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:	19 October 2023
Centre ID:	OSV-0000446
Fieldwork ID:	MON-0041640

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:	28

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 19 October 2023	09:00hrs to 18:00hrs	Sean Ryan	Lead
Thursday 19 October 2023	10:00hrs to 18:00hrs	Niall Whelton	Support

What residents told us and what inspectors observed

Residents living in Kilrush District Nursing Home told inspectors that they felt safe living in the centre and that staff were kind and polite to them. Inspectors found that residents received a satisfactory standard of person-centred care from a team of staff who knew their individual needs and preferences. Residents expressed high levels of satisfaction with the service, including the provision of meaningful and engaging activities that supported them to develop good social connections with other residents, and staff.

Inspectors arrived unannounced at the centre and were met by nursing staff, and later by the person in charge. Following an introductory meeting with the person in charge and a director of the company, inspectors walked through the centre and met with residents and staff. There was a calm, but busy atmosphere in the centre as staff were observed responding to residents' requests for assistance.

Inspectors spent time in the different areas of the centre chatting with residents and observing the quality of staff interactions with residents. Staff interactions were respectful and person-centred. Staff assisted residents in a discrete and supportive manner. Staff that spoke with the inspectors demonstrated a good knowledge of residents' individual needs and preferences.

Residents told inspectors that staff were attentive to their requests for assistance, and their call bells were answered promptly. They also spoke positively about the provision of daily activities and described how staff facilitated them to socialise with other residents. Residents spoke about changes that had occurred in the centre, including the redecoration of some bedrooms and communal areas.

The provider had carried out some maintenance works and redecoration of the premises. Walls that were previously damaged had been repaired. Sanitary ware in toilet and showering facilities had also been repaired. Nonetheless, inspectors observed that the premises both internally and externally was not in a satisfactory state of repair. Floor coverings in bedrooms, communal areas and toilet facilities were in visibly damaged and consequently appeared unclean. Walls in the original part of the building were visibly damaged, chipped and stained in multiple areas. Externally, the grounds were poorly maintained. Tarmacadam was uneven and damaged in places. There was also a significant build-up of debris and moss along pathways creating a potential trip hazard. The external walls of the building were in a poor state of repair as a result of a number of contributing factors such as water damage, poor ventilation and cracks. These issues continued to impact on the quality and safety of the care environment.

Residents' personal clothing was laundered on-site in an external building. The laundry area was not managed in a manner that promoted effective infection prevention and control. Floors and tiled walls were damaged, uneven, and visibly unclean. Water from washing machines and sinks was discharged into an open drain

that ran along the back of the laundry machines. This created a risk of splashing waste water and posed a risk of cross contamination.

The quality of environmental hygiene had improved in some areas such as bedrooms, dining room and communal dayroom. The provider had also procured and installed equipment in the sluice room to facilitate effective decontamination of residents toileting equipment. However, inspectors found that ancillary storage area, vacant bedrooms, and some areas of the catering environment were not cleaned to an acceptable standard. This included equipment such as fridges and freezers, and sanitary facilities for catering staff.

The provider had taken some action to improve fire safety in the centre. Locked ancillary storage areas had keys in close proximity to support timely access to the areas in the event of a fire emergency. However, inspectors saw a number of fire risks throughout the centre. This included inappropriate storage of oxygen in multiple location such as an office, storage cupboard, and clinical room. In addition, inspectors observed a number of fire doors that were damaged or impaired. Some doors were missing essential smoke seals and this created a gap between the doors. This compromised the function of the doors to contain the spread of smoke and fire, in the event of an emergency. Inspectors also observed a lack of fire detection devices in some areas of the centre that included a nurses station and laundry area.

The residents dining experience was observed to be a pleasant, sociable and relaxed occasion for residents. Residents had a choice of meals from a menu that was updated daily. Staff were observed to provide assistance and support to residents in a person-centred manner.

Residents were engaged in activities throughout the day. There was a detailed weekly activity schedule on display to support residents to choose what activities they would like to participate in. Inspectors observed the interactions between residents and staff during activities and found that staff supported residents to enjoy the social aspect of activities. Staff were observed spending time with residents in their bedrooms chatting.

Residents also said that they felt that their feedback was listened to at residents' meetings, and that their rights were respected.

Inspectors met with two visitors during the inspection. Visitors expressed a high level of satisfaction with the quality of the care provided to their relatives, and stated that their interactions with the management and staff were positive.

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)
- review the actions taken by the provider to address significant issues of non-compliance found on the last inspection in May 2023
- review the providers application to renew the registration of the centre.

The findings of this inspection were that, while the provider had taken some action to address issues of non-compliance found on the last inspection in May 2023, significant action continued to be required in the governance and management of the service and in the repair and maintenance of the premises. Inspectors found that there were aspects of the management systems that were not robust and did not provide adequate assurance that a safe, consistent and quality service was provided. Inspectors found that the management oversight of risk, infection prevention and control, the premises, and fire safety required further significant action to ensure compliance with the regulations.

Significant regulatory non-compliance's were identified during the last inspection of the centre in May 2023. A poorly defined organisational structure and ineffective management systems of monitoring and oversight impacted on the quality and safety of the service provided to residents. Following the inspection in May 2023, and subsequent engagement with the office of the Chief Inspector, the provider gave assurances that the necessary action would be taken to establish an effective organisational structure in line with the statement of purpose, and to establish effective systems to monitor the service and comply with the regulations. Inspectors found that while an organisational structure had been established, it had not had a significant impact on the oversight and management of risks, fire safety, or the premises.

The provider of this centre is Kilrush District Hospital Company Limited by Guarantee. The provider had submitted an application to renew the registration of the centre. The application included details of a revised organisational structure that consisted of a board of management comprising of three directors, working in a voluntary capacity. One of the directors represented the provider and attended the centre on a weekly basis to provide governance and support to the person in charge. Inspectors found that the lines of accountability and responsibility for key aspects of the service such the oversight and management of risk, fire safety and the premises were unclear. For example, the personnel responsible for the administration and oversight of the service were unable to provide information regarding outstanding fire risks in the centre or a project plan to address premises issues in the centre.

Within the centre, the clinical management support for the person in charge had improved. The person in charge was supported by a newly appointed clinical nurse manager who supported the administration of the service, supervision of staff, and monitored the quality of care provided to residents. Inspectors found that the

additional management resource had positively impacted on the supervision of the care provided to residents, and the quality of resident's clinical documentation.

The provider had implemented management systems to ensure aspects of the quality of the service was effectively monitored. Key clinical indicators with regard to the quality of care provided to residents were collated on a weekly basis. This included the incidence of wounds, restrictive practices, residents nutritional risk, falls, and other significant events. While a schedule of audits had been implemented to monitor the quality of clinical documentation, residents nutrition, and restrictive practices, inspectors found that there were ineffective systems in place to identify, monitor and improve the quality and safety of key aspects of the service such as infection prevention and control, fire safety, and the premises as evidenced by the findings under each of the regulations.

A review of the centre's risk management systems found that they did not reflect the centre's own risk management policy. For example, while some potential fire risks were identified and managed through the risk management systems, the controls and measures in place to protect residents from the risk of fire were not subject to review as new risks were identified, or resolved in the centre. Inspectors found that known risks such as those associated with outstanding electrical works had not been appropriately risk assessed which meant that actions were not in place to reduce or control the risks.

There were systems in place to record, investigate, and learn from incidents involving residents.

Inspectors reviewed the system of record management in the centre. The provider had taken action to ensure records were stored within the designated centre. However, inspectors found that records were not securely or safely stored. Records were stored in an unsecured room within the centre. Additionally, records required to be maintained under Schedule 4 of the regulations, such as records of testing and maintenance of the fire safety systems, were not available for review.

There were sufficient numbers of suitably qualified staff available to support residents' assessed needs. Staff had the required skills, competencies and experience to fulfil their roles. The team providing direct care to residents consisted of two registered nurse on duty at all times and a team of health care assistants. A review of the rosters evidenced that there was adequate staffing in place to support housekeeping, laundry, catering and social care activities.

A review of staff training records found that all staff had up-to-date mandatory training in fire safety, safeguarding of vulnerable adults and infection prevention and control. However, staff spoken with, and observed by inspectors did not demonstrate appropriate levels of knowledge, commensurate to their role. For example, staff were unclear with regard to the fire evacuation procedure.

In addition, the system in place to supervise staff was not effective. Inspectors observed repeated poor practice in relation to fire safety, and infection prevention and control.

Regulation 15: Staffing

On the day of inspection, there was adequate staff available to meet the needs of the current residents taking into consideration the size and layout of the building. There were satisfactory levels of health care staff on duty to support nursing staff. The staffing compliment included cleaning, catering, activities staff and administration staff.

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 all residents. This was evidenced by:

- inadequate supervision of staff allocated to the cleaning process in the centre, and infection prevention and control practices.
- poor fire safety awareness as evidenced by fire doors wedged open and limited knowledge on evacuation procedures.

Judgment: Substantially compliant

Regulation 21: Records

The management of records was not in line with regulatory requirements.

- Records required under Schedule 3 and 4 of the regulations were not maintained in a manner that was safe, or securely stored. For example, records of residents medical and nursing care were stored in an unsecured area on the ground floor of the premises. A sitting room, and communal toilet facilities were accessed through the record storage room.
- Records required under Schedule 4 were not made available for review. This included records of testing and maintenance of fire equipment.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider had an up-to-date contract of insurance against injury to residents and protection of residents property.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors were not assured that the registered provider had allocated adequate resources to the maintenance of the premises, and fire safety systems. For example, the provider had failed to address all the fire risks identified in a fire safety risk assessment that was completed in October 2021.

While there was a management structure in place, lines of accountability and responsibility were unclear. For example, accountability and responsibility for the oversight and management of key aspects of the services such as the management of risk, the premises and fire safety were not established. This resulted in ineffective action been taken to address the risks and non-compliances in those areas of the service.

Inspectors found that significant improvement was required to strengthen the overall governance and management of the centre. Management systems were not sufficiently robust to ensure the service was safe, appropriate, consistent and effectively monitored. For example,

- The provider had failed to take appropriate actions to ensure that the fire risks identified in a fire safety risk assessment completed in 2021 were addressed. The management were unable to provide assurance that all outstanding works detailed in the assessment report were completed.
- Risk management systems were not effectively monitored or implemented. A number of fire risks identified in a fire safety risk assessment had not been appropriately reviewed or updated in the risk register and the fire safety action plan did not accurately detail works outstanding or a time-line for completion.
- The systems in place to monitor, evaluate and improve the quality of the service were not effective in identifying deficits and risks in the service. For example, there was a lack of robust auditing and monitoring of infection prevention and control, fire safety, and maintenance of the premises. This meant that risks and deficits in the quality and safety of the service were not identified or subject to quality improvement action plans.

Judgment: Not compliant

Quality and safety

Overall, 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 were satisfied with their access to health care, and reported feeling safe and content living in the centre. While the provider had taken some action to improve the maintenance and quality of the premises for residents, there were aspects of the premises and associated facilities, that were in a poor state of repair and did not support effective infection prevention and control management. Action was also required to ensure residents were protected from the risk of fire, and to ensure that arrangements were in place to support residents to manage their finances, in line with best practice guidelines.

A review of fire precautions in the centre found that records with regard to the maintenance and testing of the fire equipment, means of escape, building fabric and building services were not consistently maintained or available for review. Inspectors found that registered provider did not have adequate arrangements in place to ensure that residents were protected from the risk of fire. Inspectors identified deficits in the system of fire containment and management of fire safety. Further findings are discussed under Regulation 28: Fire Precautions.

The provider had taken some action with regard to the maintenance of the premises since the previous inspection. Corridors, communal areas, and a number of bedrooms had been redecorated, and some floor coverings had been repaired. Facilities in use by residents, such as private and communal toilet facilities had benefited from re-plastering, redecoration and repair of sanitary equipment. The provider had also decommissioned a number of bedrooms that were unsuitable to be occupied by residents. Following the previous inspection, and in recognition of significant concerns with regard to the premises, the provider had engaged the services of a structural engineer to assess the quality and safety of the premises. The report identified that the building was in reasonable condition structurally, however the building is showing signs of deterioration. The report highlighted that the issues identified with the outdated electrical installation, and the outbuilding to the rear, required urgent attention. Further findings are discussed under Regulation 17: Premises.

A review of the care environment found that the provider had taken some action to improve and sustain an appropriate standard of environmental, and equipment hygiene. Facilities necessary to support effective infection prevention and control had been improved through the installation of a bedpan washer to support effective decontamination of residents toileting aids. While there was a cleaning schedule in place, inspectors observed that some areas of the centre were not visibly clean. This included vacant bedrooms, storage areas, and communal toilet facilities that were not in frequent use. Inspectors found that the systems in place to monitor infection prevention and control standards was not effective. This issue is discussed further under Regulation 27: Infection control.

A sample of residents’ assessment and care plans were reviewed. Residents’ needs were assessed on admission to the centre through validated assessment tools in

conjunction with information gathered from the residents and, where appropriate, their relative. The information was used to develop care plans that provided person-centred information on the current care needs of the residents.

A review of residents' records found that residents had access to a general practitioner (GP) of their choice, as requested or required. Arrangements were in place for residents to access the expertise of health and social care professionals for further assessment. The recommendations of health and social care professionals was observed to be implemented, and reviewed frequently to ensure the care plan was effective.

Resident's nutritional care needs were assessed to inform the development of nutritional care plans. These care plans detailed residents dietary requirements, the frequency of monitoring of residents' weights, and the level of assistance each resident required during meal-times. There were appropriate referral pathways in place for the assessment of residents identified as being at risk of malnutrition.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of their safeguarding training and detailed their responsibility in recognising and responding to allegations of abuse. Inspectors found that action was required to ensure residents finances were managed and protected. While the provider supported a resident to manage their pension, the management system was not in line with best practice guidelines.

Resident’s rights were promoted in the centre. Residents were supported to engage in group and one-to-one activities based on residents individual needs, preferences and capacities.

Residents were supported to express their feedback on the quality of the service and staff engaged with residents to ensure the service residents received was based on their preferences and choice.

Resident meetings were held and records reviewed showed a high attendance from the residents. There was evidence that residents were consulted about the quality of the service, the menu, and the quality of activities.

Residents were encouraged and supported by staff to maintain their personal relationships with family and friends. Visitors were welcomed in the centre. Visitors were complimentary of the care provided to their relatives.

Regulation 11: Visits

The registered provider had arrangements in place to facilitate residents to receive visitors in either their private accommodation, or in a designated visiting area. Visits to residents were not restricted.

Judgment: Compliant

Regulation 17: Premises

Actions were required to ensure compliance with Regulation 17: Premises. For example;

- The premises was not maintained in a satisfactory state of repair internally and externally. Floor coverings were damaged and uneven in bedrooms, communal areas and ancillary support areas.
- Walls along corridors and in bedrooms were visibly chipped and damaged. Some areas that had plaster repaired on walls had not been appropriately redecorated.
- Externally, there was significant maintenance and repair works required to the externally walls, windows, drainage systems, and the grounds. For example, walls were visibly cracked, windows required sealing, and down pipes required repair to address issues of water damage. Additionally, building supplies were stored outside the kitchen area. The oil tank to the rear was in poor condition and was corroded.
- Areas of the premises, designated as storage facilities, were not appropriate. For example, inspectors found that medical records were stored in a re-purposed bedroom. This room was designated as family room on the centre's floor plans. Access to an adjoining sitting room and toilet facilities was through the area used to store medical records.
- Bedrooms with windows into adjacent rooms were not fitted with blinds or curtains to prevent light coming into the room.
- The layout and purpose of a number of areas in the centre did not align with the floor plans submitted.
- There was a damp patch on the ceiling of a residents en-suite bathroom. This room was poorly ventilated and had a damp odour.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents had access to adequate quantities of food and drink, including a safe supply of drinking water. A varied menu was available daily, providing a range of choices to all residents including those on a modified consistency diet.

Residents were monitored for weight loss and were provided with access to dietetic, and speech and language services when required. There was evidence that the recommendations made by those professionals were implemented and reviewed which resulted in good outcomes for residents.

There were sufficient numbers of staff to provide residents with assistance at mealtimes.

Judgment: 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. For example;

- Areas of the centre were visibly unclean on inspection. This included catering equipment and facilities, vacant bedrooms and en-suites, storage rooms, and communal bathrooms.
- Several pieces of equipment used by residents, such as shower chairs, specialised chairs, and soft furnishings were visibly damaged and in a poor state of repair. This compromised effective cleaning of those items and increased the risk of cross infection.
- The laundry facilities did not ensure that infection prevention and control standard could be met to reduce the risk of cross infection.
- Staff toilet facilities in the old part of the building were not fitted with appropriate hand hygiene facilities.
- Equipment was inappropriately stored in a communal shower room. For example, wheelchairs and mobility aids were inappropriately stored in a communal shower room.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. Improvements were required to comply with the requirements of the regulations. The service was non-compliant with the regulations in the following areas:

The registered provider was not taking adequate precautions against the risk of fire

- The arrangements for the storage of oxygen were not adequate. For example, there was a large oxygen cylinder in the treatment room, with loose storage of bulky items, creating a risk of damage to the cylinder. Hoist batteries were on charge in the adjacent storage space. The partition was not full height and both risks combined, increased the risk of fire.

- A number of fire doors were observed to be held open by means other than devices connected to the fire detection and alarm system. For example, the door to the staff canteen was open and caught on the floor covering. This was a single means of escape for the resident(s) in an adjacent bedroom and this door was required to protect that means of escape.
- Electrical panels were located on escape corridors and which were not protected by fire rated construction. This high priority risk had been identified to the provider in a fire safety risk assessment completed in 2021 but had not been addressed.
- The electrical room, located in a separate building to the rear, was found to have a significant volume of combustible material against the electrical panels. This created a risk of fire.
- A bedroom was now being used as a maintenance store, however this was not risk assessed to determine it's suitability for use as a store, or potential impact on the means of escape and fire containment measures.
- The smoking area was not fitted with a fire blanket.
- There was a portable convection heater in a residents bedroom. An appropriate assessment of risk had not been completed to determine the risk associated with their use.

Inspectors were not assured that an adequate means of escape was provided throughout the centre. For example:

- Three bedrooms, which were provided with a single means of escape, had potential fire risks on those routes. For example, there were exposed electrical panels on the corridors and fire doors were propped open on the route. There was a lack of assurance that smoke ventilation systems were functional to protect the residents within some of those rooms
- There were two bedrooms that were accessible only through the dining room. However, staff would be prevented from accessing those bedrooms if a fire occurred in the dining room. While there was an emergency exit at the end of the corridor, staff did not have a means to enter this part of the building from the outside as there were no externally facing fastenings on the exit.
- Staff spoken with indicated all doors would automatically close in the event of a fire emergency. However not all bedrooms were fitted with automatic closing devices. Some doors which were fitted with closers had a magnet holding the door open and required staff to release it. This may result in a fire door remaining open allowing the spread of fire and smoke onto escape routes.

The arrangements for maintaining of all fire equipment, means of escape, building fabric and building services was not adequate:

- A number of fire doors were observed to be impaired. For example, some did not close fully while other doors were stuck on the floor when opened. There were missing heat and smoke seals and gaps observed between doors. This compromised the function of the fire doors to contain the spread of smoke and fire.

- The emergency lighting system had been recently upgraded, however the commissioning documentation to verify it was installed correctly was not available.
- The suppression system, which is an automatic chemical suppression system to extinguish a kitchen fire, had not been serviced annually in line with best practice. The equipment was last serviced in 2019.
- The electrical installation in the building was identified in the fire safety risk assessment as high risk and required major upgrade works. These works had not yet commenced.
- There were smoke extract units at the upper floor. The control switches had flashing lights and assurances could not be provided they were functional and serviced as required.

Arrangements for the containment of fire were not adequate, for example:

- The deficits to fire doors was impacting on the fire containment of the centre.
- Assurance was required that ceilings provided adequate containment of fire where required. For example, there were attic hatches which did not appear to be fire rated.
- Service penetrations were observed in fire rated construction which were not adequately sealed to ensure containment of fire.
- Assurance was required regarding the fire rating of some elements of glazing, in particular where located within a fire compartment boundary.
- Assurance was required regarding the fire rating of the kitchen enclosure.
- A number of small store areas to the rear of the kitchen were not within fire rated enclosures.

Adequate arrangements had not been made for detecting fires:

- The building to the rear was not provided with fire detection. This included the laundry facilities, storage areas, and toilet facilities for catering staff.
- The nurse station was fitted with a heat detector and not a smoke detector.

The arrangements for evacuating residents required improvement:

- Floor plans available for review by inspectors, which showed the location of fire compartment boundaries, differed to what inspectors were told by staff. There was also confusion between fire alarm zones and the fire compartment boundaries for evacuation. This disparity was evident in drill records reviewed.
- Not all residents personal emergency evacuation plans (PEEP) were up-to-date to ensure the safe and timely evacuation of residents in the event of a fire emergency.

Adequate arrangements had not been made for giving warning of fires:

- The evacuation procedure in place as described to inspectors was one of progressive horizontal evacuation. The fire alarm system was a zoned system for the older part of the building. Staff will only know the zone where the

detector was activated. Most of the first floor of the older building was a single zone, and may take staff an extended time frame to search the zone. The inspectors also found that the boundaries and parameters of the zones did not align with the fire compartment boundaries used for evacuation. This could potentially lead to unnecessary delays in identifying the location of the fire resulting in delayed evacuation of residents.

- The fire alarm system was not extended to the building to the rear, therefore there would be no warning of fire if one started that area.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans were developed following a comprehensive assessment of need and were reviewed at four month intervals in consultation with the residents and, where appropriate, their relatives.

Care plans detailed the interventions in place to managed identified risks such as those associated with impaired skin integrity, risk of falls and risk of malnutrition. There was sufficient information to guide the staff in the provision of health and social care to residents based on residents individual needs and preferences.

Judgment: Compliant

Regulation 6: Health care

Residents had timely access to medical assessments and treatment by their General Practitioners (GP) and the person in charge confirmed that GPs were visiting the centre as required.

Residents also had access to a range of allied health care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of later life and palliative care.

Judgment: Compliant

Regulation 8: Protection

Action was required to ensure residents finances were managed through a system that protected residents and their finances. The management of pension agent arrangements required review to ensure best practice guidelines were followed.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had provided facilities for residents occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. Residents expressed their satisfaction with the variety of activities on offer.

Residents were provided with the opportunity to be consulted about and participate in the organisation of the designated centre by participating in residents meetings and taking part in resident surveys. Residents told the inspector that they could exercise choice about how they spend their day, and that they were treated with dignity and respect.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Kilrush District Hospital Limited OSV-0000446

Inspection ID: MON-0041640

Date of inspection: 19/10/2023

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Cleaning staff are supervised by Hygiene Supervisor and PIC will do a random check to make sure all areas and equipments are cleaned properly as per the infection control protocol. Management and supervisors regularly check to ensure all fire doors are kept closed at all times.
PIC has briefed all staffs on emergency door closure for all parts of the building including high lighting the different closure arrangements.

IPC training provided by a designated trainer on infection control 31/08/2023 including, best practices and cleaning products. Attended by all Kitchen/Hygiene staff, PIC, CNM. Cleaning products reviewed and new products now in use.

Fire drills are now being carried out on a monthly basis. As per discussions and a risk assessment between the Fire Warden and PIC, the frequency of drills will be kept under review going forward in order to ensure that all staff are participating in fire drill practices on a regular basis, as there is a large number of staff working in the building on different shifts (day/nights).

Specific evacuation procedures have been devised for areas of the building that are deemed as higher risk due to the layout. Fire drills focused on these more high risk areas are scheduled to be carried out in the second week of December in order to further enhance awareness and knowledge for our existing staff of the appropriate actions that should be followed (Completed 29 November 2023). These drills are logged on our Fire Drill schedule and will continue to be carried out on a regular basis going forward.

Two members of staff have carried out dedicated Fire Warden training as at October 2023, in addition to standard Fire Training which all staff attended in June 2023. We have also arranged for on-site specialised fire training to take place with our current Fire Wardens in December 2023. The specialized fire warden training will also include a

review of our current fire evacuation procedures and possibly identify any additional safeguards that we can implement.
Following advice from a fire specialist, we are intending to expand the number of staff fire wardens.
The local fire brigade also carried out an on-site inspection of the building on 22/11/2023. They have offered feedback on the layout and potential hazards in the event of a fire which will be incorporated into our Fire Emergency Plan. The plan going forward is to maintain regular contact with the local fire service as our plans and drills evolve.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Medical records are now contained in a secure, dedicated room within the building. The sitting room and communal toilet are not in use and not accessible to residents or staff. The Medical Records room is locked at all times and access is available to restricted personnel only. The floor plans of the building have been updated to reflect changes to purposes of rooms.

Emergency lighting in the building was tested on 26/10/2023 and a certificate is on file for same.

Ansul Fire Sprinkler in the kitchen is due to be serviced on 28th November 2023 (Completed)

Testing and Service of Automatic Smoke Vents is scheduled for 30th November 2023. (Completed)

The frequency and timeline for testing of the Fire Equipment has been added to the Facilities Log and will be maintained as per regulatory requirements going forward.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the

regulations.

The management structure of the nursing home has changed in recent months, including the appointment of a Clinical Nurse Manager – this is reflected in our Statement of Purpose which details the organisational structure and lines of accountability. This has been communicated to Supervisors and staff and all employees have been made aware of their accountability and responsibilities. Roles and responsibilities have been clarified to all staff and regular risk mitigation information / updates communicated to all staff by the PIC.

Weekly governance meetings are held and are attended by a representative from all departments in the nursing home and a board member. Minutes are maintained of all meetings and staff are encouraged to discuss issues/developments that are arising in different areas. Fire risk is an agenda item on weekly governance meeting. Actions are then allocated re same and these actions are being followed up at each meeting to monitor progress.

Oversight of Hygiene and IPC activities has been enhanced with increased monitoring by the Hygiene Supervisor and regularly audited by the PIC. This includes the kitchen area, cleaning by the Hygiene staff, monitoring of decommissioned areas on at least a weekly basis, and feedback to relevant supervisors and staff.

The outstanding high priority item on the Fire Safety assessment of November 2021 relates to the electrical installation of the main board and sub boards. An independent expert report including indicative costing was commissioned by KDH in September 2023.

Significant remedial works are already part completed, including the clearance and weatherproofing of the main electrical store/plantroom. Expected date of completion is mid January 2024.

In the meantime, we have updated our Fire Policy and evacuation procedures in relation to high-risk areas. We have had an onsite inspection and review by the local fire service, who have engaged with our fire wardens and made some recommendations which were incorporated into our fire drills and documentation in November 2023.
As part of the PIC's regular risk monitoring, risks identified including those around premises, IPC and fire safety will be captured in the Risk Register. Any risks that can be reduced immediately will have actions put in place and any risks identified that require further action will be reported to the weekly governance meeting and escalated to the Board of Directors as necessary. All departments now have regular team meetings to address key areas of responsibility and action plans derived from the weekly governance meetings. Works are prioritized on a risk-based approach, ensuring that financial resources available are targeted most effectively. Actions will be put in place along with the responsible person and the completion date for each risk identified and this will be reviewed weekly.
Additional resources have been allocated within the existing staffing model, as we look to evolve and improve the risk management framework. We have engaged an advisory service to design and implement a more robust and standarised risk management framework. This will be completed by 31st January 2024.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Floor plans updated to reflect the current layout of the building – this includes areas that being used for storage and decommissioned areas. Our Statement of Purpose has also been updated in line with the floor plans.
Storage Facilities – Rooms being used for storage of records/equipment have now been repurposed and are not accessible to residents or general staff. Access is restricted to dedicated personnel only.
All bedroom windows have been fitted with blinds. Restorative maintenance is ongoing on the en-suite facilities. Floor coverings in communal areas such as the staff canteen and hallway have been repaired. (Complete)
The drainage system was purged on 10/11/2023 and internal and external drains are being treated on a regular basis with cleaning agents by a member of the maintenance staff.
There have been further recent electrical and premises reviews as the Board seek to improve the fabric of the facility and external grounds.
Regular testing and maintenance of plant and equipment will be captured in the Facilities Log.

Remedial works in relation to plumbing and leaks in a number of areas in November 2023 and re-decoration and refurbishment will take place on a phased basis throughout 2024.
The finding in respect of a specific resident's room has been addressed.
The replacement of the corroded oil tank is forming part of our capital intensive items. We are maintaining minimal oil levels.
Building supplies have been removed to an appropriate storage area.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
We have enhanced the checklist for the daily and weekly cleaning process – it has also been amended to reflect individual room requirements and cleaning is double checked by

the PIC on a regular basis.
The cleaning schedule has also been expanded to include areas that are decommissioned/ not in use to ensure that they are maintained to the required IPC standard.
Kitchen checks are being carried out on a daily basis by the PIC with a formal audit on a monthly basis. Regular meetings are being held between the PIC and Kitchen Supervisor providing feedback regarding IPC and cleaning.
Deep Cleaning in the Kitchen is continuing to be carried out on a bi-weekly basis –this is further checked by the PIC. Enhanced daily cleaning and maintenance of catering equipment is also being carried out by the kitchen staff and inspected by the Hygiene Supervisor, Kitchen Supervisor and PIC.
Hand hygiene facilities have been upgraded in the staff toilets in the old part of the building.
All shower chairs in use are in good condition and regular checks are carried out. A schedule has been devised for repairs to Residents furniture and this is currently underway.
Equipment is being stored in designated areas only - all staff have been made aware of this requirement and this is monitored by the management and Supervisors to ensure this is maintained.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

All oxygen cylinders are now removed and stored in a secure cage outside the main building. All fire doors are closed at all times, and all staff have been informed of the importance of closing the fire doors at all times. This is included in staff training also. The staff canteen door was adjusted by the maintenance staff and is closed all times. The items from decommissioned rooms are cleared, cleaned and tidied. The smoking area is fitted with a fire blanket. The portable heater has been removed from a resident's bedroom. Fire procedures, to include high risk areas, have been updated as outlined under Regulation 16. All residents' PEEP (Personal Emergency Egress Plan) have been reviewed to ensure the safe and timely evacuation of residents in the event of fire. Resident's PEEP's are reviewed and updated if required monthly.

Excess materials/ debris have been cleared from the Electrical Room and works have commenced on repairing the roof to reduce fire risk. Once completed, further required safety works will be reviewed and prioritized.

All staff have been briefed on the differing closing mechanisms of fire doors in different

parts of the building and the actions required in the event of a fire.

Significant remedial works are part completed, including the clearance and weather-proofing of the main electrical store/ plantroom. The expected date of completion is mid January 2024.

Emergency lighting in the building was tested on 26/10/2023 and a certificate is on file for same.

The Automatic Opening Vents have been serviced and certified on 30th November 2023.

The Ansul sprinkler has been serviced on 28th November 2023.

A scheduled fire drill focusing on the identified high-risk areas (two bedrooms adjacent to the Dining Room) was carried out on 29 November 2023. A specific evacuation plan is documented in respect to these areas, with an alternative access route now established through the rear of the building. Staff have been educated about this procedure and it forms part of the regular fire drills.

Regarding the electrical panels on the escape corridors, we are proposing to engage with the competent fire safety consultant to advise on an interim solution whilst the broader capital expenditure items are discussed with the landlord by 31st January 2023.

The maintenance store has been changed to a general storage area, as per the SOP. All maintenance related materials have been removed to provide a clear line of escape.

Review and maintenance of all fire doors and fire containment will form part of the fire risk assessment to be undertaken with the competent person in January 2024. Findings and action plan will be shared upon completion.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The nursing home is acting a pension agent solely for one resident. The resident's funds have been segregated and continue to be accurately recorded at all times within the financial system.

Due to a safeguarding issue with the resident, we have engaged an independent advocacy service to ensure that the resident's funds are managed and protected in line with best practice and current guidelines. The advocacy representative visited the resident on 12th December 2023 and has initiated the necessary process. We have requested the expected timeline and will monitor progress against this once received.

We have conducted a risk assessment in relation to same which is recorded in the Risk Register.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	24/11/2023
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	31/03/2024
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	31/12/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to	Substantially Compliant	Yellow	24/11/2023

	be safe and accessible.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	24/11/2023
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	24/11/2023
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	31/01/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Not Compliant	Orange	31/01/2024

	associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	31/01/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/12/2023
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	31/01/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/01/2024
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Orange	31/01/2024

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.	Substantially Compliant	Yellow	31/12/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	31/01/2024