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:	Kilrush District Hospital Limited
Name of provider:	Kilrush District Hospital Company Limited by Guarantee
Address of centre:	Cooraclare Road, Kilrush, Clare
Type of inspection:	Unannounced
Date of inspection:	24 May 2023
Centre ID:	OSV-0000446
Fieldwork ID:	MON-0040175

About the designated centre

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

Kilrush District Hospital is a nursing home that has been extended and reconfigured over the years. A two-storey purpose built extension was provided and the original buildings have been refurbished in recent years. It can accommodate up to 43 residents, male and female over the age of 18 years. It is located in the West Clare area, in the town of Kilrush. Care is provided for people with a range of needs: low, medium, high and maximum dependency. It provides short and long-term care primarily to older persons. The centre does not accommodate persons presenting with extreme challenging behaviours or with tracheotomy tubes. There are nurses and care assistants on duty covering day and night shifts. Accommodation is provided in both single and shared en suite bedrooms. There are separate dining and day rooms provided for residents use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	32

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 24 May 2023	10:00hrs to 19:00hrs	Sean Ryan	Lead
Wednesday 24 May 2023	10:00hrs to 19:00hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Residents living in Kilrush District Hospital told inspectors that they enjoyed living in the centre. Overall, the feedback from residents was positive with regard to the quality of care they received. Residents reported feeling safe and comfortable in the care of staff who they described as kind, friendly, and attentive to their needs.

Inspectors were met by the person in charge on arrival at the centre. Following an introductory meeting, the inspectors walked through the premises and met with residents and staff.

On the morning of the inspection, the atmosphere was busy, but pleasant. Staff were observed attending to residents requests for assistance, while also answering call bells promptly, and serving breakfast to residents in their bedrooms. Some residents were observed walking through the corridors accompanied by staff while the majority of residents spent the morning in the communal dayroom on the ground floor. Residents appeared to be relaxed and comfortable in their environment, and chatting to one another about local news and events.

Inspectors spoke with a number of residents in the communal dayroom and in their bedrooms. Residents were complimentary of the staff and described their engagements with staff as kind, respectful and caring. Staff were observed to engage with residents in a person-centred manner, and there was a friendly relationship between staff and residents, who were seen to chat and interact with each other in a relaxed manner. Residents told the inspectors that they 'never felt rushed' by the staff who assisted them with their care needs. Staff were observed to answer residents call bells promptly.

The premises consisted of a two-storey building. The centre was registered to provide accommodation to 43 residents, over two floors, in both single and twin bedroom accommodation. The original building dated back to the 1800's and had been extended to include a two-storey, purpose built, extension in recent years. The first floor of the premises was accessible to residents through a passenger lift and stairs. Inspectors observed that the communal area on the ground floor was decorated in a personalised manner, with suitable furnishings and a large flat screen television. There was a spacious lounge area on the first floor. This area was not in use by residents on the day of inspection. Residents also had access to a dining room, oratory and a designated smoking area at the rear of the building. The area surrounding the smoking area was used to store construction materials. There was no secure outdoor space available for residents to use independently.

Inspectors observed that the premises was in a poor state of repair. Floor coverings in communal bathrooms, bedrooms and along corridors were visibly damaged, unclean, and in some parts uneven. Walls were also visibly damaged, cracked and

stained. In some areas, the underlying plaster was exposed and crumbling. There was staining on the ceiling.

Toilet and showering facilities used by residents were observed to be poorly maintained. Inspectors observed damaged and broken sanitary ware such as broken taps and missing toilet seats. Some toilets in residents en-suites were missing essential components to function, such as the flushing levers, and those areas were malodorous.

On the ground floor, inspectors observed that some ancillary areas such as a sluice room and a communal toilet were accessible only through entering an unoccupied bedroom. Access to a sitting room, and communal toilet facilities, was possible only through entering another unoccupied bedroom. On the first floor, storage areas and additional sluice facilities were accessible through a training room and large store room. There were parts of the premises, toilet facilities, and equipment used by residents, that were not clean.

Inspectors observed that the kitchen and catering areas were not cleaned to an acceptable standard. Floors, cooking equipment, and food storage areas were visibly unclean on inspection.

Residents told inspectors that they were satisfied with their bedroom accommodation, furnishings and storage facilities for their personal possessions. However, equipment such as beds, tables, and chairs were observed to be damaged, and rusted in parts. Some residents had decorated their bedrooms with personal items of significance such as photographs and ornaments. All bedrooms provided en-suite facilities for residents. One residents bedroom contained a glass screened shower that had been installed within the residents bedroom.

Inspectors observed a number of doors that were held open with pieces of furniture which prevented the doors from closing. This compromised the function of the doors to contain the spread of smoke and fire in the event of a fire emergency. Some ancillary areas such as the heat distribution room were observed to be locked, and keys to access this area were not readily available. There were some external areas in use by the centre that did not have appropriate fire detection. This included the laundry and storage facilities that were not part of the designated centre but were used to store records from the designated centre.

Inspectors observed that residents in the ground floor dayroom were engaged in activities at periods during the day. This included exercises and coordination games. Activities staff were present to engage residents in activities, provide supervision and assist residents with snacks and refreshments. However, inspectors observed that some residents who remained in their bedroom were not provided with meaningful activities or social engagement until late in the afternoon. Residents told the inspectors that although they were provided with activities for part of the week, some of the activities on offer did not interest them and there were days when no activities were taking place. Two residents told the inspectors that this made 'the days feel long and boring'. Some residents expressed a wish for more outdoor activities as the weather had improved, however one residents told the inspector

that outdoor activities were dependent on the availability of staff to accompany them outdoors.

Inspectors met with visitors during the inspection in a designated visiting area. Visitors expressed their satisfaction with the quality of the care provided to their relatives and friends and stated that their interactions with the management and staff were positive. Residents and visitors told inspectors that visits were facilitated through scheduled appointments and were held in designated visiting areas around the main reception area.

The following sections of this report details the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social services to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).
- follow up on the actions taken by the provider to address issues of non-compliance identified on the last inspection of the centre in June 2022.

The findings of this inspection were that the provider had failed to fully implement the compliance plan following previous inspections of the centre, and that action was required in the governance and management of the service provided to residents.

While the provider had taken some action to address fire safety issues and to improve the provision of activities for residents, the actions taken were not sufficient to bring the centre into compliance. The provider had not ensured that there was a clearly defined management structure within the designated centre in line with the centre's statement of purpose. This meant that a weak organisational structure, and ineffective management systems of monitoring and oversight, impacted on the quality and safety of the service provided to residents. This resulted in non-compliance with the following regulations;

- Regulation 17: Premises,
- Regulation 23: Governance and management,
- Regulation 27: Infection control,
- Regulation 28: Fire safety.

In addition, the following regulations were found to be substantially compliant;

- Regulation 5: Individual assessments and care plan,
- Regulation 9: Resident's rights,

- Regulation 11: Visits,
- Regulation 16: Training and staff development,
- Regulation 21: Records.

Inspectors also reviewed unsolicited information received by the Chief Inspector, pertaining to restrictions placed on visiting, and inadequate activities. The information was found to be fully substantiated on inspection.

The provider of this centre is Kilrush District Hospital Company Limited by Guarantee. The board of the company consists of four directors, working in a voluntary capacity. On the day of inspection, the identity of the company personnel responsible for the governance and oversight of the service, and those responsible for the care and welfare of the residents, was not clear. Inspectors found that the Chief Inspector had not been notified of changes to the identity of the company directors, and chairperson, that had occurred since the last registration renewal of the centre in 2021.

Within the centre, the provider had failed to ensure that the management team was resourced, as set out in the centre's statement of purpose. The management structure, as set out in the statement of purpose, consisted of a person in charge, supported by a clinical nurse manager, and a general manager who worked full-time in the centre. Iinspectors found that the position of general manager had reduced to a part-time position. In addition, the position of clinical nurse manager had been vacant since April 2022, and there was no evidence of active recruitment to fill the position. The absence of a clinical nurse manager, resulted in a deficit of additional management resources, deputising arrangements, and support for the person in charge. This impacted on clinical oversight, nursing supervision of staff, and governance support for the person in charge. Inspectors found that this organisational structure, and absence of an effective system of governance and management, negatively impacted on the registered provider’s ability to recognise, respond to, and manage risk and regulatory non-compliance's in the centre, and maintain a safe and quality care environment for residents.

While there were management systems in place to monitor aspects of the service provided to residents, the management systems were not effective to identify deficits and risks in the service. A review of completed clinical and environmental audits found that aspects of the service, such as the physical environment, achieved a high level of compliance when assessed, and did not reflect the known issues of risk in relation to fire and the premises. Consequently, there was no quality improvement action plan developed to ensure a safe environment.

Similarly, a review of risk management systems found that the risk register did not contain some of the known risks in the centre, such as risks identified in a fire risk assessment, the premises and the reduced management support for the person in charge. The exclusion of known risks from the centre's active risk register impacted on the centre's ability to minimise and appropriately manage risk.

Inspectors reviewed the systems of record management in the centre. The provider had systems in place to ensure staff personnel files contained the information

required by Schedule 2 of the regulations. However, inspectors found that records were not securely and safely stored. For example, some resident's records were stored in an unlocked store room while other records were stored in an adjacent building that was not part of the designated centre.

A review of the centre's staffing roster on the day of inspection found that the staffing levels and skill mix were appropriate to meet the assessed health and social care needs of the residents, given the size and layout of the building. There were sufficient numbers of house-keeping, catering and maintenance staff in place. There was a system in place to ensure clear and effective communication between the management and staff.

There was a comprehensive training and development programme in place for all grades of staff. Staff demonstrated an appropriate awareness of their training with regard to fire safety procedures and their role and responsibility in recognising and responding to allegations of abuse. Staff were also facilitated to attend training relevant to infection prevention and control, and supporting residents living with dementia. There were systems in place to induct and orientate staff. However, inspectors found that the arrangements in place to supervise staff were not effective to ensure a satisfactory standard of environmental hygiene was maintained, in particular, the catering areas of the centre.

Registration Regulation 6: Changes to information supplied for registration purposes

The registered provider had failed to give notice to the Chief Inspector with regard to the changes of the identity of the company directors within the required time frame, as required by Schedule 1 of the regulations.

Judgment: Not compliant

Regulation 15: Staffing

On the day of inspection, there was adequate staff available to meet the needs of the current 32 residents taking into consideration the size and layout of the building.

The failure of the registered provider to ensure sufficient staffing resources were in place to ensure the on-going safe and effective delivery of care and supervision to residents is actioned under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of residents. This was evidenced by;

- inadequate arrangements in place for the supervision of cleaning staff, and cleaning processes within the kitchen and catering departments.
- inadequate supervision of the activities programme to ensure the social care needs of all residents were met.

Judgment: Substantially compliant

Regulation 21: Records

The management of records was not in line with regulatory requirements, and records were not kept in a manner that were safe or accessible. For example;

- Records, as set out in Schedule 3 of the regulations, were not securely stored in the designated centre. For example, records of resident's health, condition, and treatment given were found in unsecured storage rooms and cupboards.
- Records were kept in an outside building that was not registered as part of the designated centre, alongside other equipment and items.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that the service had sufficient management resources to;

- ensure the management structure was maintained in line with the centre's statement of purpose. The position of clinical nurse manager was vacant since April 2022 and the position of general manager had reduced to a part-time position. This impacted on effective governance and oversight of the service.

The registered provider had not ensured that there was an effective management structure in place, with clear lines of accountability and responsibility. For example, accountability, responsibility and oversight of key aspects of the service such as the management of risk, the premises, infection prevention and control, and the oversight of records, appeared to be allocated to both the person in charge and

general manager, with poor systems in place to escalate risk to the provider. This resulted in ineffective action being taken to address risks to residents.

The registered provider had failed to ensure there were effective governance and management systems in place to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. For example:

- The management systems in place to monitor, evaluate, and improve the quality and safety of the service were not effective to support the identification of risks and deficits. Therefore, quality improvement action plans could not be developed.
- The risk management systems were not effectively implemented to identify and manage risks in the centre. Known risks were not included in the centre's risk register. Consequently, risks were not assessed, categorised according to their priority, or controls put in place to effectively manage the risks to residents. For example, a number of fire risks identified in a fire safety risk assessment, and awaiting completion, had not been appropriately updated in the risk register and the action plan did not accurately detail outstanding works, or a time frame to complete fire safety works.
- There was poor oversight of record-keeping systems to ensure compliance with the regulations.

Compliance plans submitted following the previous inspections were not fully implemented. This resulted in repeated non-compliance in multiple regulations including governance and management, the premises, fire safety, and infection prevention and control.

Judgment: Not compliant

Quality and safety

On the day of inspection, resident's health and social care needs were maintained by a satisfactory standard of evidenced-based care and support from a team of staff who knew their individual needs and preferences. Residents reported feeling content and stated that they felt safe living in the centre. However, inspectors found that non-compliances in relation to the premises, infection prevention and control, and fire safety impacted on residents' rights, safety, and well-being and action was required to comply with the aforementioned regulations. Additionally, action was required to ensure residents care plans accurately reflected their current care needs, and that meaningful activities were accessible to all residents.

While the provider had installed new floor coverings in the dining room, inspectors found that parts of the premises did not meet the care and safety needs of the residents. There were numerous areas of the premises such as bedrooms, bathroom facilities, and communal areas that were not maintained in a satisfactory state of

repair. Walls were visibly damaged, and not suitably decorated. Facilities in use by residents, such as private and communal toilet facilities were also poorly maintained. Inspectors found that the layout of some bedrooms compromised the residents privacy. For example, a glass screen shower was observed in a bedroom occupied by a resident. While the provider had previously committed to relocate the shower to the en-suite, this action had not been completed. In addition, unoccupied rooms provided access to ancillary areas such as a sluice room. The findings identified repeated non-compliance with regard to the oversight and lack of maintenance of the premises, and were indicative of a lack of monitoring, and resources, to improve the premises. Further findings are detailed under Regulation 17: Premises.

In addition, inspectors found that the provider had not taken action to ensure the physical environment, and associated facilities, supported effective infection prevention and control measures. Inspectors found that areas of the premises, including the kitchen, resident's bedrooms, and sanitary facilities were visibly unclean. Personal equipment used by residents was unclean which posed a risk of cross contamination, and therefore a risk of infection to residents. The ineffective decontamination of resident's toileting aids further increased the risk to residents. The findings identified a failure by the provider to establish a robust infection prevention and control monitoring system and to ensure the physical environment supported effective infection prevention and control. This is discussed further under Regulation 27: Infection control.

Following the previous inspection, the provider submitted a compliance plan to address the risks identified in the systems of containment and management of fire. The provider had completed a fire safety risk assessment of the centre in October 2021 and the action plan was due to be completed in December 2022. Inspectors found that while the provider had taken some actions to address the findings of the fire safety risk assessment, the provided had failed to address all the fire risks identified in the report. In addition, inspectors found poor practice with regard to the management of keys to locked storage areas that contained flammable materials and the inappropriate storage of oxygen which posed a fire risk to residents. Further findings are detailed under Regulation 28: Fire precautions.

Inspectors reviewed a sample of resident's assessments and care plans and found that residents' needs were assessed using validated assessment tools that informed the development of care plans. While the care and support needs of the residents were known to the staff, the care plans reviewed did not always reflect person-centred, evidence-based guidance on the current care needs of the residents. This is discussed further under Regulation 5: Individual assessment and care plans.

Residents were provided with access to a general practitioner, as required or requested. There was timely referral and access to health and social care professionals and evidence that recommendations made by professionals was implemented and reviewed to ensure best outcomes for residents.

There was an activity schedule in place and some residents were observed to be facilitated with social engagement during the day. However, inspector found that the

provision of activities was not consistent and not all residents were provided with equal access to activities, in line with their interests and capabilities.

Residents had access to television, radio, newspapers and books. Residents were provided with access to independent advocacy services.

Residents were provided with opportunities to provide feedback on the quality of the service through scheduled resident meetings and through resident surveys.

While the provider facilitated visits in the centre, visiting arrangements were found to be restrictive. The restrictions in place were not underpinned by any risk assessment and, therefore, the rationale for the restrictions was not clear.

Regulation 11: Visits

The centre was open to visits on the day of inspection. However, visitors were required to book a visiting appointment, wear face masks, and meet their relatives in a designated area located near the front of the building. This was not in line with the updated national guidelines, with respect to COVID-19 restrictions.

Where the centre was operating outside of the current national guidelines, a risk assessment to underpin this decision by the management team was not in place.

Judgment: Substantially compliant

Regulation 17: Premises

There were areas of the premises that were in a very poor state of repair, both internally and externally. For example,

- Floor coverings in residents accommodation and communal areas were uneven, torn, and lifting in parts while floor tiles in some bathrooms were broken.
- Walls along corridors and in bedrooms were visibly chipped, cracked, and damaged with exposed plaster. There were water marks on the ceiling in multiple areas
- Sanitary ware, including toilet seats and taps in en-suites and communal toilet facilities were were damaged, leaking or missing. The lever to flush toilets was missing from a number of residents toilets.
- Some rooms were not laid out to meet the needs of residents. For example, a shower was located within the bedroom of one resident, while in another area of the centre, a sluice room and storage area for housekeeping equipment was accessed through an unoccupied bedroom.

- Storage facilities were not appropriately managed and were inaccessible due to the volume of stock such as personal protective equipment, chemicals, and equipment stored within the area.
- The external grounds were not appropriately maintained or suitable for use by residents. The ground was uneven and posed a tripping hazard. The outside area was cluttered with building debris and was unsightly and unsuitable for resident use.

Judgment: Not compliant

Regulation 27: Infection control

Action was required to ensure that infection prevention and control procedures were consistent with the National Standards for Infection Prevention and Control (IPC) in community settings published by HIQA. This was evidenced by;

- There was poor oversight of the cleaning procedure and the quality of environmental hygiene. Parts of the premises were visibly unclean on inspection. For example, the kitchen and catering area, communal day room, and toilets were visibly unclean.
- There was no functioning bedpan washer or macerator in the centre. Consequently, staff had to manually clean bedpans and urinals. Inspectors observed that bedpans and urinals were not appropriately cleaned. This posed a risk of infection to residents. This was a repeated non-compliance.
- Some equipment used by residents was in a poor state of repair and visibly unclean on inspection. For example, some shower chairs and raised toilet seats were visibly rusted and had a build up of organic matter on their underside.
- Staff were using incorrect cleaning and disinfectant processes to clean equipment used by residents.

Judgment: Not compliant

Regulation 28: Fire precautions

Action was required by the provider in order to comply with the requirements of Regulation 28: Fire precautions.

Arrangements for reviewing fire precautions in the designated centre required further action. For example,

- Oxygen was not securely stored within storage areas and oxygen was inappropriately stored in the nurses station.

- There was inadequate management of the keys to locked storage and service areas that contained sources of ignition, or flammable materials.The keys for locked doors were not managed appropriately, creating a high risk that those areas were not accessible in the event of a fire emergency.

Arrangements for providing adequate means of escape, including emergency lighting, required action. For example,

- Emergency lighting was not functioning in some areas of the centre.
- The fire escape plans did not accurately reflect the layout of the centre. This posed a risk as it may cause confusion in the event of an evacuation.

Arrangements for containing fire in the designated centre required further action. This was evidenced by;

- Fire doors were being kept open by means other than a hold open device, connected to the fire alarm system. This compromised the function of the door to contain the spread of smoke and fire in the event of an emergency.
- There were some areas where services such as pipes and electrics penetrated the walls and ceiling. There was a visible hole around the services in, for example, storage areas.

Inspectors were not assured that adequate arrangements had been made for evacuating all persons from the centre in a timely manner, with staff, and equipment resources available. The effectiveness of some evacuations plans had not been tested and the provider had not ensured that residents could be evacuated from all areas of the centre in a safe and timely manner.

While the provider had completed a fire safety risk assessment of the centre in 2021, the provider had failed to ensure that all fire safety works were completed within the required time frame, or provide a time frame for completion of fire safety works. This is actioned under Regulation 23: Governance and Management.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Care plans were not guided by a comprehensive assessment of the residents care needs. For example, two residents assessed as being at high risk of falls were not identified as such within their care plan. Consequently, the care plan did not reflect the residents increased risk of falls or the interventions necessary to support the resident.
- Care plans did not accurately reflect the care needs of some residents. Residents who were assessed as requiring specific care interventions to

manage their responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), did not have a care plan in place to guide the appropriate care of the residents.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner (GP) of their choice. Arrangements were in place for residents to access the expertise of health and social care professionals such as dietetic services, speech and language, physiotherapy, and occupational therapy through a system of referral.

A review of resident's care records evidenced that the treatment plans and recommendations of the medical and allied health and social care professionals was incorporated into resident's care plans.

Judgment: Compliant

Regulation 9: Residents' rights

Not all residents were provided with equal access to activities in accordance with their interests and capacities. Residents reported that the provision of activities was inconsistent and did not meet their needs. Inspectors observed that residents spent long periods of times with no facility for activity or social engagement during the inspection.

Residents could not exercise choice with regard to independent access to outdoor space. Residents access to external garden space was dependent on the availability of staff to provide supervision.

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	
Registration Regulation 6: Changes to information supplied for registration purposes	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Kilrush District Hospital Limited OSV-0000446

Inspection ID: MON-0040175

Date of inspection: 24/05/2023

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**
Registration Regulation 6: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 6: Changes to information supplied for registration purposes: - The Provider Representative has completed form NF33A via the HIQA Portal in relation to the Change of Personnel. - Going forward the Provider Representative will notify the Authority of any changes to the management team and structure as and when they happen. Proposed Time Scale: Completed 02/08/2023	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: - The Catering Supervisor has liaised with all the Staff in the Kitchen and Catering Departments and has assured the Provider Representative that there is a cleaning schedule in place in the kitchen & catering departments so as to ensure that all areas are cleaned regularly and once completed it is documented to confirm completion to a high standard. - Spot checks are carried out by the PIC/Management team weekly. Proposed Time Scale: Completed 31/05/23 - A Senior Health Care Position has recently been filled. This person is responsible for overseeing the Activities Programme and ensuring the social care needs of all of Residents are being met.	

- The HCA is keeping detailed records of activities/social engagement that residents who wish to remain in their rooms to show evidence of completion.
Proposed Time Scale: Completed 09/06/2023

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
- Records of Residents have been removed from the storage room and cupboards and stored in a secure location.
Proposed Time Scale: 25/05/2023

- Records of residents will be removed to the main building and stored in a secure location. Long term records are kept for a period of 7 years as per the regulations.

- Keys for this storage area will be kept in the safe and will only be available to Person in Charge and one senior nominated person.

Proposed Time Scale: 31/10/2023

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Risk Management and Record Management System
We will identify any risks on a day to day basis, we will record in our Risk Register and implement actions to mitigate the risk to an acceptable level.

Proposed Time Scale:31/08/2023

All records will be stored and maintained in line with regulatory requirements, and subject to regular checks and monitoring by the PIC.

Proposed Time Scale:31/10/2023

We have engaged with an outside consultant to assist in the structuring of our management procedures. The PIC will be supported by a CNM. We have appointed a CNM who will start on 21/08/2023.

The PIC will chair a weekly management meeting (from 02/08/2023) and the team will

identify areas of improvement and actions to remedy these issues during the meetings. The findings will be reported back to the board. The weekly governance meetings have already commenced from 2nd August 2023 and will be held weekly on Wednesdays going forward.

Proposed Time Scale: Completed 02/08/2023

The PIC will maintain a detailed KPI report which will be presented to the Board monthly to ensure oversight of the residents.

The PIC will carry out weekly audits of the premises and will meet with the maintenance team to inform them of any work/repairs required. Once completed the maintenance team will sign off to let the PIC know the work is completed. The PIC will then verify this is the case.

The Catering and Kitchen supervisor will liaise with the PIC and will report any issues that occur in their departments weekly.

Any outstanding issues that have not been addressed within the month will be brought to the Boards attention at the monthly Board meeting.

Proposed Time Scale: 31/08/2023

The new CNM will commence on 21/08/2023. She will complete QQI Level 6 Leadership and Management Training on 12th October 2023. The senior nurse is supporting the PIC in a supernumerary capacity for a designated number of hours per week until 21/08/2023.
Proposed Time Scale: 21/08/2023

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
The home does not have any visiting restrictions in place. Visits are encouraged. We have protected mealtimes so that residents can enjoy their meals and anyone requiring assistance can do so with privacy and dignity. We will follow any national guidelines on visiting in the future. Residents' families /NOKs were informed by telephone/ in person that restrictions were fully lifted.

Proposed Time Scale: Complete 24/05/2023

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: - Going forward, if any changes were to be made to the floor plans, we would consult HIQA and submit an application to vary. Proposed Time Scale: 30/09/2023 - A local Engineering Consultant has been instructed to review and report on the integrity of the premises. Proposed Time Scale: 30/09/2023 - The Dayroom and Dining rooms were re-decorated, and a number of bedrooms have been re-decorated. A number of the older bedrooms have been de-commissioned. We have also been in contact with a flooring company and we have instructed them to call and access the damaged flooring and replace as required. Proposed Time Scale: 31st December 2023 - We are currently liaising with a local plasterer to remedy the areas that are cracked and damaged with exposed plaster. Proposed Time Scale: 31/10/2023 - We have engaged the services of a builder to replace the ceiling tiles in the areas with water marks. Proposed Time Scale: 31/10/2023 - Our resident plumbers had been on site a number of weeks prior to the inspection on 24th May 2023. They had carried out an assessment as to the areas that needed attention. They assured us that replacement parts had been ordered, but would take about a month as they were coming in from the U.K. Proposed Time Scale: Completed 02/06/2023 - Both bedrooms have been de-commissioned. Proposed Time Scale: Completed 09/06/2023 - Storage facilities have been re-located within the nursing home. Chemicals have been disposed of. Proposed Time Scale: Completed 25/05/2023 - The external grounds in question are located to the rear of the nursing home in the Services area which is not a location that the residents would frequent. Building debris in this area was as a result of improvements carried out in the nursing home. This zone has since been de-cluttered of all debris. Proposed Time Scale: Completed 07/07/2023	

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
- The Catering Supervisor has liaised with all the Staff in the Kitchen and Catering Departments and the Provider Representative can carried out regular audits and is assured that measures have been put in place to ensure that the Kitchen and Catering areas are rigorously cleaned on a daily basis. Additional hours have already been allocated for this deep cleaning to take place (Extra 32 hours per month).
Proposed Time Scale: Completed 16/06/2023

- Hygiene staff have been allocated additional hours in the mornings to ensure all floors in the communal area are washed and buffed prior to the residents coming in to that area. The toilet areas off the communal day room are also cleaned throughout the day.
Proposed Time Scale: Completed 26/05/2023

Bedpan washer:
We have received two quotes for the purchase of a Bedpan washer. The Directors are in the process of assigning funding to purchase the bedpan washer.
Proposed Time Scale: 16th October 2023

Shower Chairs & equipment:
• As part of the cleaning supervisors role in conjunction with the PIC a weekly audit will be carried out of all equipment to ensure it is clean and rust free and functioning properly. An audit has been carried out in relation to shower chairs and toliet seats and any with rust will be replaced. Two new raised toliet seats have been ordered (31/7/2023). All equipment that required cleaning has been fully cleaned and is on a cleaning schedule which is checked weekly by the cleaning supervisor and PIC. The PIC has the approval to order any necessart equipment required.

Proposed Time Scale: 14/08/2023.

Incorrect Cleaning/Disinfectant Process:
• Storage arrangements have been reviewed. The disinfecting solution is kept in a cupboard in the sluice room and the staff have the proper knowledge on which item to use for which cleaning. Refresher training on cleaning agents will be organised for the cleaning staff.

Proposed Time Scale: 31/08/2023

Regulation 28: Fire precautions	Not Compliant

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

• Oxygen was not securely stored within storage areas and oxygen was inappropriately stored in the nurses station.
There is an outside oxygen storage area to the rear of the nursing home in which the oxygen tanks are stored in an upright position and secured with a chain. A small emergency oxygen tank is stored in the nurses station and is in a secure upright position.
Proposed Time Scale: Completed 25/05/23

• There was inadequate management of the keys to locked storage and service areas that contained sources of ignition, or flammable materials.The keys for locked doors were not managed appropriately, creating a high risk that those areas were not accessible in the event of a fire emergency.
• An arrangement has been put in place to hang the keys to these locked storage and service areas in close proximaty to the door.
Proposed Time Scale: Completed 31/05/2023

Arrangements for providing adequate means of escape, including emergency lighting, required action.
Fire Training and Fire Safety Evacuation was carried out on 20th June for all Staff. Fire Scenarios including Fire Drills were performed for Day Staff and Night staff with positive results. Staff also received training on the use of fire extinguishers. Every second month a fire drill will take place of the largest compartment with the minimum staff staffing. These drills will be recorded and any learnings identified.
Proposed Time Scale: 20/06/2023

Two staff are going to commence a fire warden course in September 2023 (21st & 22nd).
Proposed Time Scale: 22/09/2023

• Emergency lighting was not functioning in some areas of the centre.
• The emergency lighting has been checked and all faults have been referred to an electrician.

Proposed Time Scale: 25/08/2023

• The fire escape plans did not accurately reflect the layout of the centre. This posed a risk as it may cause confusion in the event of an evacuation.
• As there were a number of lists for the different fire zones which may not have been clear on the day of inspection, we have now removed these and replaced with one proper list for the Zones so as not to cause confusion in the event of a fire.
Proposed Time Scale: Completed 02/06/2023

Arrangements for containing fire in the designated centre required further action. This was evidenced by;
• Fire doors were being kept open by means other than a hold open device, connected to the fire alarm system. This compromised the function of the door to contain the spread of smoke and fire in the event of an emergency.
• Doors are not held open by any other means so as to compromise their function in the event of a fire.

Proposed Time Scale: Completed 24/05/2023

• There were some areas where services such as pipes and electrics penetrated the walls and ceiling. There was a visible hole around the services in, for example, storage areas.
• We have secured the services of a builder to secure these areas around pipes and where electrics have penetrated the walls and ceiling.
Proposed Time Scale: 30/09/2023

• Inspectors were not assured that adequate arrangements had been made for evacuating all persons from the centre in a timely manner, with staff, and equipment resources available. The effectiveness of some evacuations plans had not been tested and the provider had not ensured that residents could be evacuated from all areas of the centre in a safe and timely manner.
• Fire Training and Fire Safety Evacuation was carried out on 20th June for all Staff. Fire Scenarios including Fire Drills were performed for Day Staff and Night staff with positive results. Staff also received training on the use of fire extinghuishers.
• Regular fire drills will take place monthly for staff and through out the year this will include day & night drills. A record of these drills will be kept to monitor areas of improvement or good practice.
Proposed Time Scale: Completed 20/06/2023
While the provider had completed a fire safety risk assessment of the centre in 2021, the provider had failed to ensure that all fire safety works were completed within the required time frame, or provide a time frame for completion of fire safety works. This is actioned under Regulation 23: Governance and Management.
• Five out of six of the key findings have already been implemented, the sixth finding, namely a schedule of recommended improvements will be timelined and implemented. A the Consultant Engineer's Report is also in progress and fndings will be prioritised and scheduled accordingly September 30 2023.

Proposed Time Scale: 30/09/2023

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A review of a sample of resident assessment and care plans found that they were not in line with the requirements of the regulations.
Care plans have been updated to reflect resident's needs and will be regularly reviewed on a quarterly cycle

Proposed Time Scale: Completed 31/07/2023

The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.
- All new residents are assessed immediately by the Nurse on duty on admission to the nursing home on their personal and medical needs/care requirements.
Proposed Time Scale: Completed 31/07/2023

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Not all residents were provided with equal access to activities in accordance with their interests and capacities. Residents reported that the provision of activities was inconsistent and did not meet their needs. Inspectors observed that residents spent long periods of times with no facility for activity or social engagement during the inspection.Residents could not exercise choice with regard to independent access to outdoor space. Residents access to external garden space was dependent on the availability of staff to provide supervision.
• A Senior Health Care Position has recently been filled. This person is responsible for overseeing the Activities Programme and ensuring the social care needs of all of Residents are being met. This HCA ensures resident have access to the outdoor garden area and supervises them when they are in the garden.
• Our Senior Healthcare Assistant has ensured that all residents are included in the daily activities and social engagements. Resident's life stories have been reassessed and this is assisting staff to ensure activities meet residents' interests and are providing meaningful activity.
• We have provided outdoor seating should the residents wish to go outside. Residents can access the outdoor areas anytime they wish and are assisted to do so if necessary. We have a glass house to the rear of the building which the residents frequent on a regular basis when our resident gardener is present.
Proposed Time Scale: 09/06/2023
• We are planning to prepare a secure garden area for residents to sit outside with proper fencing by October this year.
Proposed Time Scale: 31/10/2023

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
Registration Regulation 6 (4)	The registered provider shall give not less than 8 weeks notice in writing to the chief inspector if it is proposed to change any of the details previously supplied under paragraph 3 of Schedule 1 and shall supply full and satisfactory information in regard to the matters set out in Schedule 2 in respect of any new person proposed to be registered as a person carrying on the business of the designated centre for older people.	Not Compliant	Orange	02/08/2023
Regulation 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are	Substantially Compliant	Yellow	24/05/2023

	not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	09/06/2023
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	31/12/2023
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	25/05/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	31/10/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	31/08/2023

	effective delivery of care in accordance with the statement of purpose.			
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	31/08/2023
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	31/08/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	16/10/2023
Regulation 28(1)(b)	The registered provider shall provide adequate	Substantially Compliant	Yellow	25/08/2023

	means of escape, including emergency lighting.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	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.	Substantially Compliant	Yellow	20/06/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	20/06/2023
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 and safe placement of residents.	Not Compliant	Orange	20/06/2023
Regulation 5(2)	The person in charge shall	Substantially Compliant	Yellow	31/07/2023

	arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	31/07/2023
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.	Substantially Compliant	Yellow	31/07/2023
Regulation 9(2)(b)	The registered provider shall provide for	Substantially Compliant	Yellow	09/06/2023

	residents opportunities to participate in activities in accordance with their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/10/2023