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:	New Houghton Hospital
Name of provider:	Health Service Executive
Address of centre:	Hospital Road, New Ross, Wexford
Type of inspection:	Unannounced
Date of inspection:	09 January 2024
Centre ID:	OSV-0000603
Fieldwork ID:	MON-0042173

About the designated centre

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

New Houghton hospital is situated in the town of New Ross. The building was erected in 1936 and became the fever hospital for the counties Waterford, Wexford, Carlow and Kilkenny. In 1984 the building became a care of the older person's facility. While there have been many changes, renovations and some improvements since then the design and layout of the premises is largely reflective of a small hospital from the period in which it was built. The registered provider of the centre is the Health Service Executive (HSE). The centre is registered for 42 residents over the age of 18 years, both male and female for long term care. Services provided include 24 hour nursing care with access to community care services via a referral process including, speech and language therapy, dietetics, physiotherapy, occupational therapy, chiropody, dental, audiography and opthalmic services. All admissions are planned. Residents and relatives are welcome to visit the site in advance of the placement. Residents being admitted will have been assessed by the Geriatric Assessment team and placed on a waiting list for admission. Once a bed becomes available the resident and or relative is informed and is requested to arrive to the unit before 4pm Monday to Friday. The hospital accepts all levels of dependency from level 1 (full dependency) and including residents living with dementia. The services are organised over two floors with 21 residents accommodated on each floor with a passenger lift provided. Residents' accommodation on the ground floor comprises of four, four-bedded rooms, one three-bedded room, one twin-bedded room, and one single-bedroom (end of life suite) with adjacent family/community room. All bedrooms have hand washing facilities. Residents' accommodation on the first floor also consists of four, four-bedded rooms, one three-bedded room, one twin-bedded room, and one single-bedroom (end of life suite) with adjacent family/community room. There is access to an outside suitable secure garden area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	39

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 9 January 2024	08:45hrs to 19:00hrs	Aisling Coffey	Lead
Tuesday 9 January 2024	08:45hrs to 19:00hrs	Catherine Furey	Lead

What residents told us and what inspectors observed

The overall feedback from residents was that they liked living in the centre. The residents spoken with were highly complimentary of the staff and the care they received. One resident told the inspector she was "very happy" in the centre and the staff were "very helpful". Another resident described the staff as "lovely". Staff were aware of the residents' needs and were striving to provide good quality care. Inspectors observed warm, kind, dignified and respectful interactions with residents and their visitors throughout the day by staff and management.

Inspectors arrived at the centre in the morning to conduct an unannounced inspection. Following an introductory meeting with the person in charge, the inspectors were guided on a tour of the premises. During the day, the inspectors spoke with several residents and their families to gain an insight into the residents' lived experience in New Houghton Hospital. The inspectors also spent time observing interactions between staff and residents and reviewing a range of documentation.

New Houghton Hospital is a two-storey building situated on a healthcare campus that accommodates several health and social care services in the town of New Ross. The centre is close to shops, restaurants, and public transport services. The centre provides resident accommodation over both floors, with males on the ground floor in the Abbey Unit and females on the first floor in the Brandon Unit. The centre is registered to accommodate 42 residents and provides long-term residential care and respite residential care. There were 39 residents in the centre on the morning of the inspection, with one respite resident due to go home and two respite residents due for admission. Two residents were in hospital.

The main entrance to the designated centre was accessed through an open porch leading to a locked front door into a large internal lobby area. Access to the lobby was secured via keypad access, and the code was displayed at the front door to facilitate visitors. The lobby area, used for visiting had comfortable seating, a piano and a fish tank. There was access to the first floor via a passenger lift and stairs. The centre's design and layout supported residents' free movement, with wide corridors, sufficient handrails, and armchair seating within communal areas. Communal space was adequate, with residents on the ground floor having access to an open-plan sitting and dining room and the lobby area, while residents on the second floor had access to separate sitting and dining rooms. The centre was pleasantly decorated with artwork on the walls. Inspectors found that access to the enclosed sensory garden outside the Abbey Unit sitting and dining room was restricted due to keypad access being required. This meant that residents could not freely access this area. The sensory garden was pleasant, with bright bench seating, a gazebo, a pergola and raised flower beds. This garden was also the designated area for residents who chose to smoke. While the centre was generally clean

throughout, some areas were experiencing wear and tear, requiring redecoration and repair. These findings will be discussed further within the report.

Bedroom accommodation on both Abbey and Brandon Units comprised four four-bedded rooms, a three-bedded room, a twin room and a single room reserved to offer privacy to residents at the end of life. None of the bedrooms contained ensuite facilities. Both floors had shared toilet, shower and bath facilities comprising two assisted showers and one assisted bath on each floor, as well as three shared toilets in Abbey Unit and four shared toilets in Brandon Unit. The bedrooms and assisted bathroom on each floor had ceiling tracking hoists for resident use. Privacy curtains on overhead tracking defined bed spaces. Each bed space had call bell access, a bedside locker, a lockable wardrobe, seating and television facilities. Within the curtained bed spaces, efforts had been made to make the environment homely, comfortable and pleasant for the residents. Inspectors noted that these areas had been personalised with photographs, pictures, art and other items of personal significance. Nonetheless, due to the multi-occupancy nature of the bedrooms, residents could not carry out personal activities in private, as the privacy curtains could not exclude conversations and sounds. Inspectors observed that two three-bedded rooms were being operated as four bedded rooms, contrary to the centre's statement of purpose and floor plans, which will be discussed under Regulation 23: Governance and management and Regulation 17: Premises. Inspectors also observed that two bedrooms were being used as storage areas, which impacted the residents' right to privacy within their bedrooms. This matter will be discussed under Regulation 17: Premises and Regulation 9: Residents' rights.

Meals were served in the open-plan sitting and dining room in the Abbey Unit and a separate dining room in the Brandon Unit. The centre had two sittings, the first for residents requiring mealtime assistance at 12:30 pm and the second for residents independent at mealtimes at 1:00 pm. Residents who required assistance at mealtimes were observed to receive this support in a respectful and dignified manner. Some residents were facilitated to eat at their bedsides, aligned with their preferences. Lunchtime was generally a relaxed experience, however, in the Abbey Unit, there was no separation of the dining and sitting areas. This meant that residents waiting for the second lunch sitting were seated in the sitting room chairs alongside tables of residents already dining at the first sitting. The television could not be heard over the sounds of the mealtime service. Menus were not displayed in the centre to inform residents of their choice of food.

Inspectors observed that the food provided to residents, including modified consistency diets, were not presented in an attractive and appealing way. The food provided did not correlate with the menus viewed by inspectors, and some residents had no choice in what they received. While residents receiving a regular diet received chicken, staff could not readily identify what residents were receiving in the minced and pureed diets. This impact is discussed further in the Quality and Safety section of the report. While most residents spoke positively about the food, others were less complimentary, stating, "it's not what I'd cook at home" and referencing the lack of choice.

Discussions with residents confirmed they felt very happy and safe living in the centre. Residents spoke positively about the kind and helpful staff that cared for them. Family members who spoke with inspectors were pleased with the care received by their loved ones, as well as the kindness and respect shown to residents by staff and management. Inspectors observed staff being respectful, caring and attentive to residents' needs.

Residents were up and dressed in their preferred attire and appeared well cared for. Residents freely mobilised around the centre, watching television, reading the newspaper, and chatting with other residents and staff. Some residents left the centre for the day to attend the nearby day centre within the healthcare campus. Transport was provided for this short journey. Activities were delivered by external staff working within the centre. Residents spoke positively about the activities they enjoyed in the centre, including bingo and exercises. Inspectors observed a sensory relaxation activity after lunch in the Brandon sitting room, and these same staff members were talking to residents. Inspectors saw the activity rota on display and noted a lack of variety in activity taking place at weekends, with an over-reliance on TV and radio and no evidence of interesting or engaging activities. This will be discussed further under Regulation 9: Resident's rights.

The following two sections of the report present the findings of this inspection concerning governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, inspectors found that more robust management and oversight systems were required to ensure that the service provided to residents was safe, appropriate, consistent, and effectively monitored.

This was an unannounced inspection to monitor the ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 as amended and to review the registered provider's compliance plan arising from the previous inspection. The inspection also informed the provider's application to renew registration. While the provider had progressed with some aspects of the compliance plan following the last inspection in June 2023, this inspection demonstrated deficits in the overall governance and management of the service.

Improvements continued to be required to comply with several regulations, as discussed throughout the report. In particular, repeated non-compliance was found under the following regulations;

- Regulation 28: Fire precautions

- Regulation 21: Records
- Regulation 4: Written policies and procedures

Following the inspection, an urgent action plan request was issued to the registered provider regarding significant identified risks and associated non-compliance with Regulation 28: Fire precautions and Regulation 9: Residents' rights. The provider reverted with an interim plan to manage the risks identified on the day of the inspection and committed to a series of actions to ensure that these risks were controlled and mitigated going forward.

The registered provider was not operating the centre in line with condition 01 of the registration for New Houghton Hospital. On the day of inspection, the inspectors observed that Bedroom 5 on the Abbey Unit and Bedroom 4 on the Brandon Unit, which are registered as three-bedded rooms on the floor plans and statement of purpose, were operating as four-bedded rooms.

The registered provider is the Health Service Executive (HSE). There was a clearly defined management structure with identified lines of accountability and responsibility for the service. The person in charge worked full-time in the centre, supported by the manager of older persons' services, who represents the provider for regulatory matters and who attended the onsite feedback meeting at the end of the inspection. The person in charge also oversees a day centre, which is not part of the designated centre, but is located in the same healthcare campus. The person in charge was supported by four clinical nurse managers, three dedicated to the day-to-day running of each unit, and one newly commenced as a practice development clinical nurse manager. Further care and support was provided to residents by a team of nurses, healthcare assistants, catering, activities and housekeeping staff.

While there were systems in place to monitor the quality and safety of care delivered to residents, these systems needed to be more robust to ensure wider learning for all staff to promote quality improvement throughout the centre. For example, several care plan audits were taking place to examine areas such as physical restraint, falls, nutrition, and medication management. These care plan audits identified deficits and risks in the service and had quality improvement plans associated with them, specific to the individual care plan. Notwithstanding this good practice, there was no documentary evidence of the audit findings being used to drive broader quality improvement throughout the centre. Similarly, data concerning incidents occurring within the centre was being collated but not routinely analysed to establish trends, reduce risk and promote quality improvement. For example, falls were followed up individually, with residents reviewed and care plans updated. However, the information was not analysed to determine the most frequent time, location or contributing factors for falls occurring in order to implement additional controls required to minimise their recurrence.

Documentary evidence of the communication systems within the centre and with the registered provider required review. Within the centre, the person in charge held management meetings with the clinical nurse managers on six occasions in 2023. A review of these minutes found aspects of quality service delivery, including staffing, complaints, medication management, incident management and infection prevention

and control were discussed. Notwithstanding this good practice, there was no further documentary evidence of staff meetings with nurses, healthcare assistants, catering, activities and housekeeping staff, where the sharing of learning to promote quality improvement occurred. Similarly, it was unclear what level of oversight the registered provider had in relation to the quality and safety of care and support given to residents in the centre. Minutes of clinical governance meetings between the person in charge and management personnel within HSE Community Healthcare Organisation (CHO) Area 5 were requested, but not provided to inspectors to review. The oversight and organisation of the activities programme required review. In the absence of a designated activities coordinator, the registered provider did not have adequate arrangements to oversee the activities programme.

There was a suite of centre-specific policies and procedures to guide practice in the centre. However, not all of the required policies outlined under Schedule 5 of the regulations were in place, and the majority of those in place had not been updated in line with regulatory requirements. Inspectors reviewed a sample of residents' files and found a contract of care in place for each resident setting out the majority of requirements; however, some improvements were required to ensure full regulatory compliance, which are outlined under Regulation 24: Contract for the provision of services.

While staff had access to mandatory training, gaps were identified in all areas, most significantly in fire safety and evacuation training. Additionally, the centre had staff who were trained infection prevention and control link practitioners. These practitioners and records confirmed that staff training in respect of infection prevention and control, both online and in-house, was restricted to hand hygiene and personal protective equipment (PPE). These matters will be discussed under Regulation 16: Training and staff development.

Inspectors had difficulty accessing the records of staff members working in the centre. The current system's design meant that requested documents were not easily retrievable in a timely fashion. This system required review to ensure adequate oversight of staff files and to ensure that Schedule 2 documentation was available for inspection. This will be discussed under Regulation 21: Records. There was also a lack of clarity as to the status of some personnel as staff or volunteers. These matters will be discussed further under Regulation 30: Volunteers.

The provider displayed the complaints procedure prominently at the lift area on the centre's ground floor. There were also leaflets on the HSE's complaint policy in the lobby and foyer areas. The centre had an up-to-date policy guiding complaints management, and there were advertisements for advocacy services to support residents in making a complaint. The provider had records of how complaints had been managed in the centre. Records reviewed showed that complaints had been predominantly resolved to the complainant's satisfaction at the point of escalation, with one further complaint being referred for a human resources investigation. Residents said they could raise a complaint with any staff member, and staff were knowledgeable on the centre's complaints procedure. Records reviewed also showed that the person in charge had completed an information-raising session on the complaints procedure with nine residents in June 2023. Notwithstanding the good

practice identified, some improvements were required to comply fully with the regulation and this will be outlined under Regulation 34: Complaints procedure.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider applied to renew the designated centre's registration in accordance with the requirements in the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015. At the time of inspection, this application was being reviewed.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was well-established in the position and has the required experience and qualifications to fulfil the regulatory requirements of the role.

Judgment: Compliant

Regulation 16: Training and staff development

Gaps in the records of staff training were identified. This was a repeat finding from the previous two inspections;

- 40% of staff were overdue for mandatory training in fire safety
- Infection prevention and control training was restricted to hand hygiene and the use of PPE. Staff providing direct care to residents did not have access to other core knowledge and skills required such as environmental hygiene, cleaning of reusable equipment, management of linen, management of waste, including the safe disposal of sharps, and antimicrobial resistance training.
- Eight staff were overdue for mandatory training in safeguarding adults at risk of abuse.
- Five staff were overdue for mandatory training in managing behaviour that is challenging.
- Two nurses were overdue for medication management training.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider had an electronic system which contained a directory of residents living in the centre. This system contained the majority of required information. However this system did not have a record of the following details required by Schedule 3;

- if the resident was discharged from the designated centre, the date on which he or she was discharged
- if the resident is transferred to another designated centre or to a hospital, the name of the designated centre or hospital and the date on which the resident was transferred
- where the resident died at the designated centre, the date, time and cause of death, when established
- the name and address of any authority, organisation or other body, which arranged the resident's admission to the designated centre.

Judgment: Substantially compliant

Regulation 21: Records

Improvements were required in relation to the overall system of storing staff records to ensure these documents were readily available for inspection. The inspectors sought to review Schedule 2 documents, such as photographic identification, Garda Síochána (police) vetting, professional nursing registration, references and employment history from four staff records. Inspectors were informed that personnel records were recently scanned and uploaded to an electronic records management system. Of the sample viewed by an inspector, the scanned records were significantly large and not indexed. Notwithstanding staff efforts to identify and retrieve these Schedule 2 documents for inspection, these documents could not be provided in a timely manner to assess compliance with the regulation.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had insurance in place which covered injury to residents and loss or damage to residents' property.

Judgment: Compliant

Regulation 23: Governance and management

The management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored were not sufficiently robust, as evidenced by the following matters:

- Urgent improvements were required regarding how the registered provider was taking adequate precautions to ensure that residents were protected from the risk of fire and how fire precautions were being adequately reviewed. This will be discussed further under Regulation 28: Fire precautions.
- The registered provider was operating the centre contrary to condition 01 of registration. Bedroom 5 on the Abbey Unit and Bedroom 4 on the Brandon Unit which are registered as three-bedded rooms on the floor plans and statement of purpose, were both occupied by four residents.
- Inspectors found that some practices did not fully contribute to a person-centred service and, as such, impacted the human rights of the residents. These practices included arrangements regarding storage in residents' bedrooms, which will be discussed under Regulation 9: Residents' rights.
- The oversight and organisation of the activities programme required urgent review in the absence of a designated activities coordinator. The centre's statement of purpose refers to activities coordinator directing the activities programme.
- Procedures for the recruitment, training, oversight and support of volunteers also required review. Inspectors sought to review files of volunteers; however these files were not kept on-site. The person in charge obtained Garda Siochana (police) vetting for these individuals which was reviewed on the day of inspection, but no other documentation was available. This matter will be discussed under Regulation 30: Volunteers.
- The oversight of building maintenance required improvement as referenced under Regulation 17: Premises.
- A more robust system was needed to ensure that required records were available for review, and this is discussed under Regulation 21: Records.
- Actions were required regarding review systems that monitored staff training and development and the development of policies and procedures to ensure they were current and informed of current practices. This will be outlined under Regulation 16: Training and staff development and Regulation 4: Written policies and procedures.
- While data on incidents occurring in the centre was being collated, it was not being analysed to establish trends, reduce risk and promote quality improvement. The trending of incidents was not taking place to analyse these incidents further and share learning for quality improvement.
- Documentary evidence of the communication systems within the centre and with the registered provider required review. For example, it was unclear what oversight management personnel within HSE Community Healthcare Organisation (CHO) Area 5 had in the centre, as no minutes of clinical governance meetings were available for review on the inspection day.

- The oversight of infection prevention and control required improvement to ensure residents were protected from the risk of infection. This will be discussed under Regulation 27: Infection control.
- Actions were required to ensure residents received a choice at mealtimes which will out outlined under Regulation 18: Food and nutrition.
- Auditing systems required improvement to ensure that risks identified led to wider learning for all staff to promote quality improvement throughout the centre. This is discussed under Regulation 5: Individual assessment and care plan and Regulation 7: Managing behaviour that is challenging.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Residents had a written contract and statement of terms and conditions agreed with the centre's registered provider. However, the terms relating to the resident's bedroom and the number of other occupants (if any) of that bedroom, as required by the regulation, were not recorded in the sample of contracts of care reviewed by the inspectors.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

Some improvements were required to the Statement of Purpose to ensure that it complied with Schedule 1 of the regulations. For example, it did not contain:

- Arrangements to cover periods when the person in charge is on leave or absent from the centre.
- Arrangements in place to explain, review and discuss the resident's contract of care.
- An accurate description of the updated complaints regulation, including the time frames for providing a written response to the complainant.
- Reference to the designated centre's full suite of policies.
- Details of pension agent procedures and arrangements for safeguarding residents' finances onsite.

Judgment: Substantially compliant

Regulation 30: Volunteers

The inspectors sought a sample of files for externally employed personnel. The person in charge confirmed that files for these individuals were not held in the centre. Therefore the inspectors could not assess if these individuals had been given clear guidance about their role, responsibilities and supervision arrangements and if they had received an orientation and training programme to include infection prevention and control, fire safety, and safeguarding adults at risk of abuse. There was a volunteer policy within the centre but this was out of date and required review.

Judgment: Not compliant

Regulation 34: Complaints procedure

The nominated complaints officer did not have the training records on managing complaints available for inspectors to review. This was a repeat finding from the June 2023 inspection.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

While the registered provider had prepared most policies and procedures outlined in Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People), 10 policies had not been reviewed within the required timeline of three years. Additionally, the following required policies were not in place:

- The creation of, access to, retention of and destruction of records.
- Health and safety of residents, staff and visitors, including food safety.

Judgment: Not compliant

Quality and safety

Inspectors observed kind and compassionate staff treating residents with dignity and respect. Bedroom accommodation required review to ensure that privacy was afforded to all residents. The provider required further action to improve the quality and safety of the service provided to residents, particularly concerning fire safety,

residents' rights, infection control, premises, food and nutrition, managing behaviour that is challenging, and assessment and care planning.

Inspectors observed that residents' bedrooms were clean, tidy and personalised with items of importance to them, such as family photos and sentimental items from home. Residents had adequate space for storing their clothes, toiletries, and other belongings and displaying significant possessions. Each resident had access to lockable storage. The premises of the designated centre were appropriate to the number of residents. It had communal spaces for residents and their visitors to use. There was an onsite laundry, and the registered provider had reviewed the laundry room layout to support the functional separation of the clean and dirty phases of the laundering process. Some rooms were not being operated in accordance with the statement of purpose, while other areas required maintenance and repair to fully comply with Schedule 6 requirements, which will be discussed under Regulation 17: Premises.

While the centre's interior was generally clean on the day of inspection, the environment and equipment were not managed to minimise the risk of transmitting a healthcare-associated infection. This will be discussed under Regulation 27.

The oversight of fire safety management and systems to identify fire safety risks was not effective in ensuring the safety of residents living in the centre. Significant fire safety risks were found, and an urgent action plan was issued to the provider to address those risks. Findings in this regard are detailed under Regulation 28: Fire precautions.

The centre had a paper-based resident care record system. Residents' physical, psychological and social care needs were comprehensively assessed upon admission to the centre. The outcome of the assessments informed the development of care plans that guided staff on care delivery to residents. While care plans were generally personalised, gaps and discrepancies were observed in care planning, which could negatively impact the quality of care provided to residents. This is outlined under Regulation 5: Individual assessment and care plan.

The health of residents was promoted through ongoing medical review and nursing assessment using a range of validated tools. These assessments included skin integrity, malnutrition, falls and mobility. A doctor provided regular reviews of residents in the centre. The centre maintained two single rooms for the comfort and privacy of residents requiring palliative care and their families. Residents approaching the end of life had appropriate care and comfort based on their needs, which respected their dignity and autonomy and met their physical, emotional, social and spiritual needs. There was documented evidence of advanced care planning so that the resident's wishes and preferences could be respected and facilitated.

Overall, inspectors found that the centre proactively promoted a restraint-free environment and person-centred care. There was a low use of restraints in the centre on inspection day. The centre had a comprehensive policy and training programme guiding the use of restraint. The centre maintained a register of restrictive practices in use in the centre. Improvements were required to ensure that

any restrictive practices are used in accordance with national policy and to ensure residents had the right to access the outdoors. This will be discussed under Regulation 7: Managing behaviour that is challenging.

The registered provider had taken reasonable measures to protect residents from abuse. Staff were knowledgeable about what constitutes abuse, the different types of abuse and how to report suspected abuse in the centre. The registered provider had a local policy aligned with the HSE's national safeguarding policy.

Residents could receive visitors in the centre, and it was evident that visitors were welcome. Visitors and residents confirmed there were no restrictions on visiting. Residents had access to radio, television and newspapers. There were arrangements in place for residents to access advocacy services. Residents were supported to practice their religious faith. Roman Catholic services took place in the centre monthly, and a Church of Ireland minister also visited the centre. Resident meetings were held in the centre regularly, providing opportunities to discuss different aspects of the service provided. There were facilities for recreation and opportunities to engage in activities. Notwithstanding areas of good practice, improvements were required with respect to residents' rights to engage in activities in accordance with their interests and capacities and their right to privacy within their bedrooms, which will be discussed under Regulation 9.

Despite the centre being equipped with a fully functional kitchen, meals were not prepared onsite. Instead, they were delivered cooked to the centre and served from a hot trolley to the dining rooms. On the inspection day, the second choice for the main meal had not been delivered. Staff confirmed that this was a regular occurrence, happening once to twice per week. The catering staff kept a supply of additional items, such as eggs, meats, bread and yogurts, which could be accessed at all times. Residents were provided with snacks and drinks frequently throughout the day. Areas for improvement in relation to food in the centre will be discussed further under Regulation 18.

Regulation 10: Communication difficulties

Inspectors found that residents assessed as having communication difficulties had their communication needs met. Each resident had a detailed communication care plan in place. These care plans outlined the communication aids, tools and devices used to enable them to communicate effectively.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were supported in accessing and retaining control over their personal property, possessions, and finances. Residents' clothing was laundered onsite and each resident had adequate space to store and maintain their clothes and personal possessions.

Judgment: Compliant

Regulation 13: End of life

Residents approaching the end of life had appropriate care and comfort based on their needs, which respected their dignity and autonomy and met their physical, emotional, social and spiritual needs. Residents' family and friends were informed of the resident's condition and permitted to be with the resident when they were at the end of their life.

Judgment: Compliant

Regulation 17: Premises

The registered provider was operating the centre contrary to condition 01 of the registration for New Houghton Hospital. On the day of inspection, the inspectors observed that:

- Bedroom 5 on the Abbey Unit and Bedroom 4 on the Brandon Unit, which are registered as three-bedded rooms on the floor plans and statement of purpose, were operating as four-bedded rooms. The provider was requested to convert these bedrooms back to three-bedded rooms as outlined in the floor plans under which the centre was registered.

There was inappropriate storage seen across the residential centre; for example:

- Clinical equipment, including wheelchairs, cushions, chair scales and zimmer frames, were being stored in the unused bed spaces of Bedrooms 2 and 5 in Brandon Unit which will be discussed further under Regulation 9: residents' rights.
- The laundry skip and housekeeping trolley were stored in the assisted shower room on Brandon unit.
- There were two alters, an armchair and a broken wheelchair, stored under the stairs on the Abbey unit.

While the premises were designed and laid out to meet the number and needs of residents in the centre, some areas required maintenance and repair to be fully compliant with Schedule 6 requirements, for example:

- The flooring in the Abbey day room had significant indentation, making it difficult to clean effectively.
- Walls in resident bedrooms were visibly chipped, cracked, and damaged with exposed plaster.
- The ramp outside from Brandon Unit, which was a fire escape route, had significant moss growth, posing a potential slip hazard for residents and staff evacuating in an emergency.
- The wall covering in the Abbey twin room had been recently removed from the wall, leaving exposed plaster. This room was being used by a resident on the day of inspection.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were not afforded choice of meals on the day of inspection. For example;

- The second choice for the main meal had not been delivered on the day of inspection. Staff confirmed that this was a regular occurrence, happening once to twice per week. Despite the dinner menu showing chicken, ham and stuffing as the options, on the day of inspection, all residents who did not require modified diets were served plain chicken. Staff informed inspectors that no ham, stuffing or gravy was delivered. Pepper sauce was delivered in error and served with the chicken. As all meals were delivered from another HSE facility approximately 30 kilometres from the centre, this error could not be rectified.
- For residents who required modified diets, there was no choice. The menus and ordering sheets identified one dinner option for minced diets, and one for pureed diets. For the evening meal, the minced and pureed diets option was "a bowl". Staff were unable to identify exactly what this "bowl" consisted of, and described that it was similar to the dinner option.
- Inspectors also observed that modified consistency diets were not presented in a way that was attractive and appealing.

Judgment: Not compliant

Regulation 20: Information for residents

A guide for residents was available in the centre. This guide contained information for residents about the services and facilities provided including, complaints procedures, visiting arrangements, social activities and many other aspects of life in the centre.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Records showed that when residents were temporarily discharged to another facility, all pertinent information about the resident was provided to that facility. A detailed transfer letter was used to capture relevant details. On return to the centre following the temporary absence, medical and nursing transfer letters were reviewed for any changes to the resident's care.

Judgment: Compliant

Regulation 27: Infection control

While the interior of the centre was generally clean on the day of inspection, areas for improvement relating to the management of the environment and equipment were identified to ensure residents were protected from the risk of infection and to comply with the National Standards for Infection Prevention and Control in Community Services (2018) for example:

- Management reported that the housekeeping room cannot be plumbed to contain a janitorial sink. Housekeeping staff continued filling and disposing water in the sluice room. This posed a risk of cross contamination and is repeat finding from the June 2023 inspection.
- Several bed tables were observed to be in disrepair, which impacted effective cleaning. Management stated that new bedside tables had been ordered and were awaiting delivery. This was a repeat finding from the June 2023 inspection.

A number of storage practices posed a risk of cross contamination for example:

- While the centre had a labelling mechanism to identify whether clinical equipment used by residents, including wheelchairs, hoists, mobility aids, mattresses, and weighing scales, were clean or dirty, this labelling system was inconsistently used. Therefore it was not possible to identify if equipment provided to a resident was clean.
- Equipment labelled as clean was being inappropriately stored. For example, three commodes labelled as clean were being stored in the sluice room beside the bedpan washer.
- Visibly dirty equipment, such as dirty posey alarm mats, were stored alongside clean linen.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider did not take adequate precautions against the risk of fire, which presented an urgent risk to the safety of the residents in the centre. An urgent action plan was issued to the provider to address these risks as follows:

- A personalised emergency evacuation plan (PEEP) was completed for all residents, detailing the required level of assistance and the aids needed to safely evacuate residents from their bedrooms in the event of a fire. The PEEPs identified several residents on the first floor who required a ski-sheet or similar aid in evacuation down the escape stairs opposite room 1. These aids were not available for these residents or any other resident residing on the first floor.
- The centre's fire safety plan, which was last reviewed in June 2022, states that non-ambulant residents on the first floor should be evacuated in a progressive horizontal fashion beyond the nearest closed fire-resisting door set, and if danger increases, then further movement becomes necessary to other areas and eventually outside the building. Depending on the location of the fire, evacuation plans on display on the first floor showed evacuation routes from all bedrooms down either the escape stairs opposite Room 1 or the main internal staircase. No fire safety audit or risk assessment had identified the complete absence of any evacuation aid to assist in this type of evacuation.
- Staff confirmed that they had not received training in stairs evacuation. Staff could not identify how they would safely evacuate residents down the stairs. Additionally, 40% of staff were overdue for mandatory fire safety training. This training was completed in an online format. A full overview of the training provided to staff in the centre is required to ensure that this training is centre-specific and suitably identifies the evacuation procedures, building layout and escape routes within the centre.
- Evacuation drills were conducted on both the first and ground floors. The outcome of these drills detailed the learning, including multiple occasions where it was identified that ski sheets or similar aids were required. Records showed that these deficits had been escalated to management; however, there was no evidence of action taken to address the concerns raised.

An urgent action plan was issued to the provider to address these risks.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of residents' assessment and care planning documentation on both units. While there was evidence of personalised and detailed

care planning for some residents, this was inconsistent. For example, in the Abbey Unit, the majority of records viewed did not contain any assessment concerning the resident's social care needs; therefore, the specific supports necessary for the residents to maximise their quality of life were not identified and outlined as a personalised care plan.

Not all care plans and assessments were updated within the required four-month timeframe.

Judgment: Substantially compliant

Regulation 6: Health care

The medical and nursing needs of residents were well met in the centre. There was evidence of good access to medical practitioners through access to a doctor and out-of-hours services when required. Systems were in place for residents to access the expertise of health and social care professionals through a referral system, including physiotherapy, speech and language therapists, dietitian services and tissue viability specialists.

There was a very low level of pressure ulcer formation within the centre due to the appropriate delivery of evidence-based, preventative skin assessments and regular monitoring for pressure-related skin damage

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The centre's use of restraint, such as bed rails, was not in accordance with national policy published by the Department of Health or the centre's restraint policy, which required that consideration of all alternative interventions must be explored and deemed inappropriate before a decision on an episode of restraint may be taken. There was no documented evidence that alternatives had been trailed before the restrictive device was used, and the centre's documentation did not prompt such consideration.

Management had not recognised the restricted access to the garden from the Abbey Unit sitting and dining room as a restrictive practice. The door to the enclosed garden was locked, requiring a keypad code for residents to enjoy the outdoors. This restriction and the rationale for its implementation were not appropriately risk assessed.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had taken measures to protect residents from abuse. There was a policy and procedures in place for the prevention, detection and response to allegations or suspicions of abuse. Staff were familiar with the procedure for reporting suspected abuse. All residents spoken with stated that they felt safe in the centre. The registered provider was pension agent for seven residents living in the centre and there were transparent arrangements in place to safeguard residents' finances.

Gaps in staff training in relation to safeguarding adults at risk of abuse are addressed under Regulation 16: Training and staff development.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors found that some practices did not fully contribute to a person-centred service and as such, impacted upon the human rights of the residents.

The registered provider did not ensure that all residents had opportunities to participate in activities in accordance with their interests and capabilities;

- As identified under Regulation 5, social assessments were not completed for all residents therefore there was no documented evidence of the residents' preferences for activities, which could then inform the activity program.
- Inspectors noted that the organisation of the activities schedule was poor, resulting in limited activity taking place in the Abbey Unit on the day of inspection.
- Inspectors reviewed activity rotas and noted a lack of variety in activity, particularly at weekends, where there was an over-reliance on passive activities.

The registered provider did not ensure that residents could undertake personal activities in private within a person-centred and homely environment:

- Clinical equipment, including wheelchairs, cushions, chair scales and zimmer frames, were being stored in the unused bed spaces of Bedrooms 2 and 5 in Brandon Unit. This meant that staff would have to enter the residents' rooms to retrieve and return these items.

- Additionally the privacy curtain tracking in three-bedded rooms remained configured for four residents. This did not maximise the space that could be available for the three residents in the room.

Inspectors issued an urgent action plan to the provider to have the stored clinical equipment and the additional curtain tracking removed from resident bedrooms.

Inspectors observed nursing staff administering medication in the dining room at lunchtime. This was not a person-centred approach to care and interrupted the residents' dining experience.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	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 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for New Houghton Hospital OSV-0000603

Inspection ID: MON-0042173

Date of inspection: 09/01/2024

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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Fire:

• All staff, except those who are on long term leave e.g. maternity/sick, have now completed Fire Training online as at 26/02/2024. Those returning from such absences will be facilitated to complete training as part of their return to work induction.
• All staff, except for those on leave, have completed the site-specific fire training which includes: site specific evacuation training, horizontal and vertical fire evacuation, procedures in case of clothes catching fire, fire prevention, safety and management training.
• Further onsite training date is planned for 27th February 2024 to capture those staff who had been on leave in January.

Infection Prevention and Control
• The training needs assessment has been reviewed and the training matrix has been updated to include: environmental hygiene, cleaning of reusable equipment, management of linen, management of waste, sharps management, and antimicrobial resistance training to the appropriate grades of staff.

Safeguarding:
• All staff, except those who are on long term leave, have now completed the Safeguarding training as at 26/02/2024.

Managing Behaviours that challenge:
• The 5 staff members identified to complete the training are booked for 29/02/2024.

Medication Management

• All appropriate staff have now completed the medication management training as at 26/02/2024.

Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
The Directory of Residents, which is retained on the HSE's SHIPPAS system, includes all required information including:

• if the resident was discharged from the designated centre, the date on which he or she was discharged
• if the resident is transferred to another designated centre or to a hospital, the name of the designated centre or hospital and the date on which the resident was transferred
• where the resident died at the designated centre, the date, time and cause of death, when established
• the name and address of any authority, organisation or other body, which arranged the resident's admission to the designated centre

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
There is a dedicated member of South East Community Healthcare's HR staff currently allocated to reviewing the New Haughton Hospital personnel files stored on "Therefore", the HSE's employee file management system in order to break-down large historical bulk uploads to individual Schedule 2 files. All new documentation, for example new training certifications, are uploaded individually so this is a time-limited issue while the historic back-scans are reviewed and appropriately indexed. This will significantly reduce search time for any individual record for any staff member.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. Fire Regulation compliance:
• Fire safety online training is now complete as at 26/02/2024 for all staff barring those on long term leave who will complete as part of their return to work.
• Site specific, in person training has been carried out for all staff actively working with a follow-up session for those on leave in January booked for 27th February 2024.
• New Haughton Hospital has now purchased 6 X ski sleds to be used as additional vertical evacuation aids if the primary horizontal evacuation procedure cannot be safely followed. As these are new evacuation aids to the centre, supplementary specialist training will be provided on full uses of these sleds. This training will be provided on Thursday 2nd May 2024.

2. Occupancy: Bedroom 4 in Brandon and Bedroom 5 in Abbey are three bedded as per condition 01 of registration, floor plans and Statement of Purpose and will not be used for more than 3 residents in line with same.

3. Storage:
• A maintenance request has been submitted to put in extra shelves in linen rooms on both floors.
• New Haughton Hospital is currently trialing placement of resident's own nursing/specialised chairs at their bedside rather than a general armchair in order to reduce time to transfer to chair on resident request. There are still visitor's chairs available in each bedroom and communal areas. This has reduced need to store specialised chairs away from their owners.
• A further request has been sent to maintenance to assess the suitability and safety regarding converting/ utilizing the open balcony area upstairs to a storage area and additional outdoor area for residents if safe to do so.

4. Activities: Oversight and organization of the activities programme is currently being coordinated by Director of Nursing and CNM 2 Practice Development during the current absence of activities coordinator.

5. Volunteers: Our volunteer policy is now updated and has included orientation programme and details of mandatory training for volunteers. Completed on 20/02/2024.

A file will be held on each volunteer to include the following in line with Regulation 30:
• A written record of their roles and responsibilities
• Their supervisory structure
• Documentation to confirm they have attended orientation programme
• A vetting disclosure in accordance with the National Vetting Bureau Act 2012
• Proof of Identity
• Records of Mandatory training including Safeguarding of Vulnerable Adults, Infection Prevention and Control, Manual Handling, and Fire Safety and other suitable identified training requirement.

6. Maintenance: The Director of Nursing has now implemented a more robust process for requesting and escalating formal requests for maintenance/minor works to the Wexford Maintenance Manager including visual aids to demonstrate the issue at hand.

Administrative support has also recently been allocated to the Wexford Maintenance Manager which will support management and prioritization of such referrals.

7. Records: There is a dedicated member of South East Community Healthcare's HR staff currently allocated to reviewing the New Haughton Hospital personnel files stored on "Therefore", the HSE's employee file management system in order to break-down large historical bulk uploads to individual Schedule 2 files. All new documentation, for example new training certifications, are uploaded individually so this is a time-limited issue while the historic back-scans are reviewed and appropriately indexed. This will significantly reduce search time for any individual record for any staff member.

8. Staff Training:
• The training needs assessment has been reviewed and the training matrix has been updated to include: environmental hygiene, cleaning of reusable equipment, management of linen, management of waste, sharps management, and antimicrobial resistance training to the appropriate grades of staff.
• A CNM 2 has taken up the role of Practice Development in New Haughton Hospital as of December 2023 and will oversee the training requirements, and development of policies and procedures to ensure that they are current and informed and in line with best practices.

9. Incident Forms Tracking and Trending
• An updated series of excel spreadsheets are in place to track and trend the incidents at ward and hospital level. Tracking and trending of incidents results will be collated on a monthly basis and reviewed at governance meetings and ward meetings to share learning and action plans for Quality Improvement.
• Trending of Incidents is also discussed at the Wexford Residential Older Persons Services Quality and Patient Safety Meeting (QPS) (quarterly) along with the other 3 Older Persons sites in Wexford and issues are escalated from QPS to the regional Older Persons Quality and Safety Executive Committee (QSEC) (bimonthly). Learning and improvements from other sites is also cascaded from QSEC – QPS – Community Nursing Units.
• There is a dedicated Quality and Patient Safety Advisor working across Waterford Wexford Older Persons Community Nursing Units to support with collating and trending of incidents and who reviews all patient safety incidents on notification which helps identify emerging trends.

10. Clinical Governance Meetings: There are local clinical governance meetings held at New Houghton Hospital on monthly basis. The recent dates of the said meetings are 29/01/2024, 08/01/2024, 11/12/2023, 13/11/2023, 16/10/2023/ 25/09/2023, 14/08/2023 and minutes are available for same.
There are quarterly governance meetings with the Registered Provider Representative (last held 14/12/2023) that have now been stepped up to bimonthly to provide additional oversight as required. The next such Governance meeting is scheduled for 29/02/2024.

11. Oversight of Infection Prevention and Control – This will be a standing item on both clinical and operational governance meetings to ensure IPC-related incidents are reviewed and appropriately responded to and that IPC Audit outcomes are progressed in

a timely fashion.

12. Choice at Mealtimes – In consultation with the Wexford Catering Officer, we have ensured choice for all residents, including those on modified diets and are working to improve communication processes to support the Catering function for New Haughton Hospital.

13. Oversight of Audit - Initial meeting was held 20/02/2024 regarding initiating the Quality Care Metrics system in New Houghton Hospital and CNMs are undergoing training to implement same. Progression of Audit Action Plans will be a standing item on both clinical and operational governance meetings with additional emphasis on identifying action owners.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
The Contracts of Care issued to the residents in New Houghton Hospital are being reviewed to ensure there is identification of the room number and number of residents in their shared bedroom.

The clause regarding a required change of bedroom e.g. due to need for isolation due to infection or due to the changing care needs and requirements of residents has also been reviewed and a process put in place to document such changes.

Before a resident is moved from a room to another room, the rationale is discussed with the residents and respective families. The details of this communication is documented in the respective care plans and also attached as an addendum to the contract of care.

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 is being reviewed and updated to be in line with Schedule 1 of the regulations by including
• the deputizing arrangements for PIC
• Arrangements in place to explain, review and discuss the resident's contract of care including any change in bedroom allocation.

• Complaints Policy is being reviewed and updated to fully reflect Regulation 34
• Reference to the full suite of policies in New Houghton Hospital
• Details of Pension agent arrangements and procedures for safeguarding residents' finance onsite.

A revised statement of purpose will be supplied on completion (29/02/2024)

Regulation 30: Volunteers	Not Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:
Our volunteer policy is now updated to include an identified orientation programme and details of mandatory training for volunteers.

A file will be held on each volunteer to include the following in line with Regulation 30:
• A written record of their roles and responsibilities
• Their supervisory structure
• Documentation to confirm they have attended orientation programme
• A vetting disclosure in accordance with the National Vetting Bureau Act 2012
• Proof of Identity
• Records of Mandatory training including Safeguarding of Vulnerable Adults, Infection Prevention and Control, Manual Handling, and Fire Safety and other suitable identified training requirement.

For existing volunteers, each will be met with to re-confirm their roles and responsibilities and their supervisory structure.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The nominated Complaints Officer (PIC) has completed HSE Effective Complaints Investigation as of 21/02/2024.

The complaints procedure is also being updated on the Statement of Purpose to ensure New Haughton Hospital is in line with Regulation 34.

Progression of complaints within regulatory timelines will be reviewed at each Governance Meeting with the Registered Provider Representative.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The full suite of policies, including Schedule 5 Policies, are being reviewed and updated where required by the CNM2 Practice Development in conjunction with the Director of Nursing and updates provided on progression at the bimonthly Governance meetings with the Registered Provider Representative.

The following policies are now in place:
• The creation of, access to, retention of and destruction of records
• Health and safety of residents, staff and visitors, including food safety

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Bedroom 4 in Brandon and Bedroom 5 in Abbey are now maintained as three bedded rooms as per condition 01 of registration, floor plans and Statement of Purpose.
• A request has been submitted to maintenance to re configure the curtain tracking in the above rooms to 3 bays to ensure maximum available space is available to the 3 residents.
• All equipment, not personal to the bedroom residents, that was being stored in any unused area in bedrooms has been removed.

• Request has been placed with Maintenance to add an extra shelf in linen rooms on both floors to increase storage.
• New Haughton Hospital is currently trialing placement of resident's own nursing/specialised chairs at their bedside rather than a general armchair in order to reduce time to transfer to chair on resident request. There are still visitor's chairs available in each bedroom and communal areas. This has reduced need to store specialised chairs away from their owners.
• A further request has been sent to maintenance to assess the suitability and safety regarding converting/ utilizing the open balcony area upstairs to a storage area and additional outdoor area for residents if safe to do so.

• Broken chairs and Alters and other items have been disposed of from under the stairs and the stairwell is kept free from all obstruction.

• Maintenance request has been submitted to assess and repair/ upgrade the flooring in the Abbey Day Room and repair/refresh walls in residents bedrooms. • Fire Evacuation Ramp from the Brandon Unit has been power washed and is on the calendar for regular maintenance. • The wall saver in the Abbey Twin room is now temporarily repaired and request has been placed with Maintenance for replacement.

Regulation 18: Food and nutrition	Not Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: • In consultation with the Wexford Catering Officer, a system has now been put in place to inform of any change to the previously notified menu • Meals are delivered daily at approximately 12.15 and 3.30pm from St. John's Community Hospital which is approximately 30 minutes away. New Houghton catering staff have been instructed to review the delivery on receipt each day as there will be time to rectify in advance of dinner and supper if there are any items missing. • Choice is available for all residents on pureed diets and menus have now been supplied to New Haughton to support residents in making their selection. • The Catering Officer and the Senior Speech and Language Therapist in Enniscorthy have reviewed the minced diets offering and a choice of meal will be available from 18th March 2024. • The New Haughton Hospital will display the 4 week menu cycle in the kitchen for catering staff to become more familiar with all meals being offered so they can speak to same. All deliveries, including for modified diets, are clearly labelled so there should be no confusion as to what a meal consists of. • The catering department send separate containers of pureed meat, veg and potato. These should be presented on the plate separately to make the meal appealing to the resident. The Catering Officer has attended on site to provide training in presentation to the local catering staff.	
Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control: • The Person in Charge has now requested for a janitorial sink to be installed in the housekeeping room in Abbey Unit. A further request has been made to Maintenance to assess and redesign the Female staff area in Brandon to allow a more spacious and convenient Housekeeping room in Brandon. • New Haughton Hospital has received the first shipment of 7 bed tables (Feb 2024) which has allowed for the disposal of the damaged tables. Replacement of all bed tables have been approved by the Provider Representative and ordered and will be delivered over coming weeks. There are unfortunately unavoidable delays with this equipment. • Staff have been educated further to use the available labelling system to indicate clean or dirty equipment and correct segregated storage of same. • Awaiting installation of shelves in the linen room for storage of crash mats and poesy mats and further appropriate segregation of clean and dirty equipment.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Fire safety online training is now complete for all staff as at 26/02/2024 barring those on long term leave who will complete as part of their return to work. • Site specific, in person training has been carried out for all staff actively working with a follow-up session for those on leave in January booked for 27th February 2024. • New Haughton Hospital has now purchased and installed 6 X ski sleds to be used as additional vertical evacuation aids if the primary horizontal evacuation procedure cannot be safely followed. As these are new evacuation aids to the centre, supplementary specialist training will be provided on full uses of these sleds on Thu 2nd May 2024. • Unannounced evacuation drills are scheduled on a monthly basis and include ground and first floor simulated drills including stairs evacuation. • A follow up meeting is scheduled for 13th March with HSE Fire Officers to further review fire safety plan and identify and progress and further supplementary actions to further improve fire prevention and safety at New Houghton Hospital. This will also include review of feasibility study as to upgrading the center's passenger lift as tertiary evacuation method. It is planned to have quarterly meetings with the Fire Officers specific to New Haughton Hospital which will be stepped up if required. These meetings will be minuted commencing with 13th March.

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:
All care plans and assessments are currently being updated post audit and staff meetings with additional emphasis on social care needs.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• Restraint policy education provided for relevant staff. Restraint care plan and assessments are being updated to include documentation of all the alternative non-restrictive measures trialed before restraints were used.
• Restricted access to the garden and key pad coded entrance /exit doors are appropriately risk assessed. It is intended that where low/manageable levels of risk are present that the door to the garden will remain open and level of risk will be actively monitored.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Social assessments are now completed for most of the residents and will be completed for all by 10/03/2024. Staff have communicated with respective families to seek their input into their loved ones preferences where communication difficulties exist.
• On completion of social assessments, an exercise will be undertaken to review and collate the finding to further inform the activities programme.
• Initial meeting held with activity team and their external agency lead on 29/01/24 for improving the activity schedule and to promote their active involvement in holistic care of the resident under the supervision of the nursing team.
• The Director of Nursing and CNM2 Practice Development are taking a lead role in overseeing and developing the activities programme in absence of the activities coordinator.

• A request has been submitted to maintenance to re configure the curtain tracking in the above rooms to 3 bays to ensure maximum available space is available to the 3 residents.
• All equipment, not personal to the bedroom residents, that was being stored in any unused area in bedrooms has been removed.
• New Haughton Hospital is currently trialing placement of resident’s own

nursing/specialised chairs at their bedside rather than a general armchair in order to reduce time to transfer to chair on resident request.

• A review of medication round timing is underway to ensure those who require medication with their meals can be administered in a manner that supports the dining experience.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/03/2024
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	30/06/2024
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	30/06/2024

Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	18/03/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	26/02/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/06/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/06/2024
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the	Substantially Compliant	Yellow	31/03/2024

	number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
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	30/03/2024
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Red	15/01/2024

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.	Not Compliant	Red	15/01/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Red	15/01/2024
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	29/02/2024
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	29/02/2024
Regulation 30(a)	The person in charge shall	Not Compliant	Orange	30/03/2024

	ensure that people involved on a voluntary basis with the designated centre have their roles and responsibilities set out in writing.			
Regulation 30(b)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre receive supervision and support.	Not Compliant	Orange	30/03/2024
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Substantially Compliant	Yellow	30/03/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/04/2024
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1) available to staff.	Substantially Compliant	Yellow	30/04/2024
Regulation 04(3)	The registered provider shall review the policies	Not Compliant	Orange	30/04/2024

	and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	10/03/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	10/03/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4	Substantially Compliant	Yellow	10/03/2024

	months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	29/02/2024
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	29/02/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Orange	30/03/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably	Substantially Compliant	Orange	26/02/2024

	practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Red	15/01/2024