Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Kilrush District Hospital Limited
Name of provider:	Kilrush District Hospital Company Limited by Guarantee
Address of centre:	Cooraclare Road, Kilrush, Clare
Type of inspection:	Unannounced
Date of inspection:	28 August 2024
Centre ID:	OSV-0000446
Fieldwork ID:	MON-0043527

About the designated centre

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

Kilrush District Hospital is a nursing home that has been extended and reconfigured over the years. A two-storey purpose built extension was provided and the original buildings have been refurbished in recent years. It can accommodate up to 26 residents, male and female over the age of 18 years. It is located in the West Clare area, in the town of Kilrush. Care is provided for people with a range of needs: low, medium, high and maximum dependency. It provides short and long-term care primarily to older persons. The centre does not accommodate persons presenting with extreme challenging behaviours or with tracheotomy tubes. There are nurses and care assistants on duty covering day and night shifts. Accommodation is provided in both single and shared en suite bedrooms. There are separate dining and day rooms provided for residents use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	25

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 28 August 2024	09:15hrs to 17:45hrs	Sean Ryan	Lead

What residents told us and what inspectors observed

Residents living in Kilrush District Hospital told the inspector that they enjoyed living in the centre and were supported to have a good quality of life. Residents reported feeling safe and comfortable in the care of staff who they described as kind, friendly, and attentive to their needs.

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

The inspector met with a number of residents in the communal dayroom and in their bedrooms and spoke to them in detail about their experience of living in the centre. Staff were observed to provide care to residents in an unhurried manner and engage with residents socially. Residents who spoke with the inspector were complimentary in their feedback about the staff. Residents described how staff never made them feel rushed, and they reported that they were always greeted with 'respect and friendliness'. Residents told the inspector that they enjoyed engaging with all staff, and that they spent time chatting with them throughout the day. One resident told the inspector about their experience of coming to live in the centre. While the resident expressed that they missed their own home, moving to the nursing home was necessary because they wanted 'friendship' and support their care needs. The resident described how staff supported them to adjust to living in the centre and socialise with other residents.

The premises was bright, spacious, and warm. The centre provides accommodation over two floors, and comprised of both single and shared bedroom accommodation. The first floor of the premises was accessible to residents through a passenger lift and stairs. The provider had reduced the number of bedrooms in the centre as part of a plan to manage issues of non-compliance relating to the premises and fire safety. The provider had redecorated some areas of the premises, including bedrooms and an office. Some action had been taken to improve aspects of the external premises. This included the removal of debris and moss from footpaths, power washing of the external walls, and painting of some window sills. Nonetheless, there were areas of the premises, both internally and externally, that remained in a poor state of repair, including walls, skirting boards, handrails, and doors that were visibly stained and chipped. The floor coverings were also in a poor state of repair in many areas of the centre, impacting on the cleanliness and quality and safety of the environment.

Resident's personal clothing was laundered on-site. Residents expressed their satisfaction with the service provided, and described how staff took care with their personal clothing and returned it promptly to their bedroom. However, the laundry area was in a poor state of repair and did not support effective infection prevention

and control. Floors and walls were visibly damaged and waste water from washing machines continued to be discharged into an open drain creating back splash. This increased the risk of cross contamination.

The inspector also noted some fire safety concerns on the walk around of the centre. A number of fire doors were visibly damaged or not closing correctly. Some essential smoke seals were also damaged. This may compromise the function of the doors to contain the spread of smoke and fire in the event of a fire emergency. There were numerous areas of the premises where services such as pipes and electrics penetrated and walls and ceiling. This resulted in gaps around the service penetrations which had the potential to impact on the containment of smoke and fire.

Residents were complimentary of the dining experience and the quality of the food they received. The dining experience was observed to be a social and enjoyable experience for residents. Staff were available to provide discrete assistance and support to residents, if required. Food was freshly prepared and met residents individual nutritional requirements. Residents confirmed the availability of snacks and refreshments outside of scheduled meal times.

Residents spoke about how staff supported them every day to maintain their individual style and appearance. This included assisting residents to select their clothing, apply make-up, and clean their jewellery. All residents were observed to be dressed and groomed, in line with their personal preference and style.

Throughout the day, residents were actively engaged in a variety of meaningful activities. There was a detailed activity schedule developed in consultation with the residents. Residents were observed to be engaged in games and other activities during the afternoon. Staff were observed to engage in activities with residents and this added to the social experience of the activities.

Residents confirmed that they had opportunities to meet with the management team to discuss their views on the quality of the service.

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

Capacity and capability

This unannounced inspection was carried out by an inspector of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended). The inspector also followed up on the actions taken by the provider to address significant issues of non-compliance identified during the last inspection in October 2023 regarding fire

safety, the premises, and infection prevention and control.

The findings of this inspection were that, while the provider had taken some action to improve the repair and maintenance of the premises and the quality of environmental hygiene, significant action continued to be required with regard to the governance and management of Kilrush District Hospital, particularly in relation to fire safety. While the registered provider had engaged the services of competent persons to identify fire risks in the centre, the provider had failed to put effective systems of monitoring and oversight in place to manage the fire risk to residents living in the centre.

Previous inspections of the centre identified significant non-compliance with Regulation 28, Fire precautions, and that the provider had repeatedly failed to address serious deficits with the systems of detection, containment and management of fire. Following the last inspection in October 2023, and subsequent engagement with the office of the Chief Inspector, the provider gave assurances that the necessary action would be taken to comply with the regulations. Consequently, the Chief Inspector renewed the registration of the centre with additional restrictive conditions. The conditions required the provider to complete all requisite fire safety works to achieve compliance with the regulations by 31 December 2024, and to ensure the premises met the needs of the residents by 28 February 2025. Simultaneously, the number of residents who may be accommodated in the designated centre was reduced from 43 to 26, in recognition of significant fire safety risks in the centre.

Following the last inspection, the provider had completed fire safety risk assessments of the centre in December 2023 and April 2024. These assessments identified significant issues with the systems of detection, containment and management of fire. The provider had taken some steps to improve the fire safety systems in the centre since the last inspection. This included the installation of fire detectors in areas that previously had no detection, and arrangements were in place for the periodic testing and maintenance and of the emergency lighting and fire detection systems. However, requisite works to address fire containment risks in the centre had not progressed. The provider did not present a clear time-bound project plan of works completed to date, and the outstanding works required. As a result, there was no clear time-line for the works to be completed, and no effective risk management systems in place to manage the risk associated with inadequate fire containment within the centre, and the risk to the care and welfare of residents. Similarly, there was no clear time-bound project plan of works to ensure the premises met the requirements of Schedule 6 of the regulations.

The registered provider of this centre is Kilrush District Hospital Company Limited by Guarantee. The organisational structure had changed since the last inspection through the appointment of two general managers. The general managers were responsible for monitoring non-clinical and operational aspects of the service, such as housekeeping and the catering department, in addition to providing governance and support to the person in charge. A maintenance manager had also been appointed and they were responsible for implementing a programme of

maintenance in the centre.

Lines of accountability and responsibility were not fully defined. While responsibility for key aspects of the service were delegated among the management personnel, it was unclear who was accountability for ensuring known risks and deficits in the service were appropriately managed. For example, while the management personnel were aware of deficits in the maintenance of the premises, fire safety and infection prevention and control, there was no evidence that action had been planned or taken to progress to address the deficits within the confines of the conditions of registration.

The system in place to manage risk was not effective. The centre's risk management policy detailed the interventions that should be in place for the oversight of risk in the centre. This included maintaining a risk register to record all potential risks to residents' safety and welfare. A review of the centre's risk management systems found that it did not reflect the centre's own risk management policy. While the provider had identified significant risks and deficits in the systems of fire management and containment of fire, there was no risk management plan in place to mitigate the risk to residents. This impacted on the provider's ability to monitor and manage risks to resident's safety and welfare.

A schedule of clinical audits had been implemented to evaluate the quality of the physical environment, clinical documentation and the care provided to residents. The provider had introduced additional infection prevention and control audits to monitor and measure the quality of environmental hygiene and infection prevention and control practices among staff. There were arrangements in place for the management team to analyse and discuss audit results, complaints and incidents with the provider representative at governance and management meetings. There was evidence that quality improvement action plans were developed and progressed to completion. For example, an improvement action plan had identified a requirement to replace catering equipment and this action had been completed.

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

Record management systems comprised of a paper-based system. A review of staffing records found that all staff personnel files contained a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021. However, not all files contained the information specified in Schedule 2 of the regulations. For example, some records did not contain details of relevant qualifications, or references for some staff.

The staffing levels were appropriate for the size and layout of the building, and to meet the assessed needs of the residents. There was adequate nursing staff on duty supported by a team of health care staff. A review of the rosters found that there were adequate staffing in place to support housekeeping, catering and social care activities. Rosters showed that staffing numbers were sufficient to respond to planned and unplanned leave in the service.

The policies and procedures, as required by Schedule 5 of the regulations, had been reviewed by the provider at intervals not exceeding three years, and were made available to staff.

While staff were facilitated to attend training with regard to fire safety, inspectors found that staff were not appropriately trained with regard to fire safety procedures, revised following fire safety works in the centre, to be followed in the event of a fire emergency.

Regulation 15: Staffing

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

Judgment: Compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements. Records required under Schedule 2 of the regulations were not appropriately maintained. For example;

- Two staff files did not contain a satisfactory history of any gaps in employment.
- One record did not contain documentary evidence of relevant qualifications or references from a person's most recent employer.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had not ensured there was a clearly defined management structure in place, with clear lines of accountability and responsibility. For example, it was unclear who held overall accountability and responsibility for key aspects of the service that included the management of risk, fire safety, and infection prevention and control. This resulted in ineffective action being taken to address risks to residents.

The management systems to ensure the service was safe, appropriate, consistent

and monitored were not effective. This was evidenced by a failure to;

- implement effective risk management systems to monitor and manage known risks with the potential to impact the safety and welfare of residents living in the centre. For example, a number of significant risks identified by the provider had not been appropriately reviewed or recorded in the risk register. Consequently, the provider failed to put controls in place to mitigate and manage fire risks to the safety of residents in the centre.
- Ensure residents were protected from the risk of fire and received care in an environment that met their individual and collective needs. There was poor monitoring and oversight of fire safety and premises issues in the centre. This was compounded by the absence of a clear time-bound project plan to address significant fire and premises risks in the centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

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

Judgment: Compliant

Regulation 4: Written policies and procedures

The required policies were in place and reviewed within the three year time-frame set out in the regulations.

Judgment: Compliant

Quality and safety

Resident's health and social care needs were met to a satisfactory standard from a team of staff who knew their individual needs and preferences. Residents were satisfied with their access to health and social care. However, the quality and safety of the environment did not reflect the care delivery. While the registered provider had taken some action to improve aspects of the premises and environmental hygiene, there continued to be aspects of the premises and associated facilities that were in a poor state of repair and did not support effective infection prevention and control management. The provider did not ensure that residents received care in an

environment that protected them from risk of fire.

The provider had completed fire safety risk assessments of the centre in December 2023 and April 2024, and a draft project plan to address the assessment findings was being developed. There was no time-bound action plan in place for the commencement and completion of the required fire safety works. The inspector found that while the provider had taken some action to ensure all areas of the centre had fire detection in place, the provider had failed to take appropriate actions to mitigate the risks to residents until the fire works were completed. This was evidenced by the lack of awareness demonstrated by staff, of all fire risks in the centre such as impaired fire doors. Consequently, residents were not protected from the risk of fire.

The centre's risk management policy contained all the information required under Regulation 26, however, the content of the policy had not been implemented as discussed under Regulation 23. Risks were not recorded in line with the centre's own policy.

The centre was found to be visibly clean in areas occupied by residents, such as the communal dayrooms and dining room, with the exception of areas of the centre where deficits in the premises, such as impaired floor coverings, compromised effective cleaning. Staff spoken with were knowledgeable regarding the established cleaning procedure in the centre. Facilities necessary to support effective infection prevention and control had been improved through the provision of equipment to support effective decontamination of toileting aids. There was a cleaning schedule in place to support the systematic cleaning of all areas of the centre. This included both occupied and vacant bedrooms, storage area, communal dayrooms and toilets, and the kitchen. Nonetheless, there were some aspects of the physical environment that continued to impact on effective infection prevention and control. This included the laundry area, storage areas, equipment and some bedrooms that were in a poor state of repair and impacted on effective cleaning.

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

Residents were reviewed by a medical practitioner, as required or requested. Arrangements were in place to ensure residents had timely access to health and social care professionals for additional professional expertise. There was evidence that recommendations made by professionals had been implemented to ensure best outcomes for residents.

The needs of residents, who had difficulty communicating, were identified and staff supported residents to communicate their views and needs directly. Residents who required supportive equipment to communicate were provided with such equipment. Residents care plans reflected their communication needs and preferences.

The person in charge was actively promoting a restraint-free environment and the use of restraints, such as bed-rails, had significantly reduced. Residents who experienced responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) received non-restrictive care and support from staff that was kind, and respectful.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre. The provider had arrangements in place to appropriately support residents to manage their finances. This is a completed action from a previous inspection.

Residents' rights were promoted in the centre. Residents were free to exercise choice in how to spend their day. Activities were observed to be provided by dedicated activities staff, with the support of health care staff. Residents told the inspector that they were satisfied with the activities on offer. There were opportunities for the residents to meet with the management team and provide feedback on the quality of the service.

Regulation 10: Communication difficulties

The registered provider had arrangements in place to ensure residents who experienced communications difficulties were appropriately assessed. Staff demonstrated an appropriate knowledge of each residents communications needs, and the aids required by some residents to support their needs, in line with the residents individual care plan.

Judgment: Compliant

Regulation 17: Premises

Notwithstanding the maintenance action completed to date, a project plan to address non-compliance with the premises had not yet commenced. Consequently, there were areas of the premises that were in a poor state of repair, both internally and externally. For example;

- Walls along corridors and in bedrooms were visibly stained, chipped, cracked, and damaged.
- Multiple doors and skirting were scuffed, chipped and damaged.
- Floor coverings in areas were not appropriately maintained. For example, floor along corridors were visibly damaged.

- Externally, walls, drainage systems, and the grounds were found to be in a poor state of repair. The oil tank to the rear of the building remained in a poor condition and was corroded.

Judgment: Not compliant

Regulation 26: Risk management

There was an up-to-date risk management policy in place. The risk management policy contained all of the requirements set out under regulation 26(1).

Arrangements were in place for the identification, investigation and learning from serious incidents or adverse events involving residents. There was an emergency plan in place for responding to major incidents.

However, the failure of the provider to manage risk in line with the risk management policy is actioned under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 27: Infection control

Infection prevention and control procedures were not consistent with the National Standards for Infection Prevention and Control (IPC) in community settings published by HIQA.

The environment and equipment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- There were poorly maintained areas of the premises that impacted on effective cleaning where floors, walls and surfaces of furniture were damaged.
- The laundry facilities did not ensure that infection prevention and control standards could be met to reduce the risk of cross infection.
- Some facilities in the older part of the building were not fitted with appropriate hand hygiene facilities.
- Some equipment used by residents was visibly damaged. This included soft furnishings and beds. This compromised effective cleaning of those items.

Judgment: Not compliant

Regulation 28: Fire precautions

A programme of fire safety works had not yet commenced, and therefore significant fire risk remained in the centre. Consequently, the following aspects of fire safety were not in compliance.

Arrangements for the containment of fire were not adequate.

- The deficits to fire doors presented a risk to the fire containment of the centre. A number of fire doors were observed to be impaired. For example, some did not close fully while other doors were stuck on the floor when opened. There were missing heat and smoke seals and gaps observed between some doors. This may compromise the function of the fire doors to contain the spread of smoke and fire.
- Service penetrations were observed in fire rated construction which were not adequately sealed to ensure containment of fire.
- There were persistent deficits to the fire containment measures throughout the building, identified in the provider's fire safety risk assessment.

At the time of inspection, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire, nor were fire precautions being adequately reviewed. For example;

- Despite significant deficits being identified in the systems of containment and management of fire, the fire evacuation procedure had not been reviewed or updated to mitigate known fire risks in the centre. This included the risk associated with impaired fire doors. Consequently, staff did not have full knowledge of the extent of fire risks in the centre, or the potential impact of fire evacuation procedures.
- There was no documented plan in place to ensure a safe system of managing the known fire risks in the centre.
- Poor practices were observed where fire doors were being kept open by means other than appropriate hold open devices connected to the fire alarm system.
- There were two bedrooms that were accessible only through the dining room. However, staff would be prevented from accessing those bedrooms if a fire occurred in the dining room. While there was an emergency exit at the end of the corridor, staff did not have a means to enter this part of the building from the outside as there were no externally facing fastenings on the exit. Staff spoken with gave inconsistent responses with regard to the means of accessing this area in the event of a fire emergency.

The arrangements for maintaining the fire equipment, means of escape, building fabric and building services were not adequate.

- There was no periodic inspection report of the electrical installation available to ensure the electrical installation was free of fault or risk.
- Electrical panels were located on escape corridors and were not protected by

fire rated construction. This high priority risk had been identified in a fire safety risk assessment completed in 2021 but had not been addressed.

There was no time-bound project plan of works in place to demonstrate the progress made with addressing fire containment measures, or the outstanding work required.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A sample of resident's assessments and care plans found that they were not in line with the requirements of the regulations.

Care plans were not always guided by a comprehensive assessment of the residents care needs. For example, some resident's care plans did not accurately reflect the needs of the residents, and did not identify interventions in place to support residents when identified as being at high risk of malnutrition. Consequently, staff did not always have accurate information to guide the care to be provided to the residents.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to General Practitioners (GP) of their choice and the person in charge confirmed that GPs attended the centre as required. Residents also had access to a range of health and social care professionals such as physiotherapy, occupational therapy and tissue viability nursing through a system of referral.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Restrictive practices, such as bed rails, were managed in the centre through an ongoing initiative to promote a restraint free environment. Restrictive practices were only initiated following an appropriate risk assessment, and in consultation with the resident concerned.

Residents who experienced responsive behaviours had appropriate assessments completed, and person-centred care plans were developed that detailed the

supports and intervention to be implemented by staff to support a consistent approach to the care of the residents. Care plans included details of non-pharmacological interventions to support the resident to manage responsive behaviours. Interactions observed between staff and residents was observed to be person-centred and non-restrictive.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. Safeguarding training was up-to-date for all staff and a safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

The provider had a plan in place to ensure residents' pensions and social welfare payments were managed in line with best practice guidance.

Judgment: Compliant

Regulation 9: Residents' rights

Staff ensured that residents' rights were upheld in the designated centre. Staff were observed to engage in positive, person-centred interactions with residents.

There was an activity schedule in place. Residents were observed to be socially engaged throughout the day of the inspection.

There were opportunities for residents to meet with the management team and provide feedback on the quality of the service. Minutes of resident meetings reviewed by the inspector showed that relevant topics were discussed including mealtimes, staffing, and activities.

Residents were provided with information on the facilities and services available to support them. This includes details of independent advocacy services and educational information on equipment available to support their needs.

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 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Kilrush District Hospital Limited OSV-0000446

Inspection ID: MON-0043527

Date of inspection: 28/08/2024

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Corrective Actions a) The two staff files have been updated to include details re history of any gaps in employment. Timeframe: Completed b) The staff file has been updated to contain evidence of their qualifications, and associated references. Timeframe: Completed c) An audit of all staff files shall be completed against Schedule 2 of the regulations. Timeframe: 30/11/2024 Preventative Actions d) An ongoing audit of a sample of staff files, against Schedule 2 of the Regulations, shall be carried out every month and the results presented to the Management Team. Timeframe: Commencement – 01/12/2024	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Corrective Actions a) The role of the General Manager has been clarified as having accountability, and	

authority, for the management of fire safety on the premises.
Responsibility: Registered Provider
Timeframe: Completed

b) The role of the Director of Nursing has been clarified as having accountability, and authority, for all residents Personal Emergency Egress Plans (PEEPs).
Responsibility: Registered Provider
Timeframe: Completed

c) The role of the Director of Nursing has been clarified as having accountability, and authority, for all aspects of the Infection Prevention and Control programme.
Responsibility: Registered Provider
Timeframe: Completed

d) The role of the General Manager has been clarified as having accountability, and authority, for the management of non clinical risks within the organisation.
Responsibility: Registered Provider
Timeframe: Completed

e) The role of the Director of Nursing has been clarified as having accountability, and authority, for the management of clinical risks within the organisation.
Responsibility: Registered Provider
Timeframe: Completed

f) The roles of the General Manager, and Director of Nursing, shall be reviewed, and revised, to ensure clarity on all aspects of accountability and authority, in relation to the delivery of clinical and non-clinical services.
Responsibility: Registered Provider
Timeframe: 31/10/2024

g) The roles of each member of the Management Team, shall be reviewed, and revised, to ensure clarity on all aspects of accountability and authority.
Responsibility: Registered Provider Representative / General Manager / Director of Nursing
Timeframe: 31/10/2024

h) The Management Team, chaired by the General Manager, shall meet formally, on a weekly basis to determine timeframes, and review the necessary actions, of the following programmes:

- Fire Safety (including electrical safety) (including actions and timeframes)
- Infection Prevention and Control (including actions and timeframes)
- Risk Management (including controls and timeframes)
- Capital Development (including change control and timeframes)

Timeframe: Commencement: 14/10/2024

i) A review, and redevelopment, of the Risk Management Policy shall be undertaken, with external expertise to ensure an effective risk management system.

Timeframe: 31/10/2024

j) A review, and redevelopment, of the Risk Register (clinical and non-clinical) shall be undertaken, with external expertise, to ensure that known risks will be appropriately identified and controlled. This will include all previously identified risks from the most recent Fire Risk Assessment from April 2024. The risk register will evolve in line with the remedial project timeline, with new risks identified and addressed in a timely manner, whilst ensuring that we continue to prioritise residents rights.
Timeframe: 31/10/2024

k) Risk Management Training shall be provided to the Management Team.
Timeframe: 31/10/2024

Preventative Actions

l) A report shall be presented to the Board of Directors, on a monthly basis, in relation to the following programmes:

• Fire Safety (including electrical safety)
• Infection Prevention and Control
• Risk Management
• Capital Development
Timeframe: Commencement: 01/11/2024

m) An independent governance audit shall be undertaken on an annual basis. This shall include:

• Clarity of Roles and Responsibilities of Managers
• Effectiveness of Management / Care Teams

Timeframe: Commencement: 01/01/2025

n) An independent risk management audit shall be undertaken on an annual basis. This shall include:
• Comprehensive Risk Identification
• Appropriate Controls
• Effective Monitoring of Actions

Timeframe: Commencement – 01/01/2025

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	

Corrective Actions
a) Damaged corridor and bedroom walls:
• Prioritisation list determined based on need and access
• Walls made good and repainted.
Timeframe: 31/12/2024

b) Damaged doors and skirting:
• Prioritisation list determined based on need and access
• Doors and skirting made good and repainted.
Timeframe: 31/12/2024

c) Damaged floor coverings:
• Prioritisation list determined based on need and access
• Areas part of capital redevelopment programme excluded for immediate replacement (clean and maintain)
• Cleaning / rectification / replacement
Timeframe: 31/12/2024

d) Corroded oil tank:
• Reduce storage of oil < 25% of capacity for safety
• Daily checks to ensure safety
Timeframe: Commenced
• Decommission
Timeframe: 31/03/2025

e) External walls requiring repair:
• Prioritisation list determined based on need
• Areas part of capital development programme excluded for immediate repair
• Cleaning / rectification / repaint
Timeframe: 31/03/2025

f) Drainage system requiring repair:
• Prioritisation list determined based on need
• Areas part of capital development programme excluded for immediate repair
• Cleaning / rectification
Timeframe: 31/03/2025

g) Grounds requiring repair:
• Prioritisation list determined based on need
• Areas part of capital development programme excluded for immediate repair
• Rectification
Timeframe: 31/03/2025

Preventative Actions
h) Ongoing schedule of maintenance work agreed, and monitored, by the Management Team
Timeframe: 01/12/2024

i) Major Capital Development Programme

• Design and Planning
Timeframe; Completed
• Put to tender
Timeframe Completed
• Award Tender
Timeframe Q4 2024
• Commence onsite works
Timeframe Q1 2025
• Completion of Works
• Timeframe: Q4 2025
• The upgrade of the main operational hub of the older section of the building will be carried out in Phase 1 of the remedial works. This will include new corridor walls, new flooring , skirting and soft furnishings, reducing the IPC risk on an incremental basis. This incremental risk reduction will continue throughout the programme of works. The project will be subject to oversight of a competent IPC professional.
Responsibility: Board of Directors

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Corrective Actions
a) Poorly maintained areas of the premises (impacting on effective cleaning):
• See Reg 17 above
Timeframe: 01/12/2024

b) Damaged furniture (impacting on effective cleaning):
• Prioritisation list determined based on need and infection control risk
Timeframe: Completed
• Furniture replacement programme commenced in 2024
• Outstanding chairs have been temporarily repaired onsite, or decommissioned, until they can be re-upholstered professionally
Completion 31/03/2025
• Damaged bed replacement programme
Timeframe - Commencing 01/11/2024 Completion 31/03/2024

c) Laundry area:
• Open drain closure
Timeframe: Completed
• Remedial development programme plan including floor and wall repair.
Timeframe: 31/12/24

d) Hand hygiene units:
• Hand hygiene unit review re staff accessibility.

Timeframe: Completed
• Provision of additional hand hygiene units as identified.
Timeframe: Completed
Timeframe: 01/12/2024

e) Cleaning schedule:
• Review, and revision, of cleaning schedule and practices
Timeframe: Completed

Preventative Actions
f) Monthly Infection Prevention and Control (IPC) audits, presented to the Management Team for action prioritisation.
Timeframe: Commenced

Staff Training
g) All staff shall undertake Infection Prevention and Control refresher training.
Timeframe: Completion 11/11/2024

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Corrective Actions
a) Bedroom decommissioning due to fire egress risk
• Approval to reduce resident numbers by two, to allow for the decommissioning of the two bedrooms which were identified as a fire evacuation risk. This will eliminate the requirement for staff to enter that section of the building in the event of a fire.
Responsibility: Board of Directors
Timeframe: Completed

• Restriction on all further admissions until the overall number of residents has reduced by two.
Timeframe: As rooms become available

• Change control, including resident engagement, on relocation of affected residents to new rooms.
Timeframe: As rooms become available,

b) Fire evacuation plan review and redevelopment
• Fire hazards review to determine all specific risks re fire evacuation
• Redevelop fire evacuation procedure to mitigate known fire risks in the centre.
• Update all residents Personal Emergency Egress Plans (PEEPs)
Timeframe: 01/12/2024

c) Fire evacuation training and drills enhanced program

• All staff have attended fire evacuation training update, based on redeveloped plan.
• Fire evacuation drills, based on the updated evacuation procedures to be carried out regularly and recorded in Fire Risk Register.
Timeframe: 01/12/2024

d) Fire door access
• Daily check to be carried out to ensure fire doors are not inappropriately kept open.
Timeframe: Commenced

e) Deficits in fire containment measures and fire doors.
A major capital development programme has been commissioned to satisfy all fire safety regulations.
• Design and Planning
Timeframe; Completed
• Put to tender
Timeframe Completed
• Award Tender
Timeframe Q4 2024
• Commence onsite works
Timeframe Q1 2025
• Completion of Works
Timeframe: Q4 2025
As per the proposed schedule of remedial works, Phase 1 will address the electrical infrastructure, which has been identified as the most significant fire risk in the Centre. The electrical Main Boards and sub-boards will be replaced and encapsulated in a certified fire rated enclosure. 48% of the deficient fire doors identified in the most recent Fire Risk Assessment will also be rectified in Phase 1 of the works. The estimated timeframe for completion of Phase 1 is 4 months from the date of commencement. The remaining remedial works in relation to fire containment and fire doors will be completed over the remainder of the project.
Responsibility: Board of Directors

f) Fire door remedial work on existing doors
• Prioritisation list determined based on high risk
Timeframe: Completed
• On-going interim fire door repair programme
Timeframe: Completion 31/03/2025

g) Electrical fire risks
• Extensive electrical and mechanical surveys have been carried out, (findings reflective of inspection), and shall be fully addressed by major capital development plan, primarily in Phase 1.
Timeframe: See above
Responsibility: Board of Directors

h) Fire safety enhancements
• Eight additional fire extinguishers, particularly carbon dioxide as electrical fire has been identified as the highest risk for the Centre. Additional extinguishers, and re-location of some existing extinguishers throughout the building.

Timeframe; Completed
• Interim fire stopping works to exposed pipework as recorded in fire risk assessment report have been addressed.
Timeframe; Completed
• Portable Appliance Testing shall be completed for all relevant equipment.
Timeframe; Completed 14/10/2024
• Three members of full-time staff have completed additional Fire Warden training and are now able to train existing staff on fire safety.
Timeframe; Completed

i) A review, and redevelopment, of the Fire Risk Management Plan shall be undertaken, with external expertise to ensure an effective fire management system.
Timeframe: 11/11/2024

j) A review, and redevelopment, of the Fire Risk Register shall be undertaken, with external expertise, to ensure that known fire risks will be appropriately identified and controlled.
Timeframe: 11/11/2024

Preventative Actions

k) Monthly review of electrical installations to ensure all possible safety controls, within current limitations, are implemented.
Timeframe: Commencement – 30/11/2024

l) A structured internal audit plan shall be developed, and implemented to regularly assess compliance with the Fire Risk Management Plan and Register. Audits shall occur monthly, with results reviewed by the Management Team.
Timeframe: Commencement – 30/11/2024

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Corrective Actions
a) All residents MUST scores shall be reviewed, and recalculated where necessary. Reflective care plans shall be updated.
Timeframe: Completed

b) Residents assessed as high risk of malnutrition shall be reviewed by a dietician.
Timeframe: Completed

c) All care assessments shall be reviewed for all residents.

Timeframe: 01/11/2024

d) All residents care plans, shall be updated, and communicated, in line with the reviewed assessments.
Timeframe: 01/12/2024

Preventative Actions
Care Reviews

e) Care Team meetings shall be held every Monday to discuss the specific needs of the residents as identified by the review.
Timeframe: Commenced 21/10/24

Staff Training
r) All nursing staff shall undertake Malnutrition Universal Screening Tool refresher training.
Timeframe: Completion 11/11/2024

Internal Audit Programme
s) A structured internal audit plan shall be developed, and implemented to regularly assess compliance with care planning and resident assessments. Audits shall occur monthly, with results reviewed by the Management Team.
Timeframe: Commencement 01/12/24

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	25/09/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and	Not Compliant	Orange	31/10/2024

	details responsibilities for all areas of care provision.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/10/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/10/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	31/12/2025
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including	Not Compliant	Orange	25/09/2024

	emergency lighting.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/12/2025
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	Orange	25/09/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the	Substantially Compliant	Yellow	04/09/2024

	assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			