Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	St Colman's Residential Care Centre
Name of provider:	Health Service Executive
Address of centre:	Ballinderry Road, Rathdrum, Wicklow
Type of inspection:	Announced
Date of inspection:	10 January 2024
Centre ID:	OSV-0000492
Fieldwork ID:	MON-0042093

About the designated centre

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

St. Colman's Residential Care Centre is a community facility providing a variety of services to the elderly population of Wicklow. St. Colman's Residential Care Centre provides residential care, respite and palliative care for a total of 92 residents both Male and Female, over the age of 18 years. Accommodation is provided on three units, Primrose Place (26 female), Clover Meadow (30 male), Lavender Vale (30 female,5 male and 1 rehab). Bedroom accommodation is mostly multi-occupancy three and four bedded rooms. There are two twin rooms and four single bedrooms - two of which are allocated to palliative care.There is a designated smoking area for residents on Primrose Place, Clover Meadow and Lavender Vale.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	83

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 10 January 2024	09:05hrs to 19:10hrs	Bairbre Moynihan	Lead
Wednesday 10 January 2024	09:05hrs to 19:10hrs	Niamh Moore	Support

What residents told us and what inspectors observed

Inspectors observed that many residents chose to spend time in the numerous communal areas available for their use and staff were observed supervising these areas throughout the inspection. For residents' who chose to mainly spend their day in their bedroom this was supported with staff observed going to individual rooms to provide supervision, a chat or assistance with meals. Residents praised the staff team, with comments such as "the staff are great", with another resident reporting that they "have us all spoiled". Overall visitors spoken with were complimentary of the service their relative received, with one family member reporting that the staff were very caring towards the residents and treated them like a family member.

Inspectors observed that visitors were an integral part of the lives of the residents within St Colman's. For example, a visitor was observed joining their relative for the lunch-time meal within the centre. Inspectors were informed of two further occasions where families were supported by the management and staff team of the designated centre, including organising and facilitating the Christmas Day celebrations.

Inspectors saw activity planners across the designated centre which detailed with activities on offer Monday to Sunday. However, these schedules were dated August 2023. Inspectors observed the staff on one unit providing music for the residents which residents appeared to enjoy. There were limited group activities across all three units on the day of the inspection. Inspectors observed that a small number of residents attended snoezelen therapy as per the activity schedule on the day of the inspection.

The centre's oratory was located on the ground floor, and was found to be a calm and inviting space. Inspectors were informed that a Roman Catholic priest attended the centre twice a week to celebrate mass and a Church of Ireland reverend attended once a week. Inspectors observed mass taking place on the afternoon of the inspection with good numbers of residents in attendance. In addition, this space was also used for end-of-life ceremonies for some of the residents who had died.

The centre had access to transport with a bus and mini-bus available. The registered provider had an initiative where training was offered to staff to be eligible to drive these vehicles. This led to residents' being supported to attend outings such as a recent shopping trip and to attend outpatient appointments. Residents told inspectors how they enjoyed these outings and one resident was planning a trip to a local shop on the day of the inspection.

Inspectors viewed a number of residents' bedrooms and found they were personalised, with items such as photographs, ornaments and furniture. Overall residents were positive about their bedrooms, however one resident said they would like access to more storage space for their belongings. Inspectors observed that the rights to privacy and choice of some residents were negatively impacted by the

layout of the multi-occupancy rooms. This will be further discussed within this report.

Residents were consulted about the service through resident meetings. The statement of purpose outlined that residents' meetings should be held monthly. Furthermore, the dates for the meetings were on display on the noticeboards. However residents meeting minutes after July 2023 were not available.

The dining experience was observed in all three units. There were sufficient staff on duty to provide assistance to residents if required. Residents were provided with a choice at mealtimes and were complimentary about the food. Mealtimes were a social occasion with residents and staff interacting with each other.

Overall, the premises was warm and appeared to be clean. There were efforts to create a homely environment evident, however the wear and tear to the premises in some places had the potential to impact on the effective cleaning of these areas.

Capacity and capability

This was an announced inspection carried out following receipt of the application to renew the registration of the centre by the registered provider. The inspection was carried out over one day to monitor ongoing compliance with the regulations and standards and to follow-up on actions from the inspection in April 2023. Some areas were actioned. For example; trending of incidents was taking place, trends were discussed at the integrated quality, risk and safety meeting and actions to mitigate the risks identified. In addition, store rooms in Primrose Place and Clover Meadow were reviewed with new enclosed storage spaces for residents' clothes installed. However, some actions were either not implemented or sustained. For example; gaps remained in the directory of residents and residents in Primrose Place and Lavender Vale could not access their storage space privately. Notwithstanding this, St Colman's Residential Care Centre had effective governance and management systems in place ensuring that good quality person-centred care was delivered to residents. Improvements were required in Regulations 16: Training and staff development, 19: Directory of residents, 21: Records, 23: Governance and management and 4: Written policies and procedures.

The registered provider of St Colman's Residential Care Centre was the Health Service Executive (HSE). The person in charge reported to the manager for older person services, who in turn reported to the head of service in CHO6. The manager for older person services attended the feedback meeting at the end of the inspection. The person in charge was supported in the role by two assistant directors of nursing, clinical nurse managers on each unit, staff nurses, healthcare assistants, catering, household, activities, laundry, administration and maintenance staff. Inspectors were informed that a number of vacancies existed in the centre due to the recruitment embargo implemented by the health service executive. Gaps between staffing levels and the statement of purpose included nine staff nurse

vacancies, a clinical nurse manager post, two bus driver vacancies and one porter. Management stated that they endeavour to meet the staffing levels on a daily basis through replacement with agency staff and the reallocation of staff within the centre. On the day of inspection there were sufficient staff on duty to meet the needs of the residents.

Inspectors reviewed the training matrix and found that staff were supported to access mandatory training for fire safety and manual handling. However, records showed that a significant number of staff required training in safeguarding and refresher training in infection control. Inspectors were informed that the registered provider was planning to review access to dementia training to enhance staff knowledge and skills. Nursing and care staff were supported and supervised in their work by clinical nurse managers who worked on each unit.

While inspectors observed that improvements had been made with the establishment of an electronic directory of residents, further action was required to ensure this directory fully met the criteria as required by the regulations

The annual review of quality and safety of care was completed for 2023. The review contained an improvement plan with areas for action including reconfiguration of the curtain rails in each unit with a timescale of 31 January 2024. However, residents were not consulted about the review. Systems of communication were in place between the person in charge and HSE management every two to three months and an integrated quality and safety meeting every three months. Multi-disciplinary meetings were held with the consultant geriatrician, general practitioner and management from the centre where residents were discussed. The registered provider completed audits on quality care metrics which included care planning and risk assessments. Audits identified issues. No time bound action plans accompanied them and the inspectors were informed at the feedback meeting that findings were reported back to staff in each unit. However, this required strengthening so the registered provider could identify if repeated issues were occurring. No infection control or environmental audits were provided on the day of inspection. One audit was submitted following inspection. Audit findings were similar to the findings on inspection, however, there was no action plan linked to the audit.

A sample of staff records were reviewed. Garda vetting was in place and up to date in the majority of personnel files reviewed with the exception of one staff member. There was evidence that Garda vetting was in place prior to the commencement of employment. The professional registration of staff, where applicable, was in place and up to date. The registered provider had introduced an employment record history. Gaps were identified in the employment history of one staff members' file.

Inspectors reviewed the centre’s complaints log and noted that there was a low level of complaints received within the centre. There was one open complaint on the day of the inspection which was being reviewed in line with the centre’s complaints policy. Inspectors found that the records of verbal complaints received during residents' meetings required improvement. This is further discussed under Regulation 34.

A number of policies and procedures required review under Schedule 5 of the regulations were not available for review on the day of inspection. This is detailed under Regulation 4: Written Policies and Procedures.

Registration Regulation 4: Application for registration or renewal of registration

A completed application was submitted within the required time frame for the renewal of the registration of the centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge fulfilled the requirements of the regulations. They had the appropriate experience and qualifications.

Judgment: Compliant

Regulation 15: Staffing

Due to the national embargo on the recruitment of staff within the Health Service Executive management informed the inspector about a number of staff vacancies in the centre. However, on the day of inspection the registered provider ensured that the number and skill-mix of staff was appropriate having regards to the needs of the residents and given the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Gaps were identified in training and staff development. For example;

- Twenty three per cent of staff required refresher training and fourteen per cent of staff had not yet completed safeguarding training.
- Forty per cent of staff required refresher training in infection control.

These gaps could impact on the safety of residents living in the centre and on the

quality of care delivered to them.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents did not meet the criteria as set out within Schedule 3 of the regulations as it did not include the following information:

- The address and phone number of the next of kin for each resident.
- If the resident was 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 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

A sample of staff files were reviewed. A small number of gaps were identified:

- One file did not contain Garda vetting. Management stated that this was held centrally within the HSE and this was requested while the inspector was onsite.
- One staff personnel file contained gaps in the staff members employment history.

Judgment: Substantially compliant

Regulation 23: Governance and management

While the registered provider had a number of assurance systems in place regarding the quality and safety of the service, a number of areas were identified that required action:

- The annual review of the quality and safety of care was not prepared in consultation with the residents and their families.
- Audits submitted following inspection did not contain a time bound action

plan.
- Issues identified on previous inspections regarding residents personal storage and privacy had not been addressed.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place, however this required further review to ensure it met the criteria as required by S.I. 628 of 2022. For example; the complaints procedures did not contain the timelines outlined in the regulation for responding to complaints.

Inspectors were not assured that all complaints received and the outcomes of any investigations into complaints were fully and properly recorded. Inspectors saw evidence where two complaints were raised in a resident's meeting. However, information on both complaints could not be located on the day of the inspection and information relating to one complaint was recorded in different places such as within care record notes.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Not all policies required by schedule 5 were available for review on the day of inspection in line with regulatory requirements. For example;

- Health and safety, including food safety of residents, staff and visitors and the recruitment selection and Garda vetting of staff.
- "The creation of, access to, retention of, maintenance of and destruction of records" policy was not centre specific and was not dated.
- "The ordering, receipt, prescribing, storing and administration of medicines" policy for residents was not available with a note stating it was currently being updated.

Judgment: Not compliant

Quality and safety

Overall, residents had a good quality of life in St Colman's Residential Care Centre

and were encouraged to live their lives to their own capabilities. Residents were supported to access appropriate health care services in line with their assessed needs and preferences. Residents had regular medical reviews and were referred for appropriate expert reviews by health and social care professionals when required. Non compliance was identified in Regulations 17: Premises and 9: Residents' Rights.

Management informed inspectors that plans were in place to build a new designated centre, however, in the intervening period ongoing maintenance of the centre was required. Inspectors observed and noted some improvements to the premises had occurred since the last inspection as discussed under capacity and capability and for example; wall cladding was installed in a sluice room and shelving within store rooms. However, further action was required to ensure all areas of the premises complied with the regulations. For example; paint work on corridors and on door frames throughout the centre was chipped exposing the brick work and the flooring appeared uneven in a section within the physiotherapy room in Lavender Vale. Meeting minutes identified that the person in charge had escalated the requirement for the painting of the centre for infection prevention and control purposes at a HSE management meeting. In addition, the current configuration and layout of the multi-occupancy bedrooms required action by the registered provider.

The centre was generally clean on the day of inspection. The registered provider had identified a number of infection control link nurses who had undertaken the required training. A new post was sanctioned for the centre for a household manager. This person was in post at the time. Household staff were knowledgeable about their role. Hand hygiene sinks compliant with the required specifications were in place throughout the centre. At the time of inspection, there was a confirmed outbreak of COVID-19 in one of the units. Inspectors viewed the current management of this outbreak and found safe procedures were in place. Residents were cohorted into a multi-occupancy bedroom with door signage displayed to alert staff that infection control precautions were required. Inspectors also observed there was sufficient personal protective equipment (PPE) available for staff and visitors' use.

The risk management policy was requested prior to the onsite inspection and was reviewed. The policy did not contain all of the specified risks outlined in the regulations and the measures and actions in place to control the risks. The Emergency plan was reviewed. This contained details on, for example; how to respond to a fire alarm. However, the plan did not include how to respond to a power outage and loss of heating. The centre had two power outages and loss of heating once since the inspection in April 2023.

Staff had up-to-date fire safety training and in discussions with inspectors were aware of how to respond if there was a fire. Inspectors saw that two new fire doors were in place within the Lavender Vale unit. A review of documentation showed that regular fire drills were occurring including the completion of a fire drill based on large compartments with night time staffing levels. However, inspectors noted that there were large compartments throughout the designated centre and while these drills were occurring weekly in one unit, they were not taking place weekly in the other units. There was evidence from meeting minutes reviewed that the fire officer

was onsite had recommended the replacement of two fire doors which was complete. Despite some fire safety measures in place, inspectors found that further action was required to fully protect residents from the risk of fire. For example, furniture and resident equipment were stored in some fire exit routes and not all fire doors were closing on the day of the inspection. In addition, some individual residents' personal emergency evacuation plans (PEEPs) had not been updated when any changes to the residents' care needs had occurred.

Inspectors reviewed a sample of residents' records such as pre-assessments, assessments and care plans. Records showed that assessments were carried out prior to residents being offered a place in the centre. Care plans were observed to have been developed within 48 hours of the residents' admission, and inspectors found that care plans were reviewed at intervals not exceeding four months. Overall, inspectors were assured that the care delivered to residents within the designated centre was of a good standard by a dedicated staff team who were knowledgeable about residents' needs, however improved oversight was required to ensure that care records were managed consistently across the designated centre. For example, not all assessments had been reviewed within the last four months and some care records observed did not contain information to guide staff. This is further discussed under Regulation 5.

The registered provider updated the restraint register twice daily. The use of restrictive practices in the centre was high with almost one in three residents using a bed rail. This was not in line with the national guidance for promoting a restraint free environment. A risk assessment was undertaken prior to applying a restrictive device or practice. Less restrictive alternatives were not always trialled in line with the national guidance and the centre's own policy. Other potentially restrictive devices such as with-holding of residents' cigarettes and lighters were not identified as restrictive and required review to ensure they were not impacting on the freedom of residents. Some residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). These residents were supported by a person-centred and consistent approach to managing responsive behaviours. Behavioural assessments were completed and informed an holistic approach to managing residents' responsive behaviours. Inspectors observed person-centred and discreet staff interventions during the inspection.

Inspectors observed staff being patient and kind to residents, and residents reported being happy living in the centre. Residents were supported to access independent advocacy services as required. Inspectors saw that residents had access to newspapers and magazines, however access to wireless internet was not yet available. This was identified on the last two inspections and had not been actioned. Due to the older premises and configuration of the multi-occupancy bedrooms, inspectors found that not all residents' rights to choose was respected. For example, inspectors were told that a unit had a dedicated isolation room which facilitated piped oxygen if required. This meant that if there was an outbreak on this unit, residents in this particular room had to move out of their room to facilitate the isolated residents. In addition, despite a repeat finding from previous inspections and costings received dated February and March 2023, no action had been taken to

reconfigure privacy curtains in multi-occupancy rooms. Examples of how the current layout impacted on residents' rights is outlined under Regulation 9.

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations. For example;

- General wear and tear was noted throughout the centre including chipped skirting and doors. The ledge over many of the radiators in Primrose Place and Clover meadow were excessively chipped and the flooring in Lavender Vale was in a state of disrepair.
- Inspectors reviewed the floor space allocated to residents in some of the multi-occupancy bedrooms within Lavender Vale and saw that a number of these floor spaces measured less than 7.4m2 with measurements taken on the day of inspection ranging between 4.2 – 5.2 m2. In addition, many resident floor spaces seen did not include the space occupied by a bed, a chair and personal storage space, for each resident of that bedroom.
- The conservatory was uninviting with damaged furniture. No residents were observed here during the inspection.
- Some doors did not have appropriate signage in place. For example, a store labelled as a linen room was used as a store room for documentation.

Judgment: Not compliant

Regulation 26: Risk management

The risk management policy provided to inspectors was not in line with the regulation. For example; the policy did not contain the measures and actions in place to control two of the five specified risks - abuse and the unexplained absence of a resident.

The registered provider had an emergency plan in place but this was not sufficiently comprehensive to respond to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

Judgment: Substantially compliant

Regulation 27: Infection control

Inspectors observed that the centre was clean on the day of inspection, however,

improvements were required in order to ensure procedures are consistent with the national standards for infection prevention control in community services. For example;

- A bed pan washer in Lavender Vale was not working on the day of inspection. This is repeat finding from the last three inspections.
- Chairs and tables in the conservatory were worn, torn and damaged. This did not aide effective cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider did not have sufficiently reliable arrangements in place to monitor fire doors and evacuation routes to ensure that they were kept clear of all obstructions. For example:

- Storage of furniture and resident equipment was noted within escape routes, including two sets of dining room tables and chairs. Residents and visitors were observed to have their lunch within this area on the day of the inspection. This meant that this escape route was not free of obstruction.
- Two sets of fire doors were not fully engaging. Deficits to fire doors means that fire doors are not capable of restricting the spread of smoke and fire in the event of a fire. The inspector was informed at the end of the inspection that the doors that were affected were rectified

In a sample of residents' Personal Emergency Evacuation Plans (PEEPs) reviewed, two had not been updated to reflect changes in residents' conditions. In the event of a fire the PEEPs did not provide enough detail on residents' current needs to guide staff when evacuating the residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The registered provider had not ensured that all care documentation was reflective of the resident's current and assessed care needs. This could impact on how the designated centre arranged to meet the needs of the resident's concerned. For example:

- A resident with an identified safeguarding need did not have a relevant care plan to ensure preventative measures were in place.
- A nutritional risk assessment was miscalculated resulting in an incorrect assessment of their nutritional status..

- A smoking care plan did not provide sufficient detail or information to effectively guide staff on how to respond to the residents' required support needs.
- The recording of wound dressings was not always documented in the wound dressing charts. Some dressings were recorded on the chart and some were recorded within resident care notes and nursing handover documentation. This had the potential for mis-communication, of when the recommended wound dressings were due to occur and that trending of progress could not be completed.
- A responsive behaviour care plan did not clearly outline the triggers which may lead to a resident's anxiety and how staff were to manage and respond to the behaviour.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to medical and healthcare based on their needs. A medical officer attended the centre for 15 hours a week. Residents who required specialist medical treatment or other healthcare services, for example; speech and language therapy and or physiotherapy, could access these services in the centre upon referral. There was evidence from review of residents' records that residents were reviewed when referred. Residents weights and observations were completed at least monthly or more frequently if required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Actions are required under Regulation 7 to ensure compliance with the regulation and national policy. For example;

- Similar to findings from previous inspections, the use of bed rails was high, with 27 of 83 residents using restrictive bed rails on the day of inspection. This was not in line with the centre's policy or the national policy on promoting a restraint free environment. Furthermore, while residents and or their care representative had signed consent forms for bedrails there was no evidence that any discussion on the risks associated with bedrails had taken place.
- Not all restrictions in the centre were identified and risk assessed. For example; inspectors were informed of two instances where residents cigarettes and lighters were held by nursing staff. While these were held for safety reasons, it was not identified as a restriction and risk assessments had

not been completed.
- Staff had undertaken training in how to respond to behaviours that challenge, inspectors were informed that staff had not completed training in managing the behaviour.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Inspectors were not assured that all residents had opportunities to participate in group activities. There was one dedicated activity staff member to facilitate activities across all three units. There was limited activities occurring on the day of the inspection. This is a repeat finding from the last inspection.

Due to the layout and configuration of multi-occupancy bedrooms, Inspectors were not assured that residents' rights to undertake personal activities in private and to retain control over their environment was always respected. For example:

- In some bedrooms, residents' privacy curtains did not fully close; for example; in one triple bedroom viewed and in a number of resident bed spaces in Clover Meadow. This did not provide residents with sufficient privacy around their floor space and with dignity while carrying out personal hygiene.
- The position and placement of the television within some multi-occupancy bedrooms did not provide all residents with access to the television. For example, if a resident within some of the two person rooms, had their privacy curtain closed, the other occupant of the room could not see the television.
- Some residents' wardrobes remained outside their personal space. This meant that residents had to leave the privacy of their personal space in order to access some of their belongings, at times having to enter another residents' personal space to access their wardrobe. For example; one resident in each of the four bedded bays in Primrose Place and residents in Lavender Vale had to enter another resident's bedspace to access their belongings. In addition, the placement of some clinical hand wash sinks within bedrooms also required staff members to enter a residents' bedspace while the curtains were closed.

Improvements were required in how the centre consulted and supported resident participation in the organisation of the designated centre. Inspectors were told that residents' meetings had not occurred monthly as outlined within the centre's statement of purpose. Records reviewed showed the last residents meeting occurred in July 2023.

Similar to findings from the last two inspections, residents in the centre did not have access to WiFi.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially 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 9: Residents' rights	Not compliant

Compliance Plan for St Colman's Residential Care Centre OSV-0000492

Inspection ID: MON-0042093

Date of inspection: 10/01/2024

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: Identified as gap in training matrix. Training Certificates received are uploaded to the system as soon as possible to ensure an accurate training matrix. The information viewed on the date of Inspection was not a true reflection of the training status of our staff team. Additional staffing has been allocated to the Centre from Monday 19th February 2024 to support this (Grade V – 1.0WTE) and ensure training records are maintained in an up to date fashion. Centre management is carrying out a review of these training records and have advised that this will be in compliance by 31st March 2024.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: Schedule 3 requirements will be accurately gathered on system by identified inputter New practice of transfer capture by discharge form on exit/admission form on return to the Centre effective immediately. Deaths and cause shall be captured and updated weekly. Name /address of authority/organization/body from where resident was admitted to be captured on initial input. Paper based directory of residents has been updated and will be maintained reflective of our Residents Register.	

The General Manager is engaging with care software companies to introduce an electronic system for admin and nursing care in the coming months. Phase 1 will see the introduction of the admin role of the software that will provide for an electronic directory of residents. Estimate completion for phase 1 is 30th June 2024.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Of the two examples identified during Inspection, one was in respect of non-provision of evidence of Garda Vetting. This was requested the next working day and has subsequently being received from the GVLO. Appropriate evidence of GV now on file.

The second example related to the employment information pertaining to the PIC, which was returned next day post inspection by the Provider.

On commencement of all new staff, the Centre will continue to request copies of staff files and associated documents from the central HR service to ensure staff files remain up to date in the Centre.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Residents Survey for December now circulated and results will inform Annual Quality Review and Safety from both Residents and Family perspectives due to develop action plan upon publication of results for implementation by the 30th April 2024.

Audits review by the team will contain an action plan and projected time frame for completion. Learning and discussion of outcomes will be finalized at IQRS meeting quarterly.

All shared occupancy spaces will be reviewed to ensure appropriate delineation of bed spaces and adequate storage/wardrobes spaces. To ensure minimal disruption to residents this work will be completed on a phased basis over the coming months. Estimated completion date 28th June 2024. This date has been negotiated with the curtain supplier and technician for installation and alteration of curtain rails. Additional storage units will be supplied and fitted.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All complaints received are acted upon promptly in an effort to resolve the complaint at the earliest possible juncture. Our policy will be amended to ensure timeframes (minimum) for response to complainants are clearly set out. Each complaint when received is recorded and the resolution of same recorded as an action where necessary and appropriate.

New CHO6 complaints recording electronic system, input/informed locally by complaints officer on site for record keeping, shared learning and networking with wider CHO6 complaints committee through Divisional Integrated Quality & Risk Forum.

All complaints are managed in line with national HSE Complaints Policy. All Stage 1 complaints are managed locally and responded to the complainant verbally where appropriate. All stage 2 and above complaints are responded to formally in writing in line with policy. Opportunities for external (to service) review are set out clearly within our local policy.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
All policies (as set out under Regulation 4) during time of Inspection have been updated. A systemic review/update of all further policies within the Centre is underway with a plan to have same completed by the end of Q 1,2024

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A regular review of maintenance/infrastructural upgrade is in place which inform ongoing

maintenance plans and the minor capital investment program for 2024 for the Centre. The areas identified during the Inspection form part of the minor capital investment programme the Centre during 2024.

A clear escalation pathway to the PPIM and the Provider Representative is in place where said works on not completed to an agreed schedule and/or where additional priority works are required.

A review of two twin rooms in Lavender Vale as identified by the Inspector has been completed. These two rooms will be reduced to single occupancy and will be reconfigured in line with the curtain rail project to ensure the minimum requirement of 7.4m2 is met. This will require negotiation with existing residents, as a resident will have to move from each room. An updated Statement of Purpose and Application to Vary will follow immediately on completion of negotiations with Residents affected. Estimated completion date at this point is the 28th June 2024.

Work is ongoing in the conservatory and will be set up with new furniture to enhance area for residents.

Improvement works, including internal painting program will continue within the Centre in the coming months while ensuring minimal disruption to residents. Estimated completion date for enhancement works is 30.09.2024.

It should also be noted that the tender for the construction of a new Centre has been published on e-Tenders, with tender return date set for the 11th of April 2024.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Risk Management policy updated to include identified gaps as noted by Inspector. Update completed 31.01.2024. The policy will be further reviewed at the Divisional Quality & Patient Safety Forum.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

Bed pan washer Lavender Vale removed and replaced by macerator on 08.02.2024
2nd Macerator removed and replaced on Heather Rest on 08.02.2024
Planned pro-active maintenance schedule for water/waste extraction system agreed on a 3/12 basis by PPIM to ensure integrity of operation of said systems.

Conservatory for upgrade works under maintenance review and pricing for total re-vamp and furniture replacement. Expected completion date. (51/05/2024)

The Registered Provider Representative has also enabled external site-specific IPC Audits, two of which have taken place over the last 6 months. These audits form the basis for further improvements from an IPC practice perspective while also informing areas for investment in infrastructure and equipping.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire doors are checked daily on each unit to ensure safe egress and compartmentalisation in the event of a fire – check list at unit level recorded and available for inspection.
Fire Doors on weekly test activated and monitored for any deficits and reported immediately to maintenance as recorded in maintenance request log.

Personal Emergency Evacuation Plan (PEEPS) are updated as part of readmission policy for residents on return to Centre ensuring changes to physical health and ability are captured.

The Centre regularly initiates emergency evacuation procedures, records of which are reviewed and maintained to enable appropriate emergency response from staff. These are further reviewed, discussed at the Quality & Risk Committee meetings and with the HSE's Fire Officer where external professional audit is necessary/desirable and indicated through evacuation records.

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 are individually developed for each resident following initial and ongoing

assessments. The resident and MDT are consulted regularly and care plans are updated as residents needs change.
Care plans of residents identified on the day of inspection have been reviewed and updated. Ongoing oversight of care plans will continue with local managers and essential review mechanisms and timeframes will be re-enforced with all Clinical Nurse Managers and AHP's at the Centre

The PPIM is engaging with care software companies to introduce an electronic system for admin and nursing care in the coming months. Phase 1 will see the introduction of the admin role of the software. Estimate completion for phase 1 is 30th June 2024. Phase 2 will proceed with the nursing care element of the software with a completion date of 30th September 2024.

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:
All staff undertake mandatory education in Crisis Prevention and Intervention- this covers behaviors and how to manage de-escalation. How to intervene and prevent behavioral responses causing risk to other service users, relatives and staff.
Additional education facilitators have been increased within the Centre on needs analysis assessment with activity of incidents recorded and managed. Trends have supported this development. Three further staff have completed training to support previous staff involved.
Restrictive practice care planning reviews identified from inspectors analysis.
Additional resident-specific person centered care plan development when risk factors affecting the full unit of residents has been identified. A full MDT Approach utilised, this enables onsite training and intervention, together with training/learning from specific incidents and events in line with incident management framework. Ongoing.

A bed rail review will be carried out on the 27 residents who currently use bed rails. This review and associated actions are due to be completed by 30th April 2024. The PIC will ensure full MDT review/audit with specific alternatives trialed and recorded where the use of beds rails is maintained

The outstanding restrictions that had not been risk assessed have been completed. Care plans have been reviewed, risk assessments updated, restrictions have been added to the restraint register and will be included in quarterly returns going forward.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Programme of group activities available – on occasion, residents' preference is not to engage and this is respected as was the case on day of inspection. Activities timetable is reviewed regularly in line with resident preferences.

Since the Pandemic Residents have shown a reluctance to engage in larger group activities and the service has responded to this with additional individualised activities for some residents.
Records show individual activity up take has grown these are available to view by Resident.

Resident's personal space, wardrobe, locker have been put in place since previous inspection.
On a phased basis, a total review of multi-occupancy spaces will be undertaken in a collaborative approach coordinating all aspects of curtain rail replacement and location. Furniture relocation in an attempt to maximize the resident space to meet their requirements as long stay residents. It is planned to complete these works by the 28th June 2024.

Residents' opinions are sought through Satisfaction Survey, committee meetings so that inclusivity is key to development of the Centre. Residents and their families are also encouraged to engage with staff and highlight where their preferences are not being met towards formulating an overall plan for the Centre under this Regulation.

Wi-Fi is currently being installed in the Centre. Technicians are currently on site installing internal network to support same. This is planned to be complete by the 15th April 2024.

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(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	28/06/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	27/02/2024
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	Substantially Compliant	Yellow	27/02/2024

	the Chief Inspector.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	28/06/2024
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	27/02/2024
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Substantially Compliant	Yellow	27/02/2024
Regulation 26(2)	The registered provider shall ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.	Substantially Compliant	Yellow	27/02/2024

Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	27/02/2024
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.	Substantially Compliant	Yellow	31/01/2024
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.	Substantially Compliant	Yellow	31/01/2024
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and	Substantially Compliant	Yellow	10/02/2024

	concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.			
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	31/01/2024
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred to at paragraph (c).	Substantially Compliant	Yellow	31/01/2024
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and concluded, as soon as possible and no later than 20 working days after	Substantially Compliant	Yellow	31/01/2024

	the receipt of the request for review.			
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Substantially Compliant	Yellow	31/01/2024
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	31/01/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	27/02/2024
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs	Substantially Compliant	Yellow	27/02/2024

	of each resident when these have been assessed in accordance with paragraph (2).			
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	27/02/2024
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	30/04/2024
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	Yellow	27/02/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other	Not Compliant	Orange	27/02/2024

	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	Orange	28/04/2024
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may communicate freely and in particular have access to radio, television, newspapers and other media.	Substantially Compliant	Yellow	15/04/2024
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	27/02/2024