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:	Alzheimer's Care Centre
Name of provider:	J & M Eustace T/A Highfield Healthcare Partnership
Address of centre:	Highfield Healthcare, Swords Road, Whitehall, Dublin 9
Type of inspection:	Unannounced
Date of inspection:	23 February 2023
Centre ID:	OSV-0000113
Fieldwork ID:	MON-0039164

About the designated centre

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

Alzheimer Care Centre is a 129 bed centre providing residential and respite services to males and females with a formal diagnosis of dementia over the age of 18 years. The centre also contains a unit specific to meeting the needs of people with a diagnosis of enduring mental illness. The centre is located on the Swords Road at Whitehall in Dublin within easy reach of local amenities including shopping centres, restaurants, libraries and coffee shops. The centre comprises of an original single storey building and a large extension over three floors which was opened in 2012. Accommodation for residents is across five units. With the exception of the Grattan unit, the remaining units consist of single bedrooms with fully accessible shower and toilet en suites, dining and sitting rooms and access to safe outdoor garden areas. The centre also contains a large oratory for prayers and religious services, activity rooms, hairdressing salons, coffee dock, several private visitors rooms and designated smoking areas.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	120

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
Thursday 23 February 2023	08:00hrs to 19:30hrs	Margo O'Neill	Lead
Thursday 23 February 2023	08:00hrs to 19:30hrs	Frank Barrett	Support
Thursday 23 February 2023	08:30hrs to 19:30hrs	Siobhan Nunn	Support

What residents told us and what inspectors observed

Residents reported that they were satisfied with the service being provided to them and that they were happy living within the designated centre. Residents in the Grattan unit were particularly complimentary about the improvements to the premises. One resident described the sitting rooms as having been "beautifully" decorated.

The designated centre consists of 129 registered beds which were set out over three floors with lifts and stairs to facilitate movement between these areas. The centre was divided into five units; Addison/Clonturk, Coghill/Daneswell, Delville/Lindsay, Drishogue and Grattan units.

Residents living on the Grattan unit had single occupancy bedrooms with access to shared bathrooms. All other bedrooms on other units were single en-suite bedrooms. Inspectors observed that bedrooms were a good size and had adequate storage and display space for residents' belongings. Residents told inspectors that that they were satisfied with their bedrooms and one resident showed inspectors additional storage that had been provided for their belongings.

Most residents reported to inspectors that they were satisfied with the choice and quality of the food. Inspectors observed that there had been improvements made to the dining experience at breakfast time throughout the centre. For example on the Grattan unit, residents were observed attending the dining rooms shortly after 8:00hrs for a breakfast club which was facilitated by a member of staff. This was seen to be a social occasion with many positive respectful interactions observed between staff and residents. Staff offered a choice to residents regarding food and drinks. Some residents were engaged in reading newspapers while others chatted and laughed with staff; all appeared relaxed. Improvements too had been made regarding availability of staff on the units for plating and assisting residents with meals and for cleaning of the kitchen serving areas which now appeared visibly clean.

Inspectors were informed of plans to improve current facilities and physical infrastructure in the centre; for example, plans were outlined for a kitchenette renovation on the Drishogue unit to enhance the facilities available to residents on the unit. Inspectors observed further improvements to the environment in the Grattan unit. The sitting room and activities rooms had been redecorated and there was further replacement to portions of corridor flooring. Minor wear and tear to paint work was observed and some fixtures in the Grattan unit such as radiator covers. Management outlined to inspectors that there was an ongoing programme of work to repaint bedrooms as the rooms were vacated, on residents' request or to address maintenance issues.

Each unit had communal spaces that comprised of lounge and dining areas. Throughout the units, inspectors observed that efforts had been made to create a

homely non-clinical feel, such as having hanging baskets along halls, decorative light fixtures and residents artwork being displayed. The centre contained a large oratory for residents use; this was found to be well decorated with appropriate furniture and religious images and items to enhance the space.

The garden areas overall were well maintained with the exception of two balcony areas off the Drishogue unit. These required attention to ensure that all flooring was safe and free from trip hazards and that areas were clear, clean and set up for resident use. Immediate action was taken on the day of inspection to clear the balconies.

Residents could move around their units freely and had access to outdoor sitting areas. The Grattan unit had a system in place to allow residents to move freely in and out of the unit.

Inspectors identified again that residents' right to privacy to undertake personal activities required further action by management to ensure that these rights were upheld. Inspectors observed on the Grattan unit that not all communal bathrooms had a door lock in place.

Inspectors observed that overall staff interactions with residents were kind and respectful. Residents appeared relaxed and comfortable with staff and inspectors observed residents and staff having light hearted fun while assisting residents with their needs and during activities. Residents who were becoming anxious were patiently redirected and reassured by staff. Staff used their knowledge and understanding of residents needs to deliver safe care. Residents reported positively about staff saying they "had nothing but good things to say ". A visitor who spoke to residents said that the staff were "very good"

Inspectors reviewed the minutes of the most recent resident meetings. Residents raised a number of issues which were responded to and action plans were put in place with completion dates.

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

Capacity and capability

The registered provider had a defined management structure in place and staffing levels had improved since the last inspection. Inspectors found however that the registered provider did not comply with Regulation 31, Notification of incidents, Regulation: 28, Fire Precautions and Regulation: 27 Infection prevention and control. Management systems did not mitigate against significant risks in these areas.

The inspection was carried out to monitor compliance with the regulations and to inform the upcoming renewal of registration for Alzheimer's Care Centre. A completed application for the renewal of the centre's registration had been received and was under review. During this inspection Regulation 28, Fire precautions was assessed.

The registered provider for Alzheimer's Care Centre is J&M Eustace T/A Highfield Healthcare Partnership. There was a clear management structure in place with a group of senior managers which included a Chief Executive Officer, a Chief Operating Officer, a head of quality and patient safety and the Person in Charge. Action had been taken to strengthen the management structure and oversight systems through appointing several new clinical nurse managers to enhance oversight and support for staff on each unit. Inspectors identified the positive impact of this change during the inspection and is reflected in improved compliance in care planning and managing behaviour that is challenging.

The person in charge, who has worked in the organisation since 2016, commenced their current role in December 2022, and is responsible for the day to day operations in the centre. One assistant director of nursing was in place to provide support to the person in charge. The person in charge was well known to residents and had the necessary clinical and management experience and qualifications to meet the requirements of the regulations.

Inspectors found that action was required to ensure that management systems were effective to identify all areas of risk and to ensure these risks were effectively mitigated. For example; improvement was needed in the governance and oversight of fire safety. The provider had a fire safety risk assessment that was completed by an external competent fire safety professional in August 2022. The provider had a plan to address these risks on a phased basis over a Thirty Six month period. However, in this phased plan it was noted that the provider had not prioritised the most significant risks that were identified as being substantial risks in their report. The provider's plan did not have clear time-lines outlining when these risks would be addressed. In addition, some risks that were noted by inspectors had not been identified by the provider on their weekly fire safety checks. For example; a weekly inspection log filled out on the day of inspection failed to note the fire alarm panel was in fault mode. The panel fault was brought to the attention of the Person in Charge and was rectified before inspectors left the centre.

The registered provider had ensured that the number and skill mix of staff was appropriate to meet the needs of residents living in the centre at the time of the inspection. There were a low number of care staff vacancies and there was ongoing recruitment to fill these positions. Inspectors were informed of further improvements made to the staffing structure with the addition of the new role of team lead care staff; these staff members provided valuable additional support and supervision to care staff providing direct care to residents.

Inspectors were provided with a written statement of purpose and found that it contained the required information. A log of all incidents occurring in the centre was maintained and there was a review process in place carried out by senior managers

to ensure learning was identified following incidents. Inspectors noted improvements in the reporting of notifiable incidents to the Chief Inspector had been made since the last inspection; however, not all notifiable incidents had been reported to the Chief inspector within the time-frame as set out under the the regulations. This is detailed under Regulation 31, Notification of incidents.

Registration Regulation 4: Application for registration or renewal of registration

The designated centre was up for renewal of registration in July 2023. An application for renewal of registration had been received by the Chief Inspector and was under review.

Judgment: Compliant

Regulation 14: Persons in charge

The person appointed by the registered provider to fill the role of person in charge of the designated centre met the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had arrangements in place to ensure that the number and skill mix of staff was appropriate, to meet the individual and collective need of the 120 residents living in the centre and with due regard for the layout of the centre.

Judgment: Compliant

Regulation 23: Governance and management

Management systems in place required strengthening in order to ensure the service provided is safe, consistent and effectively monitored. The following required attention:

- The oversight of key areas such as fire safety and the maintenance of the premises were not robust or effective. Inspectors identified that the fire stopping in a number of areas including communications rooms and

compartment walls could not be assured. A review of fire containment was required for the Gratten unit. The processes in place for the identification and management of fire safety risks in the centre was not effective. Furthermore the registered provider had not put effective systems in place to address identified risks in a fire safety risk assessment carried out at the centre. For example; substantial risks identified on this risk assessment were not being rectified in a timely manner. This is detailed further under Regulation 28 Fire Precautions

- Inspectors found that the registered provider had not taken all the necessary steps to ensure compliance with Regulation 27, Infection control and the National Standards for infection prevention and control in community services (2018). Areas for improvement included infection control governance, oversight and monitoring systems. Findings in this regard are further discussed under Regulation 27, Infection control.
- Action was required to ensure that the oversight systems in place to notify the Chief Inspector of notifiable incidents were effective and efficient. Since the last inspection, several notifications had not been submitted as required under Regulation 31, Notifications of Incidents.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of residents' contracts were provided to inspectors. These were found to contain details such as the residents' bedroom number, occupancy level of the bedroom and fees payable by each resident.

Judgment: Compliant

Regulation 3: Statement of purpose

An updated statement of purpose was made available for inspectors and it contained the required information regarding the service and designated centre.

Judgment: Compliant

Regulation 31: Notification of incidents

Inspectors identified that since the last inspection in April 2022, eight notifications were submitted significantly later than the three working day requirement as

outlined in Schedule 4. This required addressing.

Judgment: Not compliant

Regulation 4: Written policies and procedures

All required policies and procedures as set out in Schedule 5 were available to inspectors. These policies had been reviewed and updated as required by the regulations.

Judgment: Compliant

Quality and safety

Overall, inspectors were assured that improvements had occurred and that residents living in the centre were enjoying a better quality of life. There was a rights-based approach to care; both staff and management promoted and respected the rights and choices of residents living in the centre. There was evidence of regular resident committee meetings where residents were consulted with and could participate in the organisation of the designated centre. However inspectors found that further action was required under Regulation 17, Premises, Regulation 27, infection Control and Regulation 28, Fire Precautions.

Relatives and friends were free to visit and public health guidelines on visiting were being followed. Visits were encouraged and practical precautions were in place to manage any associated risks. Visitors were observed attending the centre over the course of the inspection.

The provider had completed a number of works to the premises since the previous inspection in April 2022. For example; several communal spaces such as the living room and activity room on the Grattan unit had received further redecoration and upgrading. Inspectors identified, however some other rooms and areas that required attention to ensure they were maintained to a good standard. This is discussed further under Regulation 17, Premises.

The arrangements for the protection of residents from the risk of fire were reviewed. Fire extinguishers were located at appropriate points throughout the centre and these were regularly serviced by an external fire company. The centre was fitted with a fire alarm system and information panels were located throughout the building so that staff could quickly identify the location of any fire. The fire alarm system was tested on a quarterly basis by an external fire company.

The provider had developed a policy and procedure for the horizontal evacuation of

residents from one part of the building to another. Staff were knowledgeable on these procedures, including specific arrangements for the closing of bedroom doors and ensuring that areas within the building had been checked. However action was required by the provider to ensure that adequate arrangements were in place to protect residents from the risk of fire. For example, a review of the full evacuation procedure, found that staff were not given sufficient guidance on how to safely evacuate residents to an external place of safety. In addition, the evacuation procedure and layout drawings were not clearly displayed at all appropriate points throughout the centre. There was no directional signage outside the building to guide staff and residents to external assembly points. Fire evacuation was also impacted by the use of locked external fire doors. Fire safety is addressed in more detail under Regulation 28 of this report.

Inspectors reviewed care plans covering wound care, safeguarding and restricted practices and noted that the quality of care plans had improved since the last inspection. Staff had received care plan training and clinical nurse managers were monitoring care plans to ensure that they were up to date, accurate and information was recorded in the correct place.

Inspectors discussed the increase in safeguarding notifications since the last inspection with the Assistant Director of Nursing (ADON). The notifications had been analysed and additional care had been provided to protect residents and reduce the incidents of peer to peer abuse. Pre-admission assessments were being enhanced to identify potential risks of responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff who spoke to inspectors were knowledgeable about what to do in the event of a safeguarding incident. Residents who spoke to inspectors said that they felt safe.

The person in charge maintained a restrictive practice register detailing the least restrictive measures that were in place to care for residents with behaviours that challenge and dates when these measures, were to be reviewed. Staff were knowledgeable about how to respond to residents. Inspectors observed staff responding to residents in a gentle manner and redirecting them with patience and kindness when when required. The registered provider had allocated additional resources to care for residents with specific needs.

Systems were in place for cleaning and returning residents laundry. Residents reported to inspectors that they were happy with the laundry arrangements. Storage for clothing and personal items was available in residents rooms and residents had access to their money through an agreed procedure with the accounts department which delivered finances once a week to the units.

The provider had nominated an infection prevention and control link practitioner, a clinical nurse practitioner, to increase awareness of infection prevention and control issues locally whilst also supporting staff to improve infection prevention and control practices. This staff member worked across three sites and protected hours allocated to the role of infection prevention and control link practitioner and to

complete the requisite post-graduate training.

Inspectors observed there were sufficient numbers of housekeeping staff to meet the needs of the centre and the centre was observed to be visibly clean throughout. However the sluice facilities in place required attention to ensure they supported best practice. This is detailed further under Regulation 27 Infection Control.

Regulation 11: Visits

Arrangements were in place for residents to receive visitors and there was no restriction on visiting at the time of the inspection. Visitors were seen attending the centre over the course of the inspection. Visits were observed to take place in residents' bedrooms, in the outside courtyards and in the café at the reception area. Visitors who spoke with inspectors were complimentary of the care provided to their relative and were happy with the visiting arrangements in place.

Judgment: Compliant

Regulation 12: Personal possessions

Residents' bedrooms contained appropriate storage including wardrobes and a locked unit. A system was in place to collect residents laundry and return it to their rooms when it was cleaned. Residents finances were managed through agreed procedures where residents received their money once a week.

Judgment: Compliant

Regulation 17: Premises

The registered provider needed to make improvements to ensure that the premises was kept in a good state of repair internally and externally. For Example:

- Wall covering was coming off the walls in three assisted bathrooms. This wall covering was impacting on the ability of staff to effectively clean the room.
- Inspectors were not assured the ventilation extractors in some of the bathrooms and en-suites throughout the centre were in working order.
- The external decking at the Drishogue unit was lifting in places resulting in a trip hazard for residents or staff using this area. Inspectors found evidence of smoking in this area, and it was not being cleaned regularly.
- The kitchen cabinets in the Drishogue unit were in a poor state of repair. Damage to the edges of the timber where edging was peeling off the timber

made this difficult to keep clean. There was no protection attached to the wall behind the sink area resulting in the wall being water stained and damaged.
- The bath and shower room door in the Grattan unit was damaged with paint peeling off, as well as structural damage to the door. There were also cabinets constructed of chipboard in this room which were water damaged and were swelling due to moisture penetration.
- Two windows in an activities room could not be opened or closed due to broken handles.
- Maintenance of fire doors throughout the centre were found to be inadequate for example, door holders were broken in the dining room area of the Grattan unit.

The registered provider did not provide a premises with adequate storage. For example:

- Items were found stored in an electrical distribution room in the Grattan Unit. This material was removed on the day of inspection.
- An unused hoist was being stored in the assisted bathroom in the Clonturk Unit.
- Unused and rusted commodes were stored in the sluice room in the Grattan Unit.
- Excessive amounts of material were found stored in the space to the side of the dining area of the Drishogue Unit.

Judgment: Substantially compliant

Regulation 27: Infection control

The oversight of infection prevention and control practices required strengthening to ensure it was robust and in line with the National Standards for infection prevention and control in communities 2018. For example;

- Facilities did not support infection prevention and control national standards. Inspectors found that most units did not have a bedpan washer available. In the unit that had a bed pan washer, it had not been serviced since 2015 and was not in working order when inspectors attempted to run a cycle. Assurances were not provided that the decontamination of urinals was being managed in line with best practice. Due to the high risk of contamination, manual cleaning and disinfection of utensils must be avoided.
- Inspectors identified that the travel distance to sluice rooms from some units required staff to walk for quite a distance. On the unit with the bedpan washer staff were required to go through key-locked doors. This increased the risk of cross contamination.
- Domestic washing machines were inappropriately located in one of the sluice rooms and these machines were being used to wash household cleaning

equipment such as mop pads. This was not appropriate and did not support effective infection prevention and control practices.
- At the time of the inspection there was no recorded programme of surveillance of infections (such as the monitoring of multi-drug resistant organisms) as recommended by the National Standards.

Judgment: Not compliant

Regulation 28: Fire precautions

Notwithstanding some good practices identified on this inspection, the registered provider was required to take action to comply with regulation 28.

The registered provider did not make adequate arrangements for containing fires. For example:

- A review of fire doors at the centre was required as Inspectors noted that not all fire doors were in good working order. Smoke seals or intumescent strips were not fitted on most fire doors in the Grattan Unit. In addition, inspectors noted that a number of fire doors did not close properly, for example cross compartment doors at the dining room in Clonturk Unit, the dining room entrance compartment doors in Grattan Unit, a cross corridor compartment door in Drishogue Unit. This would make them ineffective at containing a fire and smoke within a room or compartment.
- The provider was unable to give assurances that fire compartments extended into the attic space in one area of the centre (Grattan).
- There were timber panels above the bedroom doors in the Grattan Unit. Assurances were required as to the fire rating of these panels.
- Holes in compartment walls, and large gaps around service penetrations in these walls were found in two communications rooms, in the kitchen walls along the Delville Unit, and the servery area of the Grattan Unit.

Improvements' were required in the arrangements to safely evacuate residents:

- Though the provider's evacuation procedure guided staff on the horizontal evacuation of residents within the centre, it did not outline how to safely evacuate residents from the building to an external point of safety. Staff were unsure of the procedure to be followed if residents were evacuated outside of the building. Records indicated that staff had practiced evacuating individual rooms but had not practiced the evacuation of an entire compartment in line with their evacuation procedure. The fire drill records also indicated that a fire drill undertaken at the centre for a single bedroom had taken eight minutes to complete. This was not a reasonable length of time, and action was noted by the assessor on the drill record, however, there was no record of action being taken by the provider to improve this drill time.
- Improvement was required in relation to signage. A number of evacuation

signs throughout the centre were faded and difficult to read. Other signs did not contain sufficient detail to guide staff, residents or visitors on the evacuation route that should be followed in case of emergencies. Signs did not contain information regarding the direction of escape, location of compartment lines, location of final exit points, fire fighting equipment and fire alarm call points. Externally, there were no signs to direct residents and staff to the fire assembly point.

- The external escape doors in the Grattan Unit were locked. The risk associated with this practice had been assessed by the provider. All fire doors had the same lock that could be opened by a single key. All staff were given a copy of this key that they kept on their person. However, on the day of inspection, a member of staff did not have a key for the fire doors.

The procedures to be followed in the event of a fire were not displayed in a prominent location in the centre as required by regulations. The procedure was located in a folder next to the main fire alarm panel but was not available to view by all staff, visitors and residents.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans viewed by inspectors reflected the care needs of residents and had been reviewed within four months. Many care plans had been reviewed at shorter intervals due to the changing needs of residents. Pre-admission assessments had been completed prior to residents moving in to the designated centre and on admission care plans were completed within 48 hours.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Inspectors reviewed two care plans for residents with behaviours that challenge. They provided clear guidance for staff on how to use the least restrictive measures to care for residents. ABC charts (Antecedent- Behaviour - Consequences) were used to review incidents. Restrictive measures were risk assessed and review dates were in place in accordance with national policy.

Judgment: Compliant

Regulation 8: Protection

A safeguarding policy and procedure was in place. Inspectors observed the Safeguarding Standard Operating Procedure on display at nurses stations. Safeguarding incidents were investigated and care plans were developed to protect residents. The registered provider acted as a pension agent for thirty two residents and managed some monies for residents who wished to avail of this. Inspectors reviewed a sample of records and found these were clear and transparent.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had access to T.V newspapers and radio. Inspectors observed, and saw photographs of residents enjoying activities, including a Valentines dinner arranged on the Drishogue unit for residents and their partners. Residents on the Grattan Unit participated in creative activities including painting and crochet. Resident meetings were held on each unit to gather feedback from residents and actions were agreed and followed up after the meetings.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Alzheimer's Care Centre OSV-0000113

Inspection ID: MON-0039164

Date of inspection: 23/02/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A Fire Safety sub-committee of the Health & Safety Committee was established in 2022. This group (reporting ultimately to the Quality and Service Improvement Committee) commissioned architects to update facility floor plans and aappointed an independent and competent fire consultant who completed a comprehensive Fire Risk Assessment (FRA) in line with HIQA fire safety guidelines. This is an extensive document and led to the development of a detailed and wide-ranging action plan. This detailed timebound action plan was developed comprising of three phases and this was submitted to the regulator. Phase one focused on life saving measures such as training, fire procedures and equipment and was completed in February 2023. This included engagement of an external fire safety consultant who completed a review of evacuation and training requirements and the training syllabus. The Senior Management Team also participated in an initial 'control and command' training session led by the external fire safety consultant in June 2022. Phases two and three, identified more structural-based remediation and necessitated further consideration in order to scope, resource and implement actions due to the size of the facility. This work commenced in March and significant fire stopping works have been completed to-date with works continuing on an ongoing basis and progress is monitored by the Fire Safety sub-Committee. Weekly fire checks continue. It should be highlighted that this focuses on the operation of the fire alarm system (bell sounding, doors closing etc.). Fire compartmentation and door integrity requires specialist input which is now being provided by external competent service providers. Infection control is discussed bimonthly at the IPC committee. The centre has employed a dedicated IPC Nurse since 2021. This nurse carries out regular infection control and hand hygiene audits and provides both induction training to new staff and refresher	

training to existing staff. She also monitors infections across the centre and reports daily to the HSE on Covid-19 infections. Discussions are now underway with the Drugs and Therapeutic committee to agree a structure for anti-microbial stewardship.

The Safeguarding committee (also reporting to the Quality and Service Improvement Committee) monitor all safeguarding incidents. Operationally, the number of persons set up to submit notifications on the HIQA portal has since increased to four nurse managers to enable timely notification of all reportable incidents. The Designated Safeguarding Officers also meet on a monthly basis to review all safeguarding incidents and the Quality, Safety and Service Improvement Committee meeting bimonthly and review all reported incidents.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All incidents are reported and logged on our incident management system and are reviewed on a weekly basis. In terms of the HIQA portal to enable timely notification of all incidents, the number of persons able to submit notifications on the HIQA portal has increased to four nurse managers.

The Safeguarding committee continues to monitor all reported safeguarding incidents to ensure timely external notification. An organisational safeguarding action plan has also been developed to ensure timely internal and external reporting of all safeguarding concerns.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The wall covering will be removed in three assisted bathrooms specified.
• The ventilation extractors in all bathrooms and en-suites throughout the centre have been checked and serviced. Some repairs have been identified.
• The external decking at the Drishogue unit is being secured. All staff have been reminded that smoking is prohibited on the premises. The decking has been added to cleaning schedule to ensure it is being cleaned regularly.
• The replacement kitchen has been received for Drishogue unit and is ready for installation.
• The bath and shower room door in the Grattan unit has been painted. The watrer damage is being reviewed.

• The two window handles in an activities room are being replaced and a review of window handles in common areas is taking place.
• Fire doors are being replaced in line with works being carried out under Regulation 28. The door to the dining room area of the Grattan unit has been prioritised for replacement.
• Storage across the centre has been reviewed and issues raised remedied and kept under regular review by the Support Service committee. Staff have been reminded regarding correct storage of equipment suchas hoists and commodes.
• The excessive amounts of material stored in the space to the side of the dining area of the Drishogue Unit have since been cleared.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The replacement bedpan washer has been received and is being installed in the next week.

A risk assessment is being conducted to address concerns raised around the location of and use of sluice rooms. The washing machines are being removed from sluice rooms. Recommendations will be presented to the IPC committee and an action plan agreed and implemented.

All infections will be monitored monthly by the IPC nurse going forward. She continues to monitor Covid-19 infections on a daily basis. A referral process to the IPC Nurse is now in place for review of individual infections, as requested. An MRSA decolonization protocol programme is in place. Discussions are underway with the Drugs and Therapeutic committee to agree a structure for anti-microbial stewardship with a multi-disciplinary approach being proposed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Following feedback from inspectors and facilitated by updated floor plans, a 'Find and Fix' programme of remedial work commenced in March 2023. Fire stopping works to address identified compartmentation issues, commenced in March with significant works completed to-date. This includes works completed in Grattan - in particular, fire stopping works in the attic spaces and in compartment walls in Grattan. Due to limited roof space in Grattan and PPE necessitated, works are time consuming, however they remain

ongoing.

A third-party certified inspection of all fire doors has been completed. The specific doors mentioned in the report have been prioritized for replacement. New doors will be ordered this month and fitted with an estimated completion date of 31st July.

Due to the age and configuration of the Grattan Unit, the fire doors do not have fire certification. A full survey of the infrastructure is required and will be organized in consultation with an architect to prepare and implement all required remedial actions. This review is being incorporated into a broader review of the function of the Unit and will be completed by September. In the interim, the above fire stopping works are continuing.

The Fire Consultant will review all survey reports with a full programme of fire door replacement drawn up with input from relevant professionals. Fire doors will be repaired or replaced as advised by the third-party certified inspector. This will be undertaken in a phased manner utilizing a risk-based approach as advised by our Fire Consultant.

A command -and -control training day for the Senior Management Team was held in 3rd June 2022. A follow up day training day, to be led by an external Fire Consultant, has been organized for 31st May to review full evacuation procedures for the centre to determine an appropriate plan for external evacuation of vulnerable residents in the event that all horizontal evacuation options have been exhausted. External signage will be updated pending the outcome of this and the major emergency plan will be updated as part of this session. This will then be communicated to staff.

Local training has taken place at unit level. All units have completed a fire drill since the inspection and response times had significantly improved to an average response time of 2.29 minutes to bring residents to a place of safety.

Directional signage is being reviewed across the centre and updated as required. External signage requirements will be agreed at the Command and Control training day based on input from the external Fire Consultant.

The fire safety procedures are kept at every nurse’s station. On foot of the feedback, these procedures will be more visibly displayed on all units.

The Fire committee meets regularly and continue to monitor all actions identified above and in line with the organisation’s Fire Risk Assessment.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/06/2023
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	05/05/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Not Compliant	Orange	01/09/2023

	associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/09/2023
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	05/05/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2023
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	Substantially Compliant	Yellow	31/07/2023

	and safe placement of residents.			
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	30/06/2023
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	05/05/2023