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:	Mount Carmel Community Hospital (Short Stay Beds)
Name of provider:	Health Service Executive
Address of centre:	Braemor Park, Churchtown, Dublin 14
Type of inspection:	Unannounced
Date of inspection:	19 January 2022
Centre ID:	OSV-0005337
Fieldwork ID:	MON-0035701

About the designated centre

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

The centre, located in South Dublin, is owned by the Health Service Executive (HSE) and operated by Mowlam Healthcare on their behalf. It offers 105 short stay beds to men and women over 18, with a focus of caring for those over 65. The aim of the service is to facilitate the discharge of medically stable patients from hospitals in the Dublin area to the centre with a care programme to enable them to return home, or where appropriate move on to long-term residential care. It is staffed with a multidisciplinary team including nurses, healthcare assistants, a general practitioner (GP), physiotherapist and occupational therapist. The service is provided on the ground, first, second and third floor of a large premises. It is divided in five units that are all staffed independently. Units had a range of single and multi-occupancy bedrooms. The building is easily accessible and provides parking for a number of vehicles. It is also close to local bus routes.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	71

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 19 January 2022	09:00hrs to 18:15hrs	Deirdre O'Hara	Lead
Thursday 20 January 2022	09:00hrs to 17:45hrs	Deirdre O'Hara	Lead

What residents told us and what inspectors observed

From what residents told the inspector and from what the inspector observed, residents were happy with the care they received within the centre and were seen to be content in the company of staff. The inspector saw many positive interactions between staff and residents. Overall, the inspector observed a relaxed and happy environment. During the two days of this inspection, there was a calm atmosphere in the centre.

When the inspector arrived at the centre they were guided through infection prevention and control measures necessary on entering the designated centre. These processes were comprehensive and included a signing-in process, hand hygiene, the wearing of face masks, and checking for signs of COVID-19. The Inspector saw the same process being implemented with visitors and evidence of COVID-19 vaccination was also sought before admittance to the centre.

The centre is a large building with three floors. Each floor can be accessed by stairs or lifts. There was ample communal space where residents were able to relax.

While single bedrooms were well laid out, residents privacy and dignity was compromised due to the current layout of residents residing in multi-occupancy rooms seen. Limited personal storage also meant that residents were unable to store or retrieve their personal items which impacted on their quality of life. Some residents in these rooms could only access their bedside locker by entering another residents' private space. Examples were seen of personal belongings being located outside privacy curtains in a number of rooms, meaning personal items were beyond the reach of that resident. In some bed spaces there was no room for residents to have chairs beside their beds which meant that residents had to sit in the communal space in their bedroom and were not able to sit in private.

As a consequence of the physical premises residents did not have privacy to carry out tasks in private, and were not able to make basic choices about how they lived their lives. The layout of the multi - occupancy bedrooms resulted in a lack of personalisation of the resident's living space and limited personal storage. Overall residents lived experiences and their quality of life in multi-occupancy rooms was impacted by poor room layout.

During the last inspection parts of the surface car park was seen to be in a poor state of repair. This had now been cordoned off to restrict access to the area. There was sufficient access to car parking for visitors or staff use.

Feedback from residents was reflected in comments from resident satisfaction surveys and through conversations with the inspector. Feedback showed that they were happy with the food on offer, had plenty of choice and the dining experience was pleasant. They said that staff were nice and helpful to them. This was borne out in interaction seen by the inspector, where staff engaged in meaningful

conversations with residents. It showed that staff knew residents well and their needs and preferences were catered for. Communication between staff and residents was seen to be respectful and dignified.

Dining areas were well laid out and the food was seen to be well presented. When assistance at meal times was needed, given in a discrete and supportive manner. There were snacks available through the day. Should a resident leave the centre to attend an appointment, their meal was put aside so they could have it when they returned.

Another resident said that "all staff" were excellent and could not have been nicer. Others commented that they had been looked after very well and that the staff were lovely. Residents who spoke with the inspector said that they were happy with the care they got and saw the doctor when they needed to.

Activities on offer on each floor were displayed on notice boards. These included, one to one activities, exercise classes, quizzes, news groups, movies, music, bingo and arts and crafts. For those residents who had dementia, a tailored activity program was developed for them to cater for their preferences and abilities. Residents exercised their religious rights through regular religious services.

Residents said they could get up or go to bed when they liked and this was seen where some residents preferred to stay in bed until later in the morning and others got up early to have their breakfast in the dining room. Residents were seen to move freely through the unit their room was located in, or outside to get fresh air or to smoke.

There was an outbreak of COVID-19 in the centre during this inspection and visiting had been restricted in this centre upon Public Health advice in order to protect residents. The inspector saw that residents were supported to keep in contact with family by social media and telephone.

An advocacy service was advertised in the centre and was available to residents on referral. Access to current affairs was made available through daily newspapers, television and radio.

Residents were consulted in the running of the centre where their voice was heard through weekly resident surveys and interaction with staff. There was a comments box located in the reception for visitors or residents to use also.

The inspector found that the issues raised were being investigated in line with the centre's own policies on preventing elder abuse and responding to allegations of abuse. Restrictive practices were reviewed frequently in consultation with residents, and families if appropriate and only used in accordance with the national policy as published by the Department of Health.

The complaints policy was displayed in a prominent position in the entrance lounge of the building and on resident notice boards, as well as being included in the residents information guide. The Inspector spoke with staff who confirmed they were aware of the complaints procedure and how to safeguard residents from

abuse. They explained how they would protect residents and report any complaints or concerns of abuse. Residents who spoke with the inspector said that they felt safe and if they have any concerns or complaints, they were dealt with quickly and they were comfortable highlighting issues to staff members.

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

Capacity and capability

The centre was well managed by a management team who were focused on improving resident's health and wellbeing. There were effective management structures in place and residents received good care and support from staff. Over all the quality of care given was good however action was required with regards to governance and management, the statement of purpose and records. This was an unannounced two day inspection to monitor ongoing compliance with the regulations.

The Registered Provider had submitted an application to renew the registration, prior to this inspection, however the documentation to support this application was not complete and the designated centre's floor plans and statement of purpose required amending to reflect the services provided. The provider informed the inspector that this had been submitted to the regulator during the first day of the inspection. These records were reviewed and required further clarity.

The centre had experienced an outbreak of COVID-19 which started on 5, January, 2022. The centre was divided into zones to care for residents who were confirmed, or were suspected cases of COVID-19. This was done to prevent onward transmission of the virus.

The centre is owned by the Health Service Executive (HSE) and operated by Mowlam Healthcare on their behalf. The centres governance structures and roles and responsibilities were clearly defined. Changes since the last inspection showed a restructuring of committees so that there was an enhanced oversight approach between the HSE and Mowlam Healthcare to oversee the service. The person in charge reported to managers from the HSE and Mowlam Healthcare.

There were management systems and processes in place to promote the service and ensure that the care was consistent. The inspector reviewed the actions outlined in the compliance plan of the previous inspection and found that most had been addressed. For example in governance and management, complaints, premises and protection, the person in charge had conducted an in-depth analysis of safeguarding incidents and had found gaps in how possible safeguarding incidents were identified. They had implemented a system where all complaints were reviewed to ensure that

any possible safeguarding incidences were identified. They put the appropriate actions in place to manage and reduce the risk of recurrence.

The registered provider failed to recognise and respond to the physical premises with regard to recognising that the personal space for those residents in multi-occupancy rooms did not meet the requirement of the S.I. No. 293/2016 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2016 from 01 January 2022. This meant that could not address the impact of the physical environment on the lived experience for these residents.

The communication system in the centre included daily handover meetings and staff meetings. In addition, there were various management meetings and committees, including committees for infection control, quality and safety, clinical governance, and care team meetings where residents assessed needs were reviewed.

The provider used a suite of audit tools to monitor the care and service delivered. For example, incidents, accidents, complaints, clinical and non-clinical data. The provider used this information to review and develop quality improvement plans in the designated centre to support residents' needs and service delivery.

The person in charge managed the day-to-day running of the centre. They had a good knowledge of the assessed needs and support requirements for each of the residents. They said that they were well supported by a clinical lead, two assistant directors of nursing, nurse managers, nurses, health care assistants, a catering and household team and reception staff. The services manager oversaw household and maintenance in the centre.

Suitable staff supervision arrangements were in place. Roles and responsibilities were clearly outlined and staff were aware of the standards that were expected of them. There was a mix of experienced and new staff in the centre, where new staff were seen to be supported in their induction to the centre. Improvement had been made to support nursing staff at induction by increasing their induction from one week to four weeks. This included mentoring by more experienced staff.

The provider had an appropriate number and skill mix of staff in the designated centre to support the residents' assessed needs. While staff turnover rates had remained high, this was reviewed regularly by the person in charge and the provider so that staffing levels ensured that resident needs were catered for. The provider had submitted an update following this inspection, with regard to a comprehensive recruitment drive to replace staff who left the organisation. Changes were seen since the last inspection with regard to staff supervision by means of reflective practice meetings which assisted in professional development.

Nursing staff were available at all times of the day and night. Worked rosters for the designated centre accurately reflected the personnel on duty. The person in charge promoted evidenced based best practice in the provision of care for residents through training and making relevant policies available to staff. However, training records for two staff were requested and were not available for inspection.

Four staff records were reviewed, while three of the records contained all the information required by Schedule 2 of the Regulations: Documents to be held in respect of the person in charge and for each member of staff, there was a two year gap in the history of employment for one nurse seen. The provider gave the inspector assurances that all staff had the required Garda vetting in place prior to commencing employment in the centre.

A complaints policy was in place which identified the person in charge as the complaints officer for the designated centre. The inspector reviewed 3 complaints, two of which were ongoing and one which had been finalised. Records documented that actions had been taken to respond to complaints in a timely manner and the outcomes were recorded.

There was evidence of consultation with residents and their representatives in a range of areas through daily interaction and weekly residents' surveys. The inspector noted that the annual review of the service for 2021 was to be completed.

Regulation 15: Staffing

At the time of inspection, there were appropriate staff numbers and skill-mix to meet the assessed health and social care needs of residents with regard to the design and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to appropriate training and fire training had to be rescheduled due the the outbreak of COVID-19 in the centre.

Judgment: Compliant

Regulation 21: Records

There was no satisfactory explanation of a two year employment history gap in records seen for one member of staff.

Training records were requested to be submitted for two allied health professionals following this inspection. These were not submitted.

Judgment: Substantially compliant

Regulation 22: Insurance

There was an appropriate contract of insurance in place that protected residents' against injury and against other risks, including loss or damage to their property.

Judgment: Compliant

Regulation 23: Governance and management

There were clear structures and systems in place by the HSE and Mowlam Healthcare to oversee the service provided.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place which set out the services that were offered by the centre. The records submitted to the regulator during the inspection was subsequently reviewed by the inspector. They showed that the statement of purpose and floor plans required a number of amendments to ensure that the description (either in narrative form or a floor plan) of the rooms in the designated centre including their size and primary function reflected the totality of premises used by the registered provider.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

An up to date complaints policy was in place which identified the key roles of those involved with implementing the policy. The procedure was on display within the designated centre. The complaints reviewed by the inspector were fully investigated and well documented.

Judgment: Compliant

Quality and safety

Overall, residents in single rooms were supported and encouraged to have a good quality of life which was respectful of their wishes and choices. While basic needs were met, residents in multi-occupancy were not able to spend time in private, with their own belongings around them. Residents' healthcare, social and recreational needs were well catered for. However improvement was required with regard to fire precautions, Infection control, premises and personal possessions.

Care plans were developed in consultation with residents, their families and medical staff, which detailed residents' wishes. The inspector found the standard of care planning was good. A range of validated clinical risks assessments were done and used to develop care plans that met the assessed needs of residents and their priorities of care. This also included the use of restrictive practice, which was seen to be used in line with best practice. Care plans were reviewed at least every month or when residents condition or needs changed.

The review of care records showed that residents had access to appropriate medical and specialist services to ensure that their right to good health was catered for. Residents had access to medical practitioners who attended to their needs, a number of times per week. Out-of-hours medical services was available by these physicians or through D-DOC services. A consultant gerontologist attended the centre weekly and visited the centre during the inspection. In addition, referrals to psychiatry of old age services were made as required.

Changes with regard to safeguarding were seen. Following an analysis of safeguarding concerns in 2020, the person in charge had implemented a number of measures where all complaints were analysed for possible safeguarding issues. They were also part of discussions that occurred in management meetings and twice daily hand over. A safeguarding policy was in place which guided staff in their response to abuse concerns, in line with best practice. Staff spoken with demonstrated their knowledge of what constituted abuse and of the steps to be taken in the event of a suspected or confirmed incident of abuse.

The inspector reviewed a sample of documentation related to investigations of allegations abuse, and found that the centres procedure had been followed and allegations had been thoroughly investigated in a timely manner and appropriate action taken.

A variety of individual and group activities were provided for residents. Due to the layout of multi-occupancy rooms, resident rights to access their belongings, undertake activities in private and uphold decision making about how they spent day were compromised.

Residents spoke to the inspector throughout the inspection said they understood why visiting was restricted was due to the outbreak. They were looking forward to being able to spend time with their families and friends again in the near future.

Firefighting systems were in place to ensure the environment was safe for residents, visitors and staff. Regular servicing of the alarm system and safety equipment was maintained. Fires safety training was provided and frequent fire alarm drills and checks were completed. However, there were no room numbers displayed on fire plans to guide people should the centre need to be evacuated in the event of a fire.

There were gaps seen in the provision of clear, visible and adequate directional signage and fire floor plans or adequate lighting to one stairwell used for egress from the building. More timely evacuation times and completed drill records were needed. For example fire drills took from three to 11 minutes and not all drill records showed the type of fire, the scenario or the participants.

While the premises was well ventilated, gaps were seen with regard to décor and flooring in some parts of the centre. The registered provider was required to reconfigure personal space for residents in multi-occupancy rooms in order to achieve compliance with regulations which underpin the privacy and dignity of residents.

The premises were largely clean. The centre had a dedicated infection prevention and control nurse who had implemented improvements in the centre. For example a pack for residents to use when they left the centre. These packs contained infection control information, tissues and alcohol based hand rub. Alcohol based hand rub had been installed at the bedside of each resident. A seasonal influenza and COVID-19 vaccination program had taken place with vaccines available to residents and staff.

While there was evidence of good infection prevention and control practice in the centre, there were gaps in practice such as cleanliness and appropriate storage of clinical equipment, dressings and food items. Monitoring of cleaning records and provision of cleaning process information for cleaners was also needed.

The risk management policy met the requirements of the regulation. There were associated risk policies that addressed specific issues. There was a risk register in the centre which covered a range of risks and appropriate controls for these risks. Risks identified were regularly reviewed by the person in charge and discussed at management meetings.

Regulation 17: Premises

Action was required to ensure the environment was safe and cleaning was effective:

- There were gaps in the monitoring records for fridges.
- There was a foul smell from carpets in the dirty laundry room and on the corridor leading to the dirty laundry room. These carpets were not clean.

- There were holes in the walls where had hygiene dispensers had been hung throughout the centre.
- The paint work in Hazel unit was in a poor state of repair.
- Flooring on the corridor outside room 5 in Hazel Unit was damaged.
- The numbering on residents doors did not correspond with the floor plans provided to the Chief Inspector.
- The registered provider failed to ensure that the premises of the designated centre were appropriate to the number and needs of the residents living in the centre. The layout of multi-occupancy rooms did not uphold resident rights to privacy, dignity and decision making about their lives.
- A number of rooms were not of a suitable size and layout to meet residents' needs. In the multi-occupancy rooms seen, the available floor space for each resident varied from 4.6 to 6.4 meters squared, and not all bed spaces could accommodate a chair or a bedside locker

The configuration of some residents sleeping areas did not provide sufficient space for residents. For example inadequate space to store their belongings, beside table or chair.

The totality of the findings listed above have informed a judgement of non-compliance with the current requirements of Regulation 17.

Judgment: Not compliant

Regulation 26: Risk management

The risk management policy met the requirements of the regulation. There were associated risk policies that addressed issues such as the unexplained absence of a resident, self-harm, aggression and violence, safeguarding and the prevention of abuse. There was an emergency plan available that was updated recently to include the contingency plan in the event of a COVID-19 outbreak.

Judgment: Compliant

Regulation 27: Infection control

Action is required in the following areas which impacted on cleanliness and the safety of residents:

- There was insufficient PPE storage units along corridors to ensure compliance with infection control practice.
- There was no soap and hand towel dispenser in the laundry room for staff to use.

- In Cedar unit intravenous trays were dusty with clear fluid residue seen on them and dressing scissors were not clean.
- Sterile dressings were not used in accordance with single use instructions, they were stored with un-opened dressings and could result in them being re-used.
- Sticky tape was used on counters and drug trollies, which were not clean and these surfaces could not be cleaned effectively.
- Hand hygiene facilities were not provided in line with best practice and national guidelines. The available hand hygiene sinks did not comply with current recommended specifications for clinical hand hygiene sinks.
- While cleaning check lists had been developed, they were difficult to navigate. Samples were seen where there were gaps in cleaning records which would mean that the provider could not be assured that cleaning was complete and monitored.
- There was no cleaning schedule for curtains.
- Cleaning protocols and instructions were not available in cleaners' rooms to guide staff with the required processes.
- Bowls of fruit were located in each nurse's station. Storing food in this way posed an infection control risk for onward transmission of infections.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were inadequate arrangements found in the following areas which did not assure the safety of residents, staff and visitors in the event of a fire occurring or during emergency evacuation:

- Insufficient emergency directional signage in the nurses station areas, in the main reception waiting area and office areas.
- There was an insufficient lighting system or directional signage on the stairs leading from Hazel unit, opposite room 5.
- There were no room numbers shown on fire floor plans which were displayed in each unit. This could result in delayed emergency evacuation of an area.
- Records for practice evacuation drills seen showed that it took between 3 to eleven minutes to evacuate a fire compartment. They did not show sufficient information with regard to the fire scenario, the type of evacuation used to bring residents and staff to safety. As a result the registered provider was unable to learn from previous evacuations.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A comprehensive assessment of residents' needs was completed on pre-admission and again within 48 hours of their admission. These assessments were used to develop care plans that were seen to be complete and person-centred.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a general practitioner who attended to them frequently in the centre, and to other healthcare services based on their assessed needs. A high standard of evidence-based nursing care was provided as evidenced by the use of regular clinical risk assessments using validated tools and regular surveillance for signs and symptoms of COVID-19.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Residents with dementia and or those with responsive behaviour were observed to be effectively and discreetly supported by staff. The person in charge and staff promoted a restraint free environment for residents. While the use of restrictive measures in the centre was high, there was evidence that the person in charge made efforts with residents to reduced this.

Judgment: Compliant

Regulation 8: Protection

A safeguarding policy guided staff in their response to concerns of abuse, and staff demonstrated their knowledge of the policy through discussion with inspectors. Concerns viewed by the inspector were fully investigated and the person in charge analysed concerns and implemented learning from their analysis.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors found that staff understood and respected residents' rights to make their own decisions and live in a way that suited them. They were consulted in the running of the centre where their voice were heard through interaction with staff and satisfaction surveys.

Judgment: Compliant

Regulation 12: Personal possessions

As a result of the layout of the two, three and four bedded rooms, residents in 16 rooms were unable to access their belongings in private. This resulted in residents having to exit their private space to access their wardrobe.

The available wardrobes were not big enough to meet the storage needs of some residents. As a result personal items were stored in bags on the floor by the side of beds and on window sills. This meant that they did not retain control over their personal possessions.

Judgment: Not compliant

Regulation 11: Visits

The inspector found that infection prevention and control measures were in place and that the person in charge ensured that the up-to-date guidance from the Health Protection Surveillance Centre was being followed and was communicated to residents and families. Due to the outbreak, visiting was restricted on Public Health advice. Contact with family and friends was through window visits, IT devices and telephone. Compassionate visits were supported by staff when needed.

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	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 11: Visits	Compliant

Compliance Plan for Mount Carmel Community Hospital (Short Stay Beds) OSV-0005337

Inspection ID: MON-0035701

Date of inspection: 20/01/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • All CVs on file have been reviewed and updated to ensure that there are no unexplained gaps in employment. • All future staff CVs will be reviewed to ensure any gaps in employment are addressed prior to commencement of employment in the hospital. • Outstanding Schedule 5 mandatory training for the 2 allied health professionals has been scheduled.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • The Statement of Purpose has been updated on 22/03/22 to reflect the floor plans and corresponding room numbers. • The floor plans and Statement of Purpose have been revised to show the totality of the space being used by the registered provider, including the description of each room and the size and function of each room in use.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	

was required to ensure the environment was safe and cleaning was effective:
• Monitoring of fridge records is completed daily and recorded by the Clinical Nurse Manager (CNM) on each ward.
• Carpets in the laundry room and in the corridor leading to the laundry room have been replaced with vinyl floor covering.
• Damaged flooring identified outside a room on one of the wards has been relpaced.
• The holes in the walls adjacent to the new hygiene dispensers have been filled and the walls have been plastered and painted.
• A painting programme has commenced which wil include the ward where paint on the wall had been shown to be in a poor state of repair.
• The floor plans have been updated on 22/03/22 to accurately reflect the numbers on patients' doors.
• Plans are being developed to ensure that the layout of the multi-occupancy rooms respect patients' rights to privacy, dignity and decision-making about their lives. Expected completion 31/05/2022.
• We will review the multi-occupancy rooms to ensure that each individual patient has the required space to enable their care needs to be met appropriately.
• We will ensure that there is sufficient bedspace available for each patient to accommodate storage space for their belongings, a chair and a bedside table/locker.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Appropriate storage units will be installed along the corridors for storage of PPE. Anticipated completion date is 15/05/2022.
• Soap and hand towel dispensers have been installed in the laundry room.
• A cleaning schedue for clinical equipment has been has been implemented; the scissors has been disposed of and replaced.
• Single use dressing are disposed of after each use.
• Sticky tape has been removed from surfaces and the trolleys have been cleaned, and there is a programmed schedule for regular and deep cleaning/ decontamination of equipment in place.
• A risk assessment of current clinical handwash sinks will be undertaken. Alcohol gel has been provided at point of care to mitigate the risk of cross infection identified completed on 15/02/2022.
• A revised cleaning checklist has been introduced to address gaps in cleaning records.
• The curtain cleaning schedule will be included in the cleaning checklist which will outline that curtains are routinely cleaned quarterly, or more regurlary as required.
• The cleaning protocols and instructions have been made available for reference by staff in the cleaner's rooms.
• Bowls of fruit which were available for staff wellbeing have been removed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A fire safety company oversees fire safety maintenace at the community hospital. They carried out a review of fire safety maintenance in the community hospital following the recent inspection. In relation to the lighting system and directional signage throughout the building, they have concluded as follows: primary and secondary escape routes are highlighted by the exit signage in the ward lobbies. These were the escape routes chosen as per design of the emergency lighting system. All works were completed to IS3217:2013 Standard. The positioning of exit signage is guided by content 8.6 in the above standard. The company has stated that no additional lighting is required in these areas. (Copy of response from Masterfire attached)
• Floor plans have been revised to accurately correspond with the room numbers shown on the fire plans displayed in each unit and completed on 22/03/2022.
• Fire safety practice evacuation drills will be enhanced to demonstrate a fire scenario and record the type of evacuation used to bring residents to safety. The safety evacuation drills will be evaluated and a record will be maintained of the learning outcomes from each drill, so that staff learning and improved safety drills can be clearly demonstrated.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• We will undertake a review of the multi-occupancy rooms to ensure that patients are able to access their belongings in a wardrobe adjacent to their bedspace.
• We will provide sufficient storage space to ensure that patients can store their personal possessions safely. Expected completion 31/05/2022.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	30/04/2022
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes	Not Compliant	Orange	31/05/2022

	and other personal possessions.			
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	31/05/2022
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	15/05/2022
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	31/05/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	23/03/2022
Regulation 28(2)(iv)	The registered provider shall make adequate	Not Compliant	Orange	23/03/2022

	arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	23/03/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/03/2022