Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	St Brigid's Hospital
Name of provider:	Health Service Executive
Address of centre:	Shaen, Portlaoise, Laois
Type of inspection:	Unannounced
Date of inspection:	30 January 2024
Centre ID:	OSV-0000531
Fieldwork ID:	MON-0042172

About the designated centre

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

St. Brigid's Hospital is a two-storey premises and provides residential care for 23 male and female residents over 18 years of age with continuing care, dementia, palliative care and respite needs. Residents' accommodation is over two floors and accessed by a mechanical lift and stairs. Both floors are of similar design. Each unit has two day rooms, one of which is a designated dining area. There is also a second dining room on the ground floor. An oratory, hairdressing salon, sensory room and activity room are also provided for residents' use. In total, there are seven single bedrooms and eight twin bedrooms. Shared toilets and washing facilities are conveniently located off the circulating corridors on both floors. Residents have access to an enclosed garden accessible from the ground floor. Adequate parking is available at the front and side of the premises. Nursing care is provided on a 24-hour basis, and the provider employs nursing staff, care staff, catering, household and administration staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

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
Tuesday 30 January 2024	10:30hrs to 19:00hrs	Sean Ryan	Lead
Tuesday 30 January 2024	10:30hrs to 19:00hrs	Niall Whelton	Support

What residents told us and what inspectors observed

Residents living in St. Brigid's Hospital told inspectors that they enjoyed living in the centre. 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 a clinical nurse manager on arrival at the centre. Following an introductory meeting, inspectors walked through the centre, reviewed the premises, and met with residents and staff.

On the morning of the inspection, the atmosphere was observed to be relaxed and pleasant for residents. Staff were observed attending to residents requests for assistance in their bedrooms promptly. A small number of residents were observed sitting in the communal dayroom watching the morning news on the television. Staff were present to provide residents with assistance and supervision. Residents appeared to be relaxed and comfortable in their environment.

Inspectors met with a number of residents in the communal dayroom and in their bedrooms and spoke to residents in detail about their experience of living in the centre. Residents complimented the staff and described them as 'friendly' and 'easy to get along with'. Residents told the inspectors that they rarely experienced delays in receiving assistance from staff, and that they 'never felt rushed' when staff arrived to assist them with their care needs.

Residents expressed satisfaction with their bedroom accommodation and were satisfied with the storage facilities for their personal clothing and possessions. Bedrooms designated to accommodate two residents were appropriately furnished. Privacy screens were appropriately placed to ensure that residents could access their storage space in private, and without impeding on the private space of other residents occupying the bedroom.

The premises was well-lit and warm for residents. The centre was registered to provided accommodation to 23 residents over two floors. Inspectors observed that the premises had been redecorated and significant maintenance works were nearing completion. Corridors were fitted with appropriately place handrails to support residents to mobilise independently and safely. New floor coverings had been installed in a number of areas. The centre had many communal areas and rooms, that residents were using during the inspection. There were large spacious day rooms and dining rooms on each floor. There was a sensory room that was a quiet space for residents to use and to meet visitors. These areas were decorated in a comfortable and homely style. There was large chapel that was accessible to residents who wished to attend religious services held in the centre. The first floor corridor was observed to have an inclination that may be a risk to residents when mobilising. Inspectors observed residents mobilising independently in this area and noted that there was limited signage in place to alert residents to the risk. Each floor provided residents with communal toilet and showering facilities. Inspectors

observed that the bathroom facilities located on the first floor were restricted and not accessible to residents who were independent due to the presence of magnetic door locks.

Areas of the premises occupied by residents, such as bedrooms, communal day rooms, dining areas and toilets, were observed to be clean. However, inspectors observed that some areas of the centre were not cleaned to an acceptable standard. This included the basement and staff areas. Residents told the inspectors that their bedrooms were cleaned daily. The inspectors observed that hand-sanitising stations were located throughout the centre. However, clinical hand wash sinks were not available, outside of those provided in residents' bedrooms and communal bathrooms, which meant that the sinks in residents' bedrooms were serving a dual purpose, as facilities for residents' personal hygiene and as hand hygiene facilities for staff. This posed a risk of cross contamination and did not support effective hand hygiene procedures.

Inspector observed that all fire doors had been fitted with automatic door closures devices. This allowed residents to keep their door open safely without impacting on fire containment measures. The fire alarm panel was located inside the main entrance, with additional repeater panels on two bedroom corridors, and these showed the system was free of fault. There was an evacuation mat mounted on the wall for each bed in the centre. There were new fire doors fitted in some locations and it was evident that fire sealing and upgrade fire safety works were in progress. However, inspectors observed some electrical charging devices and equipment along a fire escape corridor. This posed a risk fire and obstruction of an escape route in the event of a fire emergency.

Resident’s personal clothing was laundered on-site. Residents expressed their satisfaction with the service provided, and described how staff returned their laundry to their bedroom promptly.

The dining experience was observed to be a pleasant and social occasion for residents. Residents were complimentary about the food served in the centre, and confirmed that they were always afforded choice. One resident told the inspector how they looked forward to the different meal choices. Staff were observed to engage with residents during meal times and provide discreet assistance and support to residents, if necessary. The food served was observed to be of a high quality and was attractively presented. Residents in all areas had access to snacks and drinks, outside of regular mealtimes.

There was a large notice board at the main reception area that displayed a variety of information for residents. This included information on the weekly activities schedule.

Residents were provided with opportunities to express their feedback about the quality of the service during daily one-to-one interactions with the management, and through formal resident forum meetings. Residents told the inspector that staff sought their feedback on how to improve the service. There was evidence that

residents feedback was acted upon to improve the service they received in areas such as the activities programme and menu choices.

All residents in the centre were seen to be well dressed and it was apparent that staff supported residents to maintain their individual style and appearance. Residents told inspectors that staff helped them to choose their clothing daily

There were activities provided to residents throughout the day. Residents told the inspector that they could choose what activities they would like on a daily basis. Most residents chose to spend time in the dayroom chatting with staff and other residents. Residents told the inspector that they did not mind what activity they did because it was mainly the social aspect of the activity they looked forward to.

Visiting was not restricted and a number of visitors were observed attending the centre on the day of inspection.

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 was an unannounced risk inspection, carried out over one day by inspectors of social services, to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspector also followed up on the actions taken by the provider to address issues with fire precautions and the premises identified on the last inspection of the centre in September 2023.

The findings of this inspection were that while the provider had taken significant action following the previous inspection to ensure residents received care and support in an environment that met their individual and collective needs, and protected them from the risk of fire. Some action was now required to achieve full compliance with the regulations. Action was also required with regard to the governance and management of the service to ensure that management resources were in line with the centre's statement of purpose, and to ensure that management systems were effectively implemented to ensure a safe, consistent and quality service was provided to residents living in the centre.

The Health Service Executive is the registered provider of St. Brigid’s Hospital. The organisational structure, as described in the centre’s statement of purpose, was not in place. The Chief Inspector had been notified of the departure of the person in charge from the service in January 2023. In the absence of a person in charge, deputising arrangements were in place and a clinical nurse manager was responsible for the administration and oversight of the service, and facilitated the inspection. They were supported in their role by a general manager who provided governance

support and oversight. A new person in charge had been appointed and was scheduled to commence in February 2024.

Within the centre, the clinical management structure was not in line with the centre' statement of purpose, which outlined an organisational structure consisting of a person in charge, supported by three clinical nurse managers (CNM). On the day of inspection, as a result of planned leave and one CNM vacancy, the person deputising for the person in charge was unsupported clinically and administratively in their role. Consequently, the management resources for nursing oversight and governance were not in place. This organisational structure was found to impact on the consistent supervision and monitoring of aspects of the service such as residents clinical care records, and infection prevention and control.

The provider had management systems in place to monitor the quality and safety of the service. This included an audit schedule to monitor aspects of the service such as restrictive practices, fall management, and the quality of clinical records. Inspectors found that the audit schedule was not implemented and was therefore not effective to identify deficits and risks in the quality and safety of the service. For example, responsibility for completing scheduled audits of resident's clinical records was delegated to the clinical nurse management team. However, in the absence of an adequately resourced clinical nurse management structure, audits had not been completed within the centre's required time-frame.

There were systems in place to monitor and respond to risks that may impact on the safety and welfare of residents. The risk management systems were informed by an up-to-date risk management policy. A review of the risk register evidenced that clinical and environmental risks were assessed and reviewed at quarterly intervals. However, the risk register did not contain some of the known risks in the centre such as those associated with outstanding fire safety and electrical works, and the sloping corridor on the first floor. The exclusion of known risks from the centre's active risk register impacted on the centre's ability to appropriately manage risk.

Record keeping systems ensured that records, required by the regulations, were securely stored, and accessible. A sample of staff personnel files were reviewed and contained the information required under Schedule 2 of the regulations.

There were systems in place to identify, document and learn from incidents involving residents. Notifiable incidents were submitted to the Chief Inspector within the time frame specified under the regulations.

On the day of the inspection, the staffing levels and skill mix were appropriate to meet the needs of the residents. The centre had a stable and dedicated team which ensured that residents benefited from continuity of care from staff who knew them well. There were sufficient numbers of suitably qualified staff available to support residents' assessed needs. The team providing direct care to residents consisted of registered nurses on duty at all times and a team of health care assistants.

There was a 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. There were systems in place to induct, orientate and support staff.

The centre had a complaints policy and procedure which clearly outlined the process of raising a complaint or a concern.

Regulation 15: Staffing

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 and administration staff.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were facilitated to attend training relevant to their role, and staff demonstrated an appropriate awareness of their training such as fire safety, safeguarding of vulnerable people, and infection prevention and control.

Judgment: Compliant

Regulation 21: Records

Records set out in Schedules 2, 3 and 4 were kept in the centre, stored safely, and available for inspection.

Staff personnel files contained the necessary information as required by Schedule 2 of the regulations including evidence of a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not ensured that there were sufficient management resources in place to ensure the management structure was maintained in line with the centre's

statement of purpose. There was no person in charge of the centre on the day of inspection, and the clinical nurse manager structure was not maintained in line with the statement of purpose. This impacted on effective governance and oversight of the service.

The organisational structure, as described in the centre's statement of purpose, was not available and therefore not effective. As a result, accountability and responsibility for the oversight and monitoring of key aspects of the service were not clear. This included the oversight of risk management systems, fire safety, clinical care records, and the premises.

Inspectors found that the organisational structure impacted on some of the management systems in place to ensure the service provided was safe and appropriately monitored. For example;

- The provider did not present a clear time-bound project plan of works completed to date, and the outstanding works required with regard to fire safety and electrical upgrade works. As a result, there was no clear time-line for the works to be completed or effective risk management systems in place to manage any potential risk or disruption to residents during ongoing works.
- Risk management systems were not effectively monitored. Risks escalated to the provider had not been addressed. For example, a risk associated with manoeuvring evacuation mats had been escalated to the provider in 2021. While the local management team had a risk management plan in place, there had been no assessment or review of this risk by the provider.
- The systems of monitoring, evaluating and improving the quality and safety of the service were not effectively implemented. Audits were not completed within scheduled time frames. This resulted in deficits in the quality of the service going unnoticed, with no quality improvement action plans developed to address risks and deficits in the service.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifiable events, as set out in Schedule 4 of the regulations, were notified to the Chief Inspector of Social Services within the required time frames.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure in place which met the requirements of Regulation 34. A review of the complaints records found that resident's complaints and concerns were managed and responded to in line with the regulatory requirements.

Judgment: 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 significant action to improve the maintenance and quality of the premises for residents, there were aspects of the premises and associated facilities that did not support effective infection prevention and control. Action was also required to ensure resident's care plans reflected their assessed care needs. Additionally, further action was required to comply with fire precautions to ensure residents were protected from the risk of fire.

A review of fire precautions in the centre found that records, with regard to the maintenance and testing of the fire alarm system, emergency lighting and fire-fighting equipment were available for review and these were being serviced at the appropriate intervals. The fire alarm system was an L1 category alarm (smoke detection coverage to all areas). Arrangements were in place to ensure means of escape were unobstructed. The provider had also adopted a simple system of pictorial prompts on the bed to alert staff during evacuation of the evacuation aid required. Staff spoken with were knowledgeable on the procedure and were aware of potential fire safety risks. The provider took action to address fire risks identified on the day on inspection. This included relocation of an inappropriately stored oxygen cylinder and removal of a door wedged that held a fire door open. Notwithstanding this, improvements were required with regard to day-to-day fire precautions, drill practice and containment of fire. These are further discussed under Regulation 28, Fire precautions.

Action had been taken with regard to the maintenance of the premises since the last inspection. Floor coverings had been repaired and additional storage areas had been established for the storage of equipment. The centre had been redecorated and was well maintained throughout. The layout and design of the premises generally met the individual and collective needs of the residents with the exception of one area on the first floor. However, some action was required to ensure the premises complied with the requirements of the regulations. For example, residents could not access a hairdresser room or communal bathroom independently due to the

presence of steps, and a lift platform that could only be operated by a key held by staff.

A review of the care environment and ancillary storage areas found that the provider had taken action to improve facilities within the centre to support effective infection prevention and control. Housekeeping staff demonstrated an appropriate knowledge of the cleaning procedure and the system in place to minimise the risk of cross contamination. The centre was visibly clean on inspection with the exception of some areas that were not appropriately cleaned or maintained as electrical works progressed in the centre. Inspectors found that the facilities in place to support hand hygiene were not in line with best practice guidelines. Sinks within residents bedrooms were used by staff for hand hygiene purposes. This posed a risk of cross contamination, and therefore a risk infection to residents. Consequently, there was inadequate hand hygiene sinks located within close proximity to areas of the care environment.

A review of a sample of residents' assessments and care plans found that care plans were not always informed by an assessment of the resident's care needs. Consequently, the care plans reviewed did not reflect person-centred, evidence-based guidance on the current care needs of the residents. For example, some residents assessed as being at risk of malnutrition were not identified as such within their nutritional care plans.

A review of residents' records found that there was regular communication with residents' general practitioners (GP) regarding their health care needs and residents had access to their GP as requested or required. Arrangements were in place for residents to access the expertise of allied health and social care professionals for further assessment. While the recommendations of health and social care professionals was observed to be implemented and reviewed, the care plans were not always reflective of the recommendations made by health care professionals. This is actioned under Regulation 5, Individual assessment and care plan.

Residents told inspectors that they felt at home in the centre and that their privacy and dignity was protected. Inspectors observed several positive interactions between staff and residents throughout the inspection. Interactions were polite, supportive and respectful.

Staff were observed providing meaningful activities throughout the inspection. There was evidence that residents were consulted regarding the quality of the service, the menu, and activities.

Regulation 17: Premises

Some action was required to comply with Regulation 17, Premises and Schedule 6 of the regulations. For example;

- There were areas of the premises that were not laid out to meet the needs of the residents, in line with the statement of purpose. The first floor contained an assisted bathroom and hairdresser room that was on a lower floor level than the rest of the first floor area. While adaptations had been made to make this area accessible, such as a lift platform and stairs, this area could not be accessed by residents independently due to a key-code protected door in front of the stairs, and a key was required to operate the life platform.
- Safe floor coverings were not provided on the first floor. One section of the corridor had a slope and the hazard was not identified through appropriately placed signage, or a variation in the colour of the floor covering. This posed a risk to residents, particularly those who required the use of mobility aids.
- An area accessible through the staff area on the first floor containing an escape stairs was in a poor state of repair. Walls and floors were visibly damaged and in a poor state of decoration. There was also an inappropriate storage of equipment in this area.
- There was a malodour noted along a corridor that emanated from a small storage area. This cause of the malodour had not been investigated.
- The hot water room on the lower ground floor was very hot and was not adequately ventilated resulting in a build-up of excess heat.
- A shower within a communal shower area was not functioning correctly. When the shower was running, water flowed out of the area creating a risk of slips and falls.
- Repair work was required to areas where new electrical wiring had been installed and where old wires had been removed in walls and ceilings. For example, some areas of the walls and ceilings along corridors had not been repaired or redecorated following electrical works.

Judgment: Substantially 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:

- Facilities to support effective hand hygiene were not appropriate for the care environment. There were a limited number of clinical hand was sinks available for staff use. Sinks within residents rooms were dual purpose used by both residents and staff. This practice increased the risk of cross infection.
- Some areas of the premises were not subject to frequent cleaning. This resulted in areas such as store rooms, the basement area, and staff areas not being cleaned to an acceptable standard.
- There was inappropriate storage of equipment and items within sluice rooms located on the ground and first floor. This included infusion stands and items such as vases. This increased the risk of cross contamination.

- There were some areas of the premises where maintenance works had generated dust and debris on corridors. Those areas had not been appropriately cleaned following completion of works.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Notwithstanding the work completed to date, the programme of work was not yet complete and there was no date for completion of the work. Further action was required to come in to compliance with this regulation.

The provider did not have adequate precautions against the risk of fire in place. For example;

- There were bolts to the top of the doors from the chapel which meant that if they were locked when the chapel was occupied. This would render the only means of escape from the chapel unavailable
- The storage rooms leading to the chapel were filled with equipment and the doors were kept open and could not close. Electrical equipment in these rooms were being charged. This impacted on both the single means of escape from the chapel, and the containment of fire to the store rooms
- Inspectors observed hoists being charged on the bedroom corridor, introducing a risk of fire to the protected escape route.
- There was a door from a storage area leading to an adjacent area which was not part of the designated centre. This was not a fire rated door. Further assurance was required regarding potential fire risks external to the registered area, which may impact the safety of residents.

There was inadequate means of escape. For example;

- An exit from the dining room led to an open air terrace. This gate from the terrace was locked with a padlock, impeding further access to a safe area.
- The ground floor of the main stairway was being used as a visiting area. This meant that an escape route used for evacuation was obstructed.
- Escape signage was not adequate. Inspectors observed escape routes where adequate exit signage was not provided.
- Means of escape from the area at the lower level of the platform lift on the first floor had not been established. For example, egress would require negotiating steps and the means to assist immobile residents from this area had not been considered. This could impact on the safe and timely evacuation of residents from this area in the event of a fire emergency.

The oversight arrangements for the evacuation of residents were not adequate. An alternative escape route from the first floor was along an internal escape stairs. This stairs was narrow and completed drills did not provide assurance that residents

could be safely evacuated in a timely manner using equipment and staffing resources available.

Inspectors reviewed the personal emergency evacuation plans (PEEPs) for residents and found they were not all up-to-date and were not always updated where residents moved rooms to facilitate the programme of work

Arrangements for the containment of fire was inadequate. For example;

- A number of fire doors had not been replaced, and the upgrade of fire rated construction such as glazing had not been completed. This had the potential to impacted on fire containment measures in the centre. The date for completion will be provided in the compliance plan response.
- Fire sealing was required where service pipes and wires passed through fire rated construction.
- Some of the new doors installed had large gap along the locks where the doors meet and the top, middle and bottom of the door. This meant that the seals may not be effective to contain the spread of smoke.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of the residents' assessments and care plans found that they were not compliant with the regulatory requirements. For example;

- Care plans were not guided by a comprehensive assessment of the residents' care needs. Residents assessed as being at risk of malnutrition and diagnosed with impaired swallowing were not identified as such within their nutritional care plans. Consequently, care plans did not contain person-centred guidance to support appropriate care of the residents.
- Assessments of residents care needs were incomplete. For example, person-centred care plans had not been developed to reflect some residents preferences and wishes with regard to the end-of-life care. This is a repeated finding from the last inspection.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate health and social care professional support to meet their needs. Residents were provided with access to a general practitioner (GP) as required or requested.

Services such as physiotherapy, speech and language therapy, tissue viability nursing expertise, palliative care and dietitian services were available to residents through a system of referral. The recommendations from health and social care professionals was acted upon which resulted in good outcomes for residents.

Judgment: Compliant

Regulation 9: Residents' rights

There were 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 dignify 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	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially 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	Compliant

Compliance Plan for St Brigid's Hospital OSV-0000531

Inspection ID: MON-0042172

Date of inspection: 30/01/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

A candidate was identified for the post of person in charge. An NF 30A notification to notify of a change of person in charge was submitted to HIQA on the 1st Feb 2024. The PIC is in post and a fit person interview was conducted with the PIC on their appointment to the post of PIC. A staff member is in the CNM 1 post. An internal expression of interest for an acting CNM 1 / CNM 2 post will be progressed to cover the duration of the maternity leave absence. The CNM2 has reverted to their substantive post to ensure the management organisational structure is in line with the centre's Statement of Purpose.

A schedule of staff team meetings and a program of audits have been developed to ensure oversight of the operational management of the centre.

The requirement to ensure care plans reflect the current assessed needs of residents will be monitored by ongoing care plan audits.

The cleaning program will be discussed at the staff team meeting and environmental hygiene audits completed by the Infection Prevention and Control Link Nurse who has recently completed her IPC Link Nurse training. This will be supported by the PIC. Daily/weekly cleaning schedules will be updated to include all areas.

Daily walk arounds of the centre are competed by the PIC or the CNM 2 for the purpose of monitoring staff practice, hygiene and the safety of the environment.

The PIC has booked the Clinical Practice Development Facilitator to undertake inhouse training on care planning for the staff nurse team.

The PIC is working with the maintenace team to ensure all fire infrastrucural works and decorative maintence issues including removal of wiring, sealing of gaps to mitigage any fire hazard or infection risk are fully completed.

The extent of fire upgrade works undertaken to date are as a direct result of the fire risk assessment commissioned and completed by a contractor on behalf of the HSE. These fire safety upgrades which formed the basis of the fire upgrade tender will be completed by June 30th 2024. Additional works that have been highlighted which were the subject of a previous HIQA inspection have been costed, approved with a contractor instructed to proceed. These works will also be complete by June 30th 2024

The PIC has organised a schedule of meetings with all parties involved to include the manager for older persons services, HSE Estates, maintenance, and the site manager awarded the contract of the fire safety upgrades to monitor progress of the work schedule, ensure resident's safety while all necessary works are bring concluded and the remaining works are completed both in relation to fire safety and electrical upgrades by the 30th June 2024.

The risk register has been updated to include a risk assessment with controls to mitigate any risk to residents' while the outstanding works are being completed. The risk assessment will be reviewed by the team at each meeting to progress the works to completion safely and an update will be given to the Provider periodically.

The Older Person Services Manger through regular local management meetings will monitor and support the service to ensure all required works are concluded within the timeline and will regular updates will be given to the Proivder.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Accesibility to the lift will be ensured by changing the key system on the lift to a button system to allow residents access the lift independently.

Signage has been provided at the sloped floor area to identify the change in floor gradient to mitigate any risk to independently mobilising residents and to alert to changes in the incline of the floor level for residents, staff and visitors.

The storage area has been decluttered and inappropriate equipment has been removed. The damaged walls and floor will be repaired to ensure they are readily cleanable.

Estates are currently reviewing this area, it is intended to tender works required, appoint a contractor and have works complete by end of Q3 2024 to ensure all damaged walls and flooring will be repaired. In the meantime until the works are completed this area will not be used for storage.

This small store with shelving will be added to the cleaning schedule to ensure it is well maintained and ventilated on a regular basis.

Ventilation in the hot water room on the lower ground floor will be provided to prevent the build up of excess heat.

The plumber has undertaken repairs to ensure the shower is functioning correctly and draining to minimise any risk of water overspill.

Repair works to all wall areas where new electrical wiring has been installled and old wiring removed will be completed and decorated to a painted finish to ensure it is cleanable and well maintained. These works will be complete once HSE IT Service move IT/phone systems, outstanding works will be reviewed at next site meeting to ensure this action is completed.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The sinks within residents bedrooms are now designated for the use of residents. An additional clinical hand wash sink will be provided on each floor. Appropriate location to be reviewed by service in conjunction with the IPC team. It is intended to appoint a contractor and have works complete by end of Q2 2024.

Store rooms have been decluttered.The cleaning program to include the cleaning procedure and frequency has been reviewed to ensure a high standard of hygiene in all areas. The cleaning program will be discussed at the staff team meeting and an environmental hygiene audits completed by the IPC Link Nurse/PIC.

The sluice room has been decluttered and items inappropriately stored removed from this area. The sluice room will be included on the environmental hygiene audit.

All structural maintenance works on the building are now completed and a deep clean of the corridors has been undertaken. The cleaning schedule, frequency and procedure has been revised to ensure the corridors are well maintained.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The bolts from the doors are removed and the stair gates are no longer in place ensuring the fire escape route is unobstructed.

The store rooms leading to the chapel has been decluttered. Equipment not being used has been removed from the storage rooms and the doors can now close fully. This area will be monitored by the nurse management team to mitigate the risk of over stocking.

A separate area for the storage and charging of the hoist has been identified. This storage areas is separate form the storage area in the vicnity of the Chapel.

The door to the storage room will be fitted with an appropriate fire rate door.
As per the Fire Risk assessment completed, several doors were not required to be replaced or upgraded. However, a site inspection will be conducted to review this item and the need for any further works will be completed in full.

The padlock has been removed and has been replaced with an emergency release system which is connected to the fire alarm system and releases on activation of the alarm to ensure the escape route is unobstructed.

A room on the first floor has been been designated for the dual purpose of facilitating visits in private when a resident makes such a request and outside of visits the room is used for sensory activites.

Escape route have been reviewed and directional escape signage will be provided to ensure the escape routes are clearly identifiable.
A means of escape from the area at the lower level of the platform lift on the first floor is being explored to determine the most suitable option in the event of a fire and the platform lift being inaccessible. Ski evacuation mats have been placed in the area should residents who want to go to the services in this area and require evacuation in the event of a fire until a permanent, safe and efficient method of evauction is installed.
A simulated fire evacuation drill was completed to reflect the night time staffing level scenario, evacuting residents along the alternaltive escape route. Findings and recommendations from the fire drill have been implemented and the outcome of the drill was submitted to HIQA.
The programs of works have now been completed and residents PEEP's have been reviewed and updated to correctly reflect the evacuation needs and the escape route from their current designated bedroom.

The extent of fire upgrade works undertaken to date are as a direct result of the fire risk assessment commissioned and completed by a contractor on behalf of the HSE. These fire safety upgrades which formed the basis of the fire upgrade tender, will be completed by June 30th. Additional works that have been highlighted and that were the subject of a previous HIQA inspection have been costed, approved and contractor instructed to proceed, will works will also be complete by June 30th.

The majority of fire sealing through compartment walls has been completed. However, due to the current electrical upgrade works, any outstanding recent service penetrations will be fire-sealed and completed week ending 26 April 2024

The gaps around new doors were flagged previously and were adjusted by the

contractor. However, any pending item will be reviewed further and rectified and completed by week ending 26th April 2024.

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 meeting with the PIC and the nurse team has been completed in relation to care planning to discuss the review of assessment and updating of care plans. The requirement to ensure care plans reflect the current assessed needs of residents will be monitored by ongoing care plan audits.

Staff education and inhouse training on care planning is scheduled with the Clinical Practice Development Facilitator.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	15/09/2024
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	01/02/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability,	Substantially Compliant	Yellow	01/02/2024

	specifies roles, and details responsibilities for all areas of care provision.			
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.	Substantially Compliant	Yellow	01/02/2024
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.	Substantially Compliant	Yellow	30/06/2024
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	30/06/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape,	Not Compliant	Orange	01/02/2024

	including emergency lighting.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	28/02/2024
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	28/02/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	15/02/2024
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	15/05/2024
Regulation 5(2)	The person in charge shall arrange a	Substantially Compliant	Yellow	30/04/2024

	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.			