Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	St. John's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Ballytivnan, Sligo
Type of inspection:	Unannounced
Date of inspection:	07 December 2022
Centre ID:	OSV-0000660
Fieldwork ID:	MON-0036468

About the designated centre

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

The aim of St.John's Community Hospital is to provide a residential setting where residents are cared for, supported and valued within a care environment that promotes their health and well-being. The objectives of St. John's Community Hospital include providing a high standard of care in accordance with evidence based practice, providing individualised care to residents and their families respecting the choices, values, dignity and beliefs and ensuring that the residents live in a comfortable, clean and safe environment. St. John's provides a multi-disciplinary approach to the care of residents. The services provided include on-going care of dependant older people, palliative care, dementia care, and physical and mental health care. The centre comprises of five units, Tir na nÓg, Rosses, Cairde, Curam and the Hazelwood unit. St. John's accommodates male and female residents over the age of 18.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	79

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
Wednesday 7 December 2022	09:50hrs to 18:20hrs	Michael Dunne	Lead
Wednesday 7 December 2022	09:50hrs to 18:20hrs	Nikhil Sureshkumar	Support

What residents told us and what inspectors observed

The overall feedback from residents was mixed, some residents were content living in the centre, while some residents said that they would like to be at home. Residents who expressed a view told the inspectors that staff were kind and helped them with their personal care, assisted them at mealtimes and also provided support with managing their laundry. One resident said that they could access the garden area anytime they wanted.

This was an unannounced inspection. On arrival the inspector's were met by a (CNM) clinical nurse manager who guided the inspectors through the required infection, prevention and control checks such as symptom checking, temperature check and the wearing of (PPE) personal protective equipments such as face masks. Inspector's were informed that the person in charge and assistant director of nursing were off site and would attend the centre later that morning. The inspectors commenced the introductory meeting with the CNM and began the inspection with a tour of the Tir na nOg unit. Both the person in charge, the assistant director of nursing and the regional manager attended the centre later in the morning to facilitate the inspection.

The inspector observed five residents sitting in the dining room after their breakfast. This area was supervised by a student nurse who assisted residents to re-locate to the sitting room which led off the dining room. The inspectors observed that there were seven residents located in the sitting room with no member of staff in the room to supervise and offer support to residents. Rosters showed that there were eight staff allocated to this unit during the day however no staff were present in the sitting room.

Some residents had difficulty with way finding, while other residents were observed mobilising around the unit in a purposeful manner. Staff were available to monitor the residents as they mobilised around the unit and provided appropriate support and de-escalation strategies if residents became disorientated or anxious. These staff interactions were observed to be empathetic and respectful.

Many residents living in Tir na nOg were assessed as having complex care needs which required specific support to maintain their safety and well-being and care plans showed that a number of residents requiring enhanced supervision such as 15 minute observations by the staff team. Records indicated that a number of residents displayed responsive behaviours in this unit which often led to peer to peer incidents in which residents became aggressive with each other, and staff were required to intervene and de-escalate the situation to ensure the resident's safety .

Inspectors also noted that there was a significant number of residents who were aged under 65 living in the designated centre. Some of these residents were assessed as requiring personal assistants to provide additional support. Inspectors were informed by the management team that there were problems sourcing

additional supports and this often meant that residents did not have access to support in line with their assessed needs. For example the lack of personal assistant hours meant that some residents missed out on opportunities to engage in outings and activities into their local community which was impacting on the well-being and quality of life for these residents. The registered provider confirmed that they were liaising with community services in order to re-instate these services for the residents.

The daily routine was largely focused around the provision or personal care and meal time support. Inspector's were informed by the staff team that there was an activities programme for the day of the inspection but this was not displayed in the unit inspected. This meant that residents had to wait to be informed by staff as to what activity was being planned for that particular day.

The unit inspected Tir na nOg, was clean, bright and well-maintained. Flooring was in good condition and communal facilities were suitable for residents use. A finding in relation to the suitability of a fire exit was discussed with the provider who immediately updated their fire procedure and fire safety risk assessment to address this issue.

Resident rooms were tastefully decorated with all single rooms found to contain sufficient storage, seating and space for residents to be able to move about freely and access their belongings. Residents had access to televisions and radio's. Residents were found to be wearing clean and well-fitting clothes and footwear.

The next two sections of this report will present findings of this inspection in relation to the governance and management arrangements in place and on how these arrangements impacted on the quality and safety of the service provided.

Capacity and capability

This was an unannounced risk inspection by inspectors of social services carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 (as amended)

The inspectors found that while there were management systems in place to monitor and review the quality of the service provided, they were not being used to ensure that the service was safe, appropriate, consistent and effectively monitored. Although information was collected on key performance indicators, inspectors were not assured that information gathered through audit and the monitoring of key performance indicators were being used to identify quality improvements that were required.

The Health Service Executive (HSE) is the registered provider for this designated centre. There was a clearly defined management structure in place that was accountable for the delivery of safe and effective health and social care support to

residents. The management team consists of a regional manager, who supports the person in charge in the day to day running of the centre. The clinical team also consists of a director of nursing, an assistant director of nursing, and clinical nurse managers. A team of nurses, health care assistants, household, catering, maintenance, physiotherapy and occupation therapy support were also involved in the delivery of care to the residents in the designated centre.

The designated centre comprises of five individual units, three of which were open and accommodating residents at the time of the inspection, while two other units which had undergone refurbishment works were closed to residents. The findings of this inspection primarily relate to one unit inspected by the inspectors called Tir na nOg, an inspector also visited the two refurbished units called the Rosses Unit and the Curam Unit and these findings are discussed in more detail under Regulation 17 Premises. Each unit had its own dedicated cohort of staff. On the day of the inspection, 24 residents were living on Tir na nOg unit and were supported by seven staff which normally comprised three nurses and four healthcare assistants, a clinical nurse manager was also based in this unit.

While there were staffing resources identified for this unit, a number of residents accommodated required regular staff supervision, there were a number of peer on peer incidents which required notifications to be submitted to the Office of the Chief Inspector. In addition, inspectors found that residents with complex needs who were living on another unit,and who were assessed for additional supports were not in receipt of these supports. This led to poor social care outcomes for these residents and was a significant factor in the high number of peer to peer incidents reported.

A review of training records indicated that there was a range of training available for staff to attend. A mixture of online and on site training included training on positive behaviour, eplilepsy, cardio pulmonary resuscitation (CPR) and tissue viability training.There were improvements noted in staff attendance at mandatory training such as fire and safeguarding training.

While the provider maintained a number of records in line with the regulations, there was inconsistent updating of care plans and the implementation of recommendations made at (MDT) Multi-disciplinary team meetings. This meant that there was a risk that resident's assessed needs would not be met.

The provider had updated their policies in line with Schedule 5 of the regulations. However, inspectors were not assured that the centre's safeguarding policy was being implemented in full in order to protect residents. This was evidenced by the number of potential safeguarding incidents which were recorded on the centre's incident log but did not record an appropriate follow up and investigation in line with the centre's own policy. This meant that potential safeguarding risks were not being identified and managed. In addition opportunities to implement controls or to identify possible learning did not occur.

Complaints received were handled in line with the centre's own policy and procedure. There was good oversight of complaints with the provider keen to learn form the feedback in order to improve the service. The inspectors were provided

with a copy of the annual review of quality and safety for 2022 which included the views of residents and of their relatives.

Regulation 15: Staffing

The registered provider did not ensure that the number and skill mix of staff available in the unit inspected were sufficient to meet the assessed needs of the residents. For example, there were insufficient social care staff rostered to provide activities for a number of residents in the centre. As a result, those residents who required additional support to engage in meaningful activities due to their complex care needs were not sufficiently supported in the centre.

In addition, the social care plans that are in place for one-to-one support for a number of residents to attend activities outside of the designated centre were not happening due to the lack of social care staff available. Inspectors reviewed residents' care records and spoke with staff and residents. Inspectors found that the residents did not go out of the centre because there were no staff available to support them on these outings. There were 11 residents who were under 65 years living in the centre. Out of these 11 residents, additional support was secured for personal assistance hours for three residents. However, even for these three residents additional personal assistant hours for the provision of social care activities and outings and the residents were not been used effectively. This was impacting on the well-being and the quality of life for these residents.

Judgment: Not compliant

Regulation 21: Records

The provider had not ensured that all records set out in Schedule 3 of the Regulation were made available in the centre. For example:

- The records related to a resident's multidisciplinary team meetings and their recommendations, including the plan of care, were not updated in the care files in line with the regulatory requirement.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems in the centre were insufficient and required further improvement to ensure that the service provided was safe and effectively

monitored. For example:

- The oversight arrangements in place for the review of the accidents and incidents failed to identify the increased occurrence of unknown bruising and peer-to-peer incidents in the centre. As a result, the provider's systems failed to identify the level of clinical risk associated with the incident and the interventions that were required to reduce the level of risk in the centre.
- The provider's arrangements in place for the regular review of their resources for safe and effective delivery of service were insufficient. For example, the provider had not identified the risk associated with the lack of social care staff and the interventions required to support residents with complex care needs in the centre as a risk in their risk register. As a result, additional resources were not sourced to provide the additional level of support that was assessed as required to meet the resident's needs.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider had not notified the Chief Inspector in writing about three safeguarding incidents that had occurred in the centre. For example:

- An incident related to an allegation of financial abuse was not reported to the Chief Inspector.
- An incident related to unauthorised access of a member of the public into the designated centre was not notified to the Chief Inspector.
- Not all allegations of suspected abuse or incidents were notified to the Chief Inspector. For example, a number of incidents related to physical aggression between residents, which reported clear safeguarding risks to the residents, were not notified to the Chief Inspector.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had not implemented all of the policies and procedures on the matters set out in Schedule 5 of the regulation. For example:

- Several incidents of unexplained bruises, which occurred to the residents in the centre, were not appropriately managed in line with the centre's safeguarding policy. As a result, effective measures were not identified to reduce the occurrence of such incidents.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was an accessible complaints policy and procedure available in the centre which met the requirements set out under the regulation 34. Records of complaints and their outcomes were well-documented and made available for the inspector to review. The complaints policy was advertised in the unit and was found to have been updated in May 2022. There was one complaint which was open and being reviewed in line with the centre's complaints policy.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge ensured that staff had access to a range of training, which included a mixture of both mandatory training and supplementary training to assist staff perform their roles more effectively.

Judgment: Compliant

Quality and safety

The inspectors found that not all residents living in the designated centre experienced a good quality of life. Evidence found on inspection indicated that there were a number of actions required on behalf of the provider to reach full compliance with the regulations and to ensure that the service provided in the centre was safe and appropriate and that residents enjoyed a good quality of life. These actions relate to the protection and safeguarding of residents, ensuring that care records reflect the current needs of the residents and that interventions incorporate the updated guidance and treatment plans identified by clinical teams. In addition, a number of residents with acquired brain injury were not sufficiently supported to participate in activities in accordance with their interests and capabilities and were not able to access their community if they wished to do so.

Furthermore, a review of one resident's responsive behavioural record indicated that the resident's responsive behaviour has dis-improved due to the lack of meaningful activities available to them in the centre which was identified in several multi-disciplinary team meetings (MDT).

The inspectors reviewed the provider's arrangements for the residents to access and retain control over their personal property and found that the residents had access to their personal clothes. However, some residents who were accommodated in multi occupancy rooms did not have sufficient storage space to store their personal belongings, such as photographs and other personal items.

Inspectors reviewed the infection control procedures in the centre and found that the staff were knowledgeable about the infection control procedures and were implementing them in practice. Overall there were adequate supplies of hand sanitisers and personal protective equipment available. However, additional hand sanitisers were required outside a communal room to ensure residents, staff, and visitors were able to carry out hand hygiene in this busy area.

The inspectors reviewed a sample of residents' assessments and care plans and found that the care plans had not been appropriately reviewed, and as a result, the resident's current care needs were not accurately reflected in their care plan. This is further discussed under Regulation 5. Furthermore, the provider had not ensured that those residents presenting with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) received appropriate care and support in line with their needs and that the impact of responsive behaviours on the other residents living in the centre was identified and managed appropriately. This is further discussed under Regulation 7.

The centre benefited from the availability of a medical doctor who was accessible, and the residents were found to have timely access to medical services. There was evidence that residents were supported to access allied health for additional expertise such as dietitian, physiotherapy and occupational therapy services.

The inspectors reviewed the records of accidents and incidents which occurred in the centre and noted that the incidents were reported promptly to the senior managers. Even though the centre had comprehensive safeguarding and risk management policies in place, inspectors found that these policies had not been appropriately implemented as discussed under Regulation 4. As a result, significant actions were now required to ensure that all residents living in the centre were adequately protected.

On the day of inspection, the inspectors noted that there were no activities schedule available to the residents in one of the units in the centre. The inspectors observed that social care programs started only in the late morning hours, and several residents were found to be sitting in the day rooms of the centre. While day room supervision was available to support residents with responsive behaviours, the inspectors observed that some residents spent long periods with little to do and limited social interactions with staff or with each other. Even though staff were allocated to provide social care activities in the day room of Tir na nÓg unit, the provision of personal care and ensuring the safety of residents took precedence over social care programs. As a result, the residents did not receive good quality social care programs in the centre.

The inspectors reviewed the fire safety records which showed that the provider had systems to monitor the fire system and to ensure that there were arrangements in place, to protect residents in the event of a fire. Staff who spoke with the inspectors were aware of the procedures to follow in the event of a fire activation and there were records in place to evidence regular servicing. However, improvements were required regarding a fire exit to ensure that residents using mobility equipment could be evacuated safely.

A review of two registered units which were redeveloped indicated that they were not fully ready for occupation, this is discussed in more detail under regulation 17.

Regulation 12: Personal possessions

Residents who were accommodated in multi occupancy rooms required additional storage space to store their personal belongings. There was a lack of shelving available for residents to store their personal items and mementos.

Judgment: Substantially compliant

Regulation 17: Premises

The inspector did a walkabout on two units (Rosses and Curam) in the designated centre which had undergone significant redevelopment. Both of the units were tastefully decorated, bright and well ventilated. Accommodation was provided in a series of multi-occupancy rooms which comprised of five three bedded rooms and one four bedded in both of the units reviewed. There was sufficient communal space for residents to use and this was provided in sitting rooms, dining rooms and family rooms. There was access to a secure communal garden.

Both of these units were unoccupied at the time of this inspection and were not ready to accept residents. For example:

- Communal rooms required furniture such as tables and chairs
- Beds and bedroom furniture was not in place.
- Not all rooms on the floor plan were identified on the walkabout in some cases their function was not displayed.
- A toilet located on Curam unit required the fitting of grab rails.
- Simulated fire drills and evacuations were required to ensure fire safety procedures were adequate to protect residents from the risk of a fire activation.
- The garden area required additional furniture to meet the assessed needs of the residents.
- A number of bedrooms were overlooked by the garden area, this required

review to ensure residents privacy and dignity was respected.
- Call bell points were missing from a family room on Rosses unit.

Judgment: Not compliant

Regulation 26: Risk management

There was a risk management policy and procedure in place which met the requirements of Schedule 5 of the regulations. The inspector reviewed the risk register and found that a number of risks had been updated in October 2022.

There was a process in place to review risks at governance meetings, however, not all risks had been identified by the provider and this is addressed under Regulation 23 governance and management.

Judgment: Compliant

Regulation 27: Infection control

There were insufficient hand sanitisers available outside a communal room located in one unit of the centre, this reduced opportunities for residents, staff and visitors to carry out hand hygiene practices required to reduce cross-infections. Inspectors were informed that additional sanitisers would be installed in this area.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had not ensured that there were appropriate evacuation procedures in place to ensure residents could be evacuated in a fire emergency. For example;

One fire exit located in Tir na nOg unit had steps to the external pathway. This would hinder the safe evacuation of residents using mobility equipment such as wheelchairs or zimmer frames or for those residents requiring ski sheet evacuation.

There was no signage in place to indicate the location of the fire assembly point.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The provider's arrangements to meet the assessed needs of each resident were insufficient. For example, a resident who was assessed as having pain did not have an appropriate pain care plan developed to support their ongoing needs.

The provider had not ensured that the residents' care plans were appropriately reviewed in the centre to ensure that their current care needs were accurately reflected in their care plans. For example:

- Several residents who were at risk of injury and who sustained recurrent bruising did not have an appropriate assessment carried out to determine the root cause of the injuries and an appropriate care plan developed to prevent the occurrence of such incidents in the unit.
- While some residents with complex care needs have a social care plan in place to identify their additional support needs such as one to one personal assistance, care plan reviews were not identifying these care needs were not being met.

Judgment: Not compliant

Regulation 6: Health care

Residents in the centre have access to an on-site medical officer. A range of other health care services were available for residents such as physiotherapy, dietitian, occupational therapy. Arrangements were also in place to access palliative care services and psychiatry of later life.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The provider had not ensured that the residents presenting with responsive behaviours were appropriately managed in the centre. For example:

- The provider had not ensured that a resident with responsive behaviour had an appropriate care plan developed to manage and respond to this responsive behaviour. Furthermore, the review of the resident's care records and the feedback from staff indicates that although the root cause of behavioural issues was identified as a lack of meaningful activities, the resident was not sufficiently supported to engage in their preferred activities.

As a result, the resident continued to present with episodes of responsive behaviours in the centre.

- In addition, the review of the record of some residents' behavioural incidents indicates that when a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the overall management of these behaviours, including the root cause to establish aggravating factors or underlying causes and arrangements for the provision of purposeful activity and stimulation for these residents were not always supported in the centre.

Judgment: Not compliant

Regulation 8: Protection

The provider had not taken all reasonable precautions to protect the residents from abuse. For example, the records of accidents and incidents reviewed by inspectors identified safeguarding risks that were not investigated and managed in line with the centre's own safeguarding policy.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had not ensured that the residents were provided with sufficient opportunities to participate in activities in line with their interests and capabilities. For example:

- Some residents with higher cognitive needs were not provided with the opportunities to engage in meaningful activities.
- Even though staff were allocated to provide activities in Tir na nÓg unit, the inspector observed that the current level of activities for several residents with a history of responsive behaviours was insufficient. Although some staff were engaged in activities with the residents, there were instances where the residents had little to do and the staff allocated to do day room supervision were often seen carrying out safety checks to manage safeguarding issues arising from residents' responsive behaviours.

Judgment: Substantially 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 15: Staffing	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 16: Training and staff development	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St. John's Community Hospital OSV-0000660

Inspection ID: MON-0036468

Date of inspection: 07/12/2022

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 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
To ensure compliance with Regulation 15 Staffing (1). The Registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5 , and the size and layout of the designated center concerned .

Compliance will be met by the following :

1. The designated centre is currently participating in the Department of Health safe staffing phase 3 pilot in relation to residential care settings. This is in its final phase and this will determine evidence based safe staffing. This is due to be completed on the 01/04/2023
2. A review of staffing has been completed by the Person in Charge on the 06/02/2023 and whilst social care staff are not currently employed within the centre social care activities are part of the role of the HCA and HCA's are currently providing activity programmes both individually and in groups on all units. Occupational therapy assistants also provide a daily activity programme across the designated centre
3. Daily staffing allocations have been reviewed and staff are now formally allocated on a daily basis to social care activities and this is documented in the unit diary. This is in place from the 15/02/2023
4. Additional activity materials have been purchased as of the 15/02/2023 for all units and these are being utilised by the residents to enhance their quality of life
5. The activities programme has been reviewed by the Person in charge. Following this review the Person in charge has reestablished links with Sligo Sports and Recreation Partnership and a programme has been arranged. This will be in place for residents from the 06/03/2023
6. The Sligo Sports and Recreation Partnership are also working closely with the Person in Charge in the development of a business case for an outdoor gym which will support the physical and social wellbeing of residents. On completion of the business case this will be put forward for funding. It is anticipated that this will be in place in 2024
7. As part of the activity programme review the Person in Charge has reestablished links

with local musicians and artists. Bespoke programmes for the residents have been finalised. These programmes are due to commence in the designated centre from the 30/03/2023
8. Additional to the above care pals training has been sought for staff to support them with providing activities for residents and a training schedule has been developed
9. The Person in Charge has met with our education partners in the Centre for Nursing and Midwifery Education Centre on the 20/02/2023. It has been agreed following this meeting that a bespoke training programme will be provided for staff working in older persons services in respect of person centred planning and social activities as well as clinical programmes as identified by the service. These training programmers will commence on the 08/03/2023

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
To ensure compliance with Regulation 21 (1): The registered provider shall ensure that records set out in Schedule 2, 3 and 4 are kept in the designated center and are available for inspection by the Chief inspector

Compliance will be met by the following :

1. The Person in Charge has reviewed case files and ensured that updated multidisciplinary team meetings and their recommendations are now available on the residents care plan. This was completed by the 06/02/2023.
2. In line with the designated centres clinical audit and quality assurance process, care plans will be reviewed to ensure a holistic approach to care is reflective in the care plan. This is in place as off the 06/02/2023

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure Compliance with Regulation 23(a) Governance and Management 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:

To ensure Compliance with Regulation 23(c) Governance and Management the Registered Provider shall ensure that management systems are in place to ensure that

the service provided is safe, appropriate, consistent and effectively monitored.

Compliance will be met by :

1. The Person in Charge has reviewed the governance and management of all incidents within the designated centre and has implemented a robust review mechanism for all incidents that occur.
This system will ensure that all incidents are fully reviewed at the time of the incident with all appropriate measures to mitigate against any further harm. All incidents will be triangulated and reviewed by the Person in Charge/Assistant Director of Nursing. This review will be recorded on the incident review report and also in the residents care record as required. This is in place as off the 05/01/2023
2. The Person in Charge reviews all incidents on a weekly basis and formally reviews incidents on a monthly and quarterly basis as to determine and monitor any trends that are occurring. This allows the Person in Charge and the management team to discuss any patterns of concern and allows for the development of timely quality improvement plans. This process is in place as off the 05/01/2023
3. As part of the governance review all incidents are discussed at the weekly Clinical Nurse Managers meeting and the learning is shared as part of this meeting. This learning is then discussed at unit level as part of the safety pause and team meetings. This is in place as off the 05/01/2023
4. The person in charge will review all incidents within the centre as to ensure that safety measures implemented are assuring resident's safety. The person in charge will continue to assure that all incidents are reviewed in line with the HSEs National Incident Management Framework.
5. The person in charge will continue to be supported by the Quality and Patient Safety lead in reviewing all incidents which occur within the centre. This provides supports to the Person in Charge in reducing the reoccurrence of the incident/accident.
6. In addition a quality profile system is in place. This assures that the National Incident management form and the incident management system process is fully aligned. This is governed by the quality risk and patient safety division in CH CDLMS. This quality assurance system ensures that all incidents are managed appropriately and assessed and escalated as required. This provides an additional safety measure in relation to incident management and identification of possible safeguarding incidents that may require further review.
7. The Person in Charge and the Provider have reviewed the arrangements in place for regular staffing reviews and resources. Health care assistants alongside with nursing and Occupational therapy assistants in supporting the social wellbeing of residents within the center. This has been formalized and is reflected on the daily allocation of staffing as off the 15/02/2023
8. As discussed with the inspector on the day of inspection the Person in Charge and Provider met with the Disabilities Service Manager in early January. As a result of this meeting business cases have been submitted dated the 13/02/2023 via the disability services manager as part of a wider national funding application process as part of, " The Wasted lives Pilot Project ". These business cases are for activity therapists and community outreach assistants to support the younger residents residing within the center
9. The risk management policy has been reviewed and updated to reflect that in the event of unexplained bruising or incident of unknown origin the process that must be

followed. This process is as follows: An unexplained bruising flow chart to be followed and the requirement for the completion of a body chart to record incidents of unknown origin. This will support the decision making process and determination of root cause. This has been implemented as off the 23/02/2023

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
To ensure compliance with Regulation 31 (1): Notification of incidents. The Rregistered Provider where an incident as 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 .

Compliance will be met by the following :
1. A review of the safety and security within the designated centre has been completed. This identified that there was no unauthorised access to the residential centre. As an additional layer of security, the hospital is having key pad locks fitted to all doors from the main entrance to the units which will be used on the discretion of the Person in Charge following risk assessment and consultation with residents. These key padded door fittings are an additional security measure and the Person in Charge will ensure that no residents is restricted to move freely within the centre by the usage of same. This will be completed on the 10/03/2023
2. All incidents of safeguarding and those that related to potential safeguarding will continue to be reviewed ensuring the safeguarding vulnerable adult policy is fully implemented
3. A review of all peer on peer incidents within the centre has been completed. Although it was noted that all processes and protocols were followed this review did highlighted that some of the information recorded on the incident forms at the time of the incident lacked the necessary depth of information required. As and from the 05/01/2023 all incident forms have the required level of review and depth of analysis to determine the root cause and in the event that the root cause of an incident cannot be determined it will be managed in line with the designated centres Safeguarding and Protection policy as appropriate.
4. The centre will continue to liaise directly with the Social Work Team and the Safeguarding and Protection Team CH CDLMS regarding all incidents of a safeguarding nature. These services provide advice, support and onsite supports as required
5. A quality profile system is in place which quality assures that the National Incident management form and the incident management system process is aligned. This is governed by the quality risk and patient safety division in CH CDLMS. This quality assurance system ensures that all incidents are managed appropriately and assessed and escalated as required. This provides an additional safety measure in relation to incident management and identification off possible safeguarding incidents that require further review.

6. Formal links have been established with the local Garda Siochana Community Liaison Team and an identified link person is now available to the designated Centre. It is planned to have quarterly safeguarding meetings with the Garda Community Liaison officer in 2023. A meeting has been scheduled for the 30/03/2023

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
To ensure compliance with Regulation 4 (1): Written policies and procedures the Rregistered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in schedule 5 .

1. All incidents of bruising will continue to be reported on the National Incident Management system in line with the HSE's National Incident Management Framework. The medical officer will continue to review all incidents/accidents within the centre to ensure the welfare of the resident(s) affected. A review of all peer on peer incidents within the centre has been completed. Although it was noted that all processes and protocols were followed this review did highlighted that some of the information recorded on the incident forms at the time of the incident lacked the necessary depth of information required. As and from the 05/01/2023 all incident forms have the required level of review and depth of analysis to determine the root cause. In the event that the root cause of an incident cannot be determined, it will be managed in line with the designated centres Safeguarding and Protection policy as appropriate.
2. The risk management policy has been reviewed and updated to reflect that in the event of unexplained bruising or incident of unknown origin the process that must be followed to include: An unexplained bruising flow chart to be followed and the requirement for the use of a body chart to record incidents of unknown origin. This will support the decision making process and determination of root cause. This has been implemented as off 23/02/2023
3. A quality profile system is in place to quality assure the National Incident Management forms. This is governed by the quality risk and patient safety division in CH CDLMS. This quality assurance system ensures that all incidents are managed appropriately and assessed and escalated as required. This provides an additional safety measure in relation to incident management.
4. Unfortunately there is no way to prevent people from experiencing minor bruises and scratches in any engaged lifestyle. The Designated Centre supports residents to express their will and preference and their ability to make choices and self-determine.
5. The designated centre will continue to support residents to positively risk take whilst at the same time being mindful of risk assessment.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
To ensure Compliance with Regulation 12(a)(c): Personal Possessions: The Person In Charge shall, in so far as is reasonably practical, ensures that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions

Compliance will be met by the following :

1. The Person in Charge has completed a review of all resident's bedroom layouts to ensure that residents as is reasonably practical are able to access their personnel clothing and storage. This was completed dated the 14/02/2023
2. The Person in Charge has consulted with residents regarding their own personal space and if they are happy with it. Following this review changes have occurred to the residents own personal bed space as requested by the resident
3. Shelves have been ordered and will be fitted at each resident's bedside. This will support residents to display their photographs and other mementos if this is their wish. This will be completed by 30/04/2023

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure compliance with Regulation 17(1): Premises: 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

To ensure compliance with Regulation 17(2): Premises: 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

Compliance will be met by the following :

1. Two recently refurbished units within the Center remain closed. Prior to occupation all rooms will be furnished and will meet the required Regulations
2. In addition prior to the residents moving to these units stimulated fire drills will be completed with the allocated staffing team
3. Blinds have been requested for a number of bedrooms that overlook the garden area,

so as to ensure that resident's privacy and dignity is maintained. These are planned to be fitted 30th May 2023.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
To ensure compliance with Regulation 28(1) b: Fire Precautions The Registered Provider shall take adequate precautions against the risk of fire, and shall provide suitable firefighting equipment, suitable building services, and suitable bedding and furnishings.

Compliance will be met by the following :
1. The maintenance manager has reviewed the fire exit and a ramp will be fitted to the external pathway to support safe evacuation of residents in the event of a fire. This will be completed by 31/03/2023
2. Signage is now in place to indicate the fire assembly point.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
To ensure compliance with Regulation 5(1)The person in charge shall , in so far as is reasonably practical , arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2)

To ensure compliance with 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 residents family

Compliance will be met by the following :

1. The Person in Charge has completed a review of care planning processes within the designated centre. Care plans have been updated to ensure that the current care needs of the resident are accurately reflected in the care plans. Care plans are reviewed and updated at four monthly intervals or more frequently if required
2. A new care planning model is being introduced to support a more person centered comprehensive model of care. This will also identify those residents with more complex care needs and identify what supports they require to deliver care which is unique to the

resident and how this is being achieved. This change in care planning process has commenced and will be completed by 31/03/2023. This process will remain under review by the person in charge supported by the management team and practice development.
3. Staff are being supported with additional care planning training and supports from the Practice development coordinator. This is in place and will remain on-going
4. The centre for Nursing and midwifery education are also developing a bespoke training programme in respect of person centred planning for staff regarding care planning in older persons services this will be available from the 30/04/2023
5. An audit schedule is in place within the designated centre. This schedule includes care planning audits. This process ensures that national agreed standards are achieved as well as ensuring that care plans are person centred in their approach and ensuring compliance with the regulations. Following the audit process quality improvement plans are developed. This was completed on the 08/02/2023 and an on-going audit schedule is in place

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
To ensure compliance with Regulation 7 (2) .The registered provider shall ensure that, where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or other persons, the person in charge shall manage and respond to that behavior , in so far as possible, in a manner that Is not restrictive
Compliance will be met by :

1. The Person in Charge has completed a review of the care and care plans of those residents who were presenting with responsive behaviors in the designated centre. This review has ensured that residents have been assessed in line with their needs. Behavioral supports plans have also been updated for those residents whom require same. This was completed on the 20/02/2023
2. A review of activities and meaningful social engagement for residents across the centre has taken place which has resulted in the following:

• Daily staffing allocations have been reviewed and staff are now formally allocated on a daily basis to social care activities as and from the 15/02/2023. Activities will be delivered as per residents wishes, will and preference and residents will be supported as part of the assisted decision making act to engage in activities as they so wish
• Additional activity materials have been purchased as of the15/02/2023 for all units and these are being utilized by residents supported by staff as appropriate
• The activities programme has been reviewed by the Person in Charge. As part of this review the Person in Charge has reestablishing links with Sligo Sports and Recreation services and a programme will be in place for residents commencing the 06/03/2023
• The Sligo Sports and Recreation team are also working closely with the Person in

Charge in applying for funding for an outdoor gym on the grounds of the designated centre which will support the physical and social wellbeing of residents
• In addition links have been reestablished with musicians and artists and bespoke programmes have been developed for residents. These will also be part of the activity programme in the designated centre and is due to commence from the 30/03/2023
• The centre has procured the services of a specialist behavioral consultant to review incidents, support staff and residents and make recommendations in respect of specific individual residents. This review will identify if there is a need for additional training identify new ways of working or any changes which may be required to the living environment for residents. The review is to enhance the quality of life of residents residing within the designated centre. This review is planned to commence on the 07/03/2023.
• Acquired brain injury Ireland have provided additional supports and training to those staff who care for those resident under 65 whom have an acquired brain injury. This was delivered to staff on the 20/02/2023. This has supported staff in the review management and approach of these residents' conditions. This will be provided on an ongoing basis to staff who support those residents under 65
• The Person in Charge is presently reviewing the suitability of the residential centre with the Disability Services Manager for all those residents under 65. This is being completed in conjunction with the residents and their family or circle of support.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
To ensure compliance with Regulation 8 (1): Protection the Registered provider shall take all reasonable measures to protect residents from abuse

Compliance will be met by the following :

1. All schedule 5 policies have been reviewed and updated by the Person in Charge. This was completed on 15/01/2023
2. Staff have up to date Safeguarding vulnerable adults training and attend on a 3 year rolling basis In addition to this Face to face safeguarding training has been reintroduced and was provided on the 08/02/2023. Ongoing training has been scheduled to support staff
3. There are 11 Designated Safeguarding Officers within the designated centre
4. Safeguarding incidents are discussed at the Clinical Nurse Manager meetings on a weekly basis and learning is shared across all units
5. Safeguarding is an agenda item at all unit meetings
6. Governance arrangements within the centre have been reviewed and strengthened to ensure that all incidents of a safeguarding nature are investigated and managed in accordance with the centers safeguarding policy .This is in place from 05/01/21023
7. Formal links have been established with the local Garda Siochana Community Liaison Team and an identified link person is now available to the designated Centre. It is

planned to have quarterly safeguarding meetings with the Garda Community Liaison officer in 2023. A meeting has been scheduled for the 30/03/2023
8. The centre liaises directly with the social work team in CH CDLMS and the Safeguarding and protection team regarding all incidents of a safeguarding nature. These services provide advice, support and onsite supports as required.
9. The Provider and Person in Charge met with the Senior Deputy Safeguarding Officer and members of the safeguarding team to discuss all incidents that related to safeguarding on the 22/02/2023 and they were assured regarding the management of these incidents and the prevalence of incidents within the centre
10. A quality profile system is in place which quality assures that the National Incident management form and the incident management system process is aligned. This is governed by the quality risk and patient safety division in CH CDLMS. This quality assurance system ensures that all incidents are managed appropriately and assessed and escalated as required. This provides an additional safety measure in relation to incident management and identification off possible safeguarding incidents that require further review.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To ensure compliance with Regulation 9(2)(b) : Residents rights The Registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities ,

Compliance will be met by :
1. Social care activities are part of the role of the HCA and HCA's are currently providing activity programmes both individually and in groups on all units
2. Occupational therapy assistants are also providing a daily activity programme across the designated centre
3. External activities and outings are also part of the activity schedule and are scheduled as requested by the residents
4. Daily staffing allocations have been reviewed and staffs are now formally allocated on a daily basis to social care activities and this is documented in the unit diary. This is in place from the 15/02/2023
5. Activities are clearly displayed on all units within the designated centre
6. Additional activity materials have been purchased on the 15/02/2023 for all units and these are being utilised by residents as to enhance their quality of life
7. The activities programme has been reviewed by the Person in Charge. As part of this review the Person in Charge has reestablishing links with Sligo Sports and Recreation Services and a programme will be in place for the residents commencing on the 06/03/2023
8. The Sligo Sports and Recreation Partnership are also working closely with the Person in Charge in applying for funding for an outdoor gym which will support the physical and social wellbeing of residents. It is anticipated that this will be in place by 2024

9. In addition links have been reestablished with musicians and artists and bespoke programmes will be delivered to residents as part of the activity programme in the designated centre. This is due to commence on the 30/03/2023
10. All external areas are being enhanced with seating, planters and raised accessible flower beds as part of our spring activity programme which will include and involve the residents in both gardening and physical activity programmes. This will commence on the 01/04/2023
11. A dementia themed garden is being developed in the internal courtyard as part of the ongoing activity programme on the dementia unit. This will be completed by the 01/06/2023
12. Additional care pals training has been sourced for staff as to support them when providing activities for residents. This is to be completed by the 01/04/2023
13. The Person in Charge has met with our education partners the Centre for Nursing and Midwifery Education on the 20/02/2023. A bespoke training programme will be provided for staff working in older persons services in respect of person centred planning and social activities. . This training will commence on the 08/03/2023

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	30/04/2023
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/03/2023

Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	30/05/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/05/2023
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.	Substantially Compliant	Yellow	10/02/2023
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	01/04/2023

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	01/04/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/03/2023
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	Orange	10/02/2023
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	10/02/2023
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with	Not Compliant	Orange	30/05/2023

	paragraph (2).			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/04/2023
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	30/03/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	30/03/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	01/06/2023