 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 | 31st December 2018 |
| Regulation 8(1) | The registered provider shall take all reasonable measures to protect residents from abuse. | Not Compliant | Orange | 10th August 2018 |
| Regulation 8(3) | The person in charge shall investigate any incident or allegation of abuse. | Not Compliant | Orange | 10th August 2018 |
| Regulation 9(2)(a) | The registered provider shall provide for residents facilities for occupation and recreation. | Substantially Compliant | Yellow | 10th August 2018 |
| Regulation 9(3)(c)(iv) | A registered provider shall, in so far as is reasonably practical, ensure that a resident voluntary groups, community resources and events. | Substantially Compliant | Yellow | 31st October 2018 |