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:	Virginia Community Health Centre
Name of provider:	Health Service Executive
Address of centre:	Dublin Road, Virginia, Cavan
Type of inspection:	Announced
Date of inspection:	12 January 2024
Centre ID:	OSV-0000503
Fieldwork ID:	MON-0033594

About the designated centre

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

The designated centre provides 24 hour nursing care to 56 residents, both male and female who require long-term and short-term care (assessment, rehabilitation convalescence and respite). The centre is a two storey extended building located on a greenfield site. The philosophy of care is to provide a caring environment that promotes health, independence, dignity and choice. The person centred approach involves multidisciplinary teamwork which aims to embrace positive ageing.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	48

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
Friday 12 January 2024	09:20hrs to 17:20hrs	Michael Dunne	Lead

What residents told us and what inspectors observed

Residents told the inspector that they were happy living in the designated centre and that staff were kind and caring. Residents said that they felt safe and secure in the centre and could talk to any member of the staff team if they had a concern or when they needed staff support. Notwithstanding the positive feedback the inspector found that there were a number of areas of the service that required actions to ensure the service provided met the assessed needs of the residents. These areas are discussed in more detail under the relevant regulations and under the themes of Quality and Safety and Capacity and Capability.

Upon arrival the inspector was guided through the centre's infection prevention and control procedure which included symptom checking, the use of personal protective equipment (PPE), the centre was in a COVID-19 outbreak at the time of this inspection. Following an introductory meeting with the provider and the person in charge, the inspector commenced a tour of the ground floor with the provider. As there was an infection present in the centre, there was no cross over of staff or residents from the ground to the first floor.

The inspector met and spoke with several residents in the course of the inspection. Overall, the feedback from the residents and their family members was positive with regard to the standard of care provided. In addition 50 resident questionnaires had been completed whereby residents were asked for their views on food, their bedroom, access to visitors, their rights, the provision of activities, their views on the care and support received, the staff and on complaints. Over 80% of residents were supported by staff to complete the questionnaire while the remained were completed with residents family members or friends. The majority of responses to all of the questions asked were positive, for example residents said,

"Food is excellent, I can order what I want", "Food is served at a time that suits me" while residents expressed gratitude towards the staff, some comments included, "Staff are excellent, I can ask for anything its not a problem" , " Staff are generous and kind". " I feel safe".

The inspector observed a number of staff and residents interactions throughout the day, residents who had communication needs were supported by staff in a positive manner. Resident's were given time and space to make their views known and it was clear that staff were aware of residents communication needs. Staff were therefore able to respond to those needs in a constructive manner. Residents who walked with purpose were supported by staff in a dignified manner and this approach was seen to reduce potentially challenging situations and maintain the safety of those residents.

All visitors were required to follow necessary checks upon entry to the centre which incorporated the completion of infection prevention and control procedures, such as mask wearing and hand hygiene. Residents as mentioned earlier remained in their

own unit however the free movement of residents on the ground floor was compromised due to a door to a communal area found to be locked. This was brought to the attention of the person in charge who addressed it on the day so that the door was opened and residents could access this room as they wished. Virginia Community Health Centre was warm and comfortable and there was a calm atmosphere in the centre. The centre was located in a two-storied building in the outskirts of Virginia town. There are wheelchair-accessible ramps and lifts to connect the two floors and support the residents to access different floors of the centre independently.

Bedroom accommodation comprised of single and double occupancy rooms. Resident had access to bathing facilities in either en-suite or communal bathrooms. Resident bedrooms were decorated with personal items such as family photographs, and other personal items. All residents had access to a lockable facility in their bedrooms to store the valuables securely. Residents told the inspector that their bedrooms were comfortable and met their needs.

The activity schedule on the first floor offered residents a range of activities which included involvement in, reading newspapers, beauty treatments, religious services, sing along, bowling, one to one supports and hand massages. Staff were actively engaged in assisting residents engage in these activities and it was obvious that residents enjoyed spending their time involved in these pursuits. This was in contrast to residents accommodated on the ground floor unit who did not have access to activities on the day of the inspection and spent long periods of the day in their bedrooms watching television.

Residents told the inspector that they enjoyed the food. A lunch meal service consisted of options of poached salmon and shepherds pie. Resident's were observed enjoying their meal and were offered timely support with their eating and drinking. There was good interaction observed between staff and residents which added to a nice meal experience.

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

Capacity and capability

This inspection found that the oversight and governance systems that are in place required review to ensure that residents were able to enjoy a good quality of life in which their preferences for care and support were upheld and promoted.

This was an announced inspection carried out to monitor compliance with the Health Act 2007 Care and Welfare of Residents in Designated Centres for Older People)

Regulations 2013 as amended. The inspector also followed up on the compliance plan actions that the provider had committed to take to address the findings of the previous inspection in January 2023.

While the provider had implemented several actions as part of their compliance plan to maintain and improve compliance with the regulations, there were some areas of the service where sustained focus was now required to bring the centre into full compliance.The registered provider of the designated centre is the Health Service Executive (HSE). A service manager represented the provider during the inspection. The management structure of the designated centre comprises of a director of nursing, a person in charge and clinical nurse managers, nurses, healthcare assistants, catering, and housekeeping staff, while the centre had access to maintenance support who were based off site. There had been a change in person in charge since the previous inspection in 2022. The current person in charge has been in the position since September 2023 following more than two months when there was no person in charge in the designated centre.

The registered provider had submitted an application to renew the registration of the designated centre. A statement of purpose was also submitted as part of the documents required to support this application. This document described the services made available by the provider in accordance with Schedule 1 of the Regulations. A review of this document confirmed that a number of amendments were required to ensure that this document accurately described the service provided.

The inspector found that the provider failed to ensure that there was sufficient staff available on the ground floor of the centre to provide a well-planned activity programme and as a consequence these residents were not in receipt of appropriate support to participate in activities that were of interest to them and in line with their capacities.

Records of staff training made available for the inspector to review were inconsistent and did not present a clear account of the level of training provided. Subsequent information provided indicated that mandatory training had been suspended due to recent outbreaks of infection in the designated centre. The provider confirmed that postponed training had been rearranged for February 2024.

Although there were oversight systems in place to monitor the quality of service provision, the inspector found that these were not effective. There was an absence of meeting records to indicate that information collected through quality assurance systems such as audits were subject to regular scrutiny on a sustained basis.

A sample of provider governance meetings held in September, October and November 2023 were made available for review. These meetings were generic in nature and did not provide sufficient information on the performance of the designated centre. Local management meetings were more specific to the centre and were found to review key performance indicators such as falls, Infection control, Medication, Fire and Health & Safety, however these meetings had not been held on

a regular basis and this meant that results from audits and monitoring reports were not followed up in a timely manner.

The provider maintained records of incidents and accidents in accordance with Schedule 4 of the Regulations however, one record of a resident who was admitted to hospital following a fall was not notified to the Chief Inspector.

A small sample of resident contracts for the provision of services were reviewed and although these documents met the majority of the requirements of Regulation 24, there were incomplete with regard to the identifying additional fees to be charged for services. In addition the amount of reimbursement payable to residents in the event of damage to their property were not completed.

There were a small number of complaints recorded for the period since the last inspection in January 2023. Of the two complaints recorded both had been resolved at an early stage of the providers complaints policy.

An annual review to report the manner and standard of services delivered from July 2022 to June 2023 was completed and available for review. While this document provided valuable information in relation to the centre's performance covering the period above, there was no evidence found that this document was developed in conjunction with residents and/or their families. This was a missed opportunity as such collaboration could have assisted in developing more targeted services for residents and address areas of concern.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider submitted a completed application to register 56 beds in the designated centre. The required information to accompany the application to renewal of registration was also received and included a statement of purpose and floor plans which represented the layout of the designated centre. accurately The required fee for the renewal of the registration was also submitted.

Judgment: Compliant

Regulation 14: Persons in charge

There was a person in charge who was solely employed in the designated centre and met the requirements as set out under Regulation 14. The person in charge was appointed to their current role in September 2023.

Judgment: Compliant

Regulation 15: Staffing

The registered provider did not ensure that there were staff available to support residents accommodated on the ground floor to engage in meaningful activities in line with their interests and capacities. Many of these residents had complex care needs and the lack of appropriate social interaction and stimulation was impacting on their quality of life.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to a comprehensive training programme which included induction training and ongoing mandatory training. However a review of staff training records found inconsistencies in the records. The oversight of staff training records required improvement and is addressed under Regulation 23.

Judgment: Compliant

Regulation 23: Governance and management

The inspector was not assured that the provider had made adequate arrangements to ensure that there was a succession plan in place so that when a person in charge left their position a suitably qualified and experienced person was available to replace them. This was evidenced by the gap of more than two months from June 2023 to September 2023 when there was no person in charge in position in the designated centre.

The inspector found some gaps in management systems currently in place to ensure the service provided is safe, appropriate, consistent and effectively monitored. These included,

· The oversight of the roster did not ensure that staff absences were covered and that staffing levels were maintained in line with the designated centre's statement of purpose.

· Staff training records did not present a clear and accurate account of staff training requirements in the designated centre.

· Audits did not identify the risk of storing clinical and non clinical items in the same location and therefore there was no action plan in place to address this risk.

· There was limited evidence of learning action plans following outbreak reviews being implemented in the centre.

· The oversight of fire safety precautions did not ensure that fire safety risks identified by competent persons were addressed in a timely manner.

· Formal resident meetings were not held on a consistent basis and as such the provider was unable to use resident feedback to monitor the quality and safety of the service.

Although there was an annual review of quality and safety of services provided to the residents, it did not incorporate resident feedback on their views on the service for the period July 2022 to June 2023.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspector reviewed three contracts for the provision of services and found that these contracts did not clearly indicate the following:

- Fees to be charged for additional services.
- The levels of reimbursement available for residents in the event of damage to their property.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose updated by the provider in January 2024 required amendment to include:

- An accurate account of the whole time equivalent numbers of staff working in the centre.
- Amendments to the narrative of how the provider meets the requirements of Regulation 34: Complaints.

Judgment: Compliant

Regulation 31: Notification of incidents

A statutory notifications was not submitted to the Chief Inspector in accordance with the requirements of Schedule 4 of the regulations: For example

A three day notification had not been submitted for a resident who required medical review in hospital following an incident that occurred in the designated centre.

Judgment: Substantially compliant

Regulation 32: Notification of absence

The registered provider gave notice in writing to the Chief Inspector that the person in charge of the designated centre would be absent for a continuous period of 28 days. Information included in the written communication indicated the duration of the absence and the expected return date of the person in charge.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider maintained an accessible complaint's policy and procedure, however there were some amendments required to ensure that this policy met the requirements of SI:628 which came into effect on 01 March 2023. For example, ensuring that this policy sets out clearly that the review officer will write to the complainant with the results of the review.

Judgment: Not compliant

Quality and safety

Residents living in this centre were receiving good-quality nursing and health care from a staff team that were aware of their assessed needs. However significant improvements were now required to ensure that residents with complex needs had access to meaningful activities and social engagement in line with their interests and capacities. In addition the inspector found poor compliance in relation to regulations covering fire safety, infection control and premises.

Overall, residents' assessed needs were being met through good access to a range of health care services and the provision of opportunities for social engagement. Residents who expressed a view said that they felt safe in the designated centre and that they could talk to any member of the staff team if they had a concern.

Residents had good access to a medical officer who visited the centre regularly throughout the week and there were arrangements in place for out of hours medical support. There was evidence of appropriate referral to and review by health and social care professionals where required, for example, physiotherapy, occupational therapy and speech and language therapist and chiropodist. Many of these services are based in the primary health care service based on the same campus. Residents also had access to specialist services such as psychiatry of old age and tissue viability nursing expertise from Cavan general hospital.

Care planning was of an acceptable standard, records reviewed confirmed that each resident had a nursing assessment and care plan in place. Residents support needs were assessed through validated assessment tools that informed the development of care plans. Care plans were reviewed in accordance with the regulations

For the most part the premises was suitable and well maintained. It was warm, comfortable and odour free. There were a range of communal areas available to residents which were tastefully furnished and contained suitable seating for residents to use. A walkabout of the centre identified a number of ceiling tiles which were damaged and required repair or replacement. In addition, there was leak damage found on a wall located on a link corridor which required repair and redecoration. The inspector was informed that maintenance personnel located in Cavan general hospital were leading on repairing this damage, however there was no resource identified and no clear time bound action plan in place setting out how and when this damage would be repaired.

While the provider addressed concerns identified on a previous inspection regarding the suitability and effectiveness of fire doors in the centre, this inspection found additional concerns in relation to effective fire stopping to prevent the spread of fire and smoke in the event of a fire emergency.

The provider had agreed to commission a fire safety risk assessment (FSRA) by a competent person following the last inspection held in January 2023, however significant delays have meant that a draft (FRSA) was only made available to the provider following this inspection. The draft report identified fire safety risks in relation to comparmentation in the centre. The draft report included some risks that the provider had been made aware of previously including the provision of additional emergency lighting and the expansion of the fire detection system to include the toilets. The provider was aware of these risks and they had been recorded on the quarterly fire reports carried out by their own fire maintenance provider. However no actions had been taken to address them at the time of the inspection.

The centre had experienced a number of outbreaks of respiratory infections since the last inspection which included two COVID -19 outbreaks. On the day of the inspection a COVID-19 outbreak was in present in the centre.

The inspector observed that staff were adhering to transmission based precautions, and there was signage in place to alert that was an outbreak was present in the centre. Information made available confirmed that the provider was in regular contact with the infection prevention control and the public health teams in the community to manage these recurring outbreaks. The provider made available a review summary of recent respiratory outbreaks in the designated centre. While this document provided information on how outbreaks were locally managed, the review failed to assess the effectiveness of current outbreak control measures in the designated centre or to identify any plans for improvement in how outbreaks could be managed more effectively.

The provider made available suitable training for staff in infection control and there was a high uptake of staff who had received training in outbreak and prevention management and in the cleaning and disinfecting of the environment and of resident equipment. On the day of the inspection the inspector observed an infection prevention and control training session on the management of bodily fluids. Despite, these infection prevention and control measures put in place by the provider, the inspector found recurring poor practices in relation to the storage of items used for clinical and non clinical use. This practice increased the risk of cross contamination in the centre. As a result the inspector was not assured that learning and improvements following recurrent outbreaks were being consistently implemented in the designated centre.

While there was an varied activity programme available for residents to attend on the first floor of the centre in line with their capacities and interests, the inspector found that due to staff absence appropriate support with activities was not available for residents residing on the ground floor on the day of the inspection. The inspector acknowledges that due to the current outbreak in the centre staff could not be redeployed from the the first floor to provide activities on the ground floor. However staff records showed that there were not staff available to support these residents on a number of other days on the roster. Furthermore resident records showed that their participation in activities was limited to occasional days.

In addition the inspector found that the rights of residents accommodated on the ground floor were further impacted by the locked door to a communal space which meant that residents who had capacity to access this area safely were not able to open the door impacting on residents' ability to move about their home freely.

The inspector was assured that residents were consulted about their daily choices such as what they wanted to wear and menu choices. Staff were observed offering choices to residents throughout the day. However the inspector was not assured that residents were adequately consulted and able to participate in the organisation of the designated centre as required under Regulation 9.

Regulation 17: Premises

A number of actions were required on behalf of the registered provider to ensure compliance with Regulation 17 and matters set out under Schedule 6 of the regulations, for example:

- A leak from the roof had penetrated the walls of one corridor. This area required redecoration.
- A number of ceiling tiles were damaged and required repair or replacement.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a risk management policy which met the requirements of the regulations. There was poor oversight and management of risk in this centre which is discussed further under the relevant regulations relating to governance and management, infection control, fire safety and premises.

Judgment: Compliant

Regulation 27: Infection control

The registered provider did not ensure that procedures consistent with the National Standards for Infection Prevention and Control in Community Services (2018) published by the Authority, were implemented: Evidence found on this inspection confirmed:

The storage of both clinical and non clinical items stored in the same location such as linen,resident toiletries, cleaning equipment and moving and handling equipment. Items stored on the floor in the store rooms meant that floors could not be adequately cleaned.
A clinical waste bin was not available in one of the sluice facilities.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had failed to put effective fire precautions in place including measures to identify and address fire safety risks in the designated centre. This was evidenced by;

· The provider arranged for a fire safety risk assessment to be carried out by a competent person in April 2023. At the time of this inspection the provider confirmed that they were in receipt of a draft report which was made available post inspection. A review of the draft report identified a number of fire safety concerns that the provider was already aware of but had not implemented an action plan to address the risks in a timely manner.

As a result the inspector found a number of not compliant finds in relation to the maintenance of building fabrics and building services, reviewing fire precautions and the testing of equipment. For example;

· Holes found in the ceiling of a store room that required fire stopping to stop the spread of smoke and fire

· There were holes in the ceiling tiles located along the corridor of one of the units which prevented effective fire stopping, creating the risk that fire and smoke could spread to other areas of the centre.

· Quarterly inspection reports identifying emergency lighting upgrades and the requirement for expanded coverage of the fire detection system to toilets had not been acted upon.

· Annual PAT testing(the testing of electrical appliances) had not yet commenced in the centre.

· Additional risks identified in a fire safety risk assessment indicated that a review of compartmentation is required to ensure that compartments provide the required level of protection in the event of a fire emergency. walls meet the roof to provide an effective compartmentation seal.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of records seen on inspection confirmed that residents had a pre-admission assessment completed prior to their admission to the designated centre. A range of suitable care plans were found to be developed for each resident based on their individual needs and following validated nursing assessments. Records reviewed also confirmed that care plans were completed for residents within 48hrs of their arrival in line with the regulations. Where residents were unable to fully engage in this process then relevant family were consulted.Care plans were reviewed every three months or as and when a significant change occurred in the residents' care needs.

Judgment: Compliant

Regulation 6: Health care

Residents had regular access to a medical officer as well as specialist treatment and expertise in line with their assessed needs. The medical officer visited the centre every day. There was also a system in place to access out of hours medical support. Specialist expertise was available via referral and included access to physiotherapy, occupational therapy, dietetic services, chiropody, and optician care. There was a well-established referral system in place for residents to access psychiatry of later life services.

Judgment: Compliant

Regulation 8: Protection

The inspector was satisfied with the measures the provider had in place to safeguard residents and protect them from abuse. Residents stated that they felt safe living in the centre. A review of three staff records found that all the required documents were in place for staff employed in the designated centre in accordance with schedule 2 of the Regulations.

The were arrangements in place to protect residents finances and the provider confirmed that they were acting as a pension agent for 16 residents living in the designated centre. A review of records made available confirmed that residents finances were managed in accordance with the providers Patient Private Property Accounts policy which meant that residents finances were maintained separate to that of the registered provider. Quarterly statements were available for residents and or their designated persons which showed credit and debit balances for the relevant period.

There was a robust system in place for residents to be able to access day to day monies held on their behalf. The system currently in use promoted resident access to their finances seven days a week.

There was a safeguarding policy in place to guide staff on how to manage a safeguarding concern and also on how to provide effective support to residents involved in this process. There were no open safeguarding concerns found on inspection.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector was not assured that residents were able to make choices in relation to where they spent their time as the door to a communal garden on the ground floor was locked and not accessible to residents without a key which was held by staff. There was no risk assessment or rationale provided as to why all residents were stopped from accessing their outside space which was an overly restrictive practice.

The inspector was not assured that residents accommodated on the ground floor unit had access to meaningful activities in line with their interests and capacities. This was evidenced by;

· Rosters showed that there was an absence of activity support for residents on one of the units which meant that residents were not offered the opportunity to pursue their group or individual interests on the day of the inspection. This was validated by the inspector's observations on the day of the inspection.

Furthermore records maintained by the provider to record activities provided on the ground floor unit were incomplete and as a result the inspector found that there were no evidence to show that activities were provided for these residents for a period of 5 days at the beginning of January 2024.

The inspector was not assured that residents were adequately supported to participate in the organisation of the designated centre. For example:

· There was only one resident committee meeting recorded from July 2023 until January 2024. This did not provide residents with an effective forum to provide feedback and be involved in decisions about the organisation of the designated centre.

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	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 32: Notification of absence	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Virginia Community Health Centre OSV-0000503

Inspection ID: MON-0033594

Date of inspection: 12/01/2024

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The provider will come into compliance with Regulation 15:Staffing as follows; • The Healthcare Assistant roster has been reviewed to incorporate a designated Healthcare Assistant to provide meaningful activities in line with Residents interests and capacity. This is clearly identified on the staff roster from 10:00 to 16:00hrs daily. These hours are replaced on the roster utilising regular agency staff. This commenced January 15th 2024. There are two other Health Care Assistants who work in the Designated Centre who have completed "Meaningful Activities" Training Programme. Where possible the Management Team will roster one of these HCA's to provide meaningful activities to the residents to meet their assessed needs. Support and supervision of HCAs providing meaningful activities to residents will be provided by the Clinical Nurse Manager.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider will come into compliance with with Regulation 23: Governance and Management as follows; • In the event of an unexpected or short term absence of the Person in Charge, one of the Clinical Nurse Managers in the Centre will deputise as Person in Charge, supported	

by the Service Manager and the Clinical Lead for Quality, Risk and Training.
• In the event of an extended of a planned absence of the Person in Charge, the Registered Provider Representative will submit all relevant H.R. forms, for the replacement of the Person in Charge in a timely and effective manner.
• The Designated Centre's roster oversight procedures have been comprehensively revised by the Service Manager and Person in Charge to ensure adequate coverage for staff absences, through the use of regular appropriately qualified agency staff, to ensure that staffing levels are maintained in accordance with the Designated Centre's Statement of Purpose.

• The Person in Charge and Clinical Lead for Quality Risk & Training have methodically reviewed the training matrix for the Designated Centre. As a result of this review Manual and People Handling training has been scheduled to take place in the Designated Centre on the 3rd April 2024. Two training sessions will be delivered on this day, which will accommodate 24 staff. This will bring the Centre into full compliance in this area. There is a plan in place in conjunction with the Centre for Nursing and Midwifery Education to deliver Basic Life Support training, awaiting confirmation of dates. The Person in Charge has linked in with the Acute Hospital training department to secure places for Basic Life Support, awaiting confirmation of same.

• Environmental and Infection Prevention and Control (IPC) audits have identified issues with storage practices in the Designated Centre. Actions to address these storage issues include:
Communicating to the maintenance department, who have sourced an external contractor who came to the Designated Centre on 19th February 2024 to review the storage requirement of the Designated Centre. Email communication of the 29th February 2024 from the external contractor, informing the person in Charge that materials required have been ordered, however there can be a lead in time of up to seven weeks for delivery of materials. Proposed date for commencement of works 1st April 2024 & proposed date of completion on the 15th April 2024.

• The Service Manager/ Registered Provider Representative developed an IPC action log, addressing all concerns from an IPC audit with took place on the 15th January 2024. All actions are clearly identified and timeframes for completion. This was sent to the Person in Charge on 21st February 2024. An update was provided on 4th March 2024, that 21 actions have been completed and closed out, two actions remain in progress, with expected completion date 6th March 2024.

• The Service Manager / Registered Provider Representative and the and Clinical Lead for Quality Risk and Training, attended a staff IPC meeting in the Designated Centre on the on February 23rd 2024 at 14:00hrs. This meeting chaired by the Person In Charge, to address IPC concerns, including inappropriate storage and outbreak management in the Designated Centre. All Staff have been reminded of their individual responsibility in maintaining storage and adhering to IPC standards.

• On the 29th February the Registered Provider Representative and the Acting Head of Service CHCDLMS, visited the Designated Centre and carried out and IPC governance walkabout/audit. It was noted that a number of the actions required on the above mentioned action log, have been completed and closed out and remaining actions are

being progressed and closely monitored by the Person in Charge.

• The Designated Centre currently have three IPC Link Nurses are in place, and a further Nurse has registered for upcoming IPC Link Practitioner Training on 4th - 8th March 2024. The Link Nurses carry out regular audits, utilising the MEG audit tool. Any identified issues or concerns are communicated directly to Clinical Nurse Managers and the Person in Charge.

• IPC is a standing agenda item at the Designated Centre's daily Safety Pause meetings on each unit. Records of any IPC issues /concerns/practices are recorded on the Safety Pause record sheet and actions required are identified, effective since February 25, 2024.

• Post outbreak reviews are carried out by the Person in Charge and the Designated Centre's management team in collaboration with the staff to enhance shared learning post outbreak. A copy of the review is posted on the staff notice board.

• Fire Safety: Following discussions and clarifications with the independent Fire Safety Consultant a revised Fire Safety Risk Assessment has been issued (dated Feb 2024) received by HSE Estates 01/03/2024. See attached.
• HSE Estates submitted a Capital submission applying for funding to address deficiencies, which has been approved on Thursday 29/02/2024.
• HSE Estates will now have to enter into a process to procure a designer to develop a schedule of works/detailed design and a tender package. Once this is completed, HSE Estates will then have to procure a contractor to complete these works in accordance with the National Financial Regulations.
• Unfortunately it is impossible to set timelines as we won't be in a position to dictate a programme for these works until a suitable contractor has been appointed. HSE Estates will endeavour to procure the designer in the coming weeks to commence the project.
• These works will then have to be completed in a phased controlled manner on the basis that this is a live environment, where the care and dignity of the Residents must take priority at all times.
• A schedule of Formal Resident meetings has been completed for 2024 and this has been provided to the inspector on the day of inspection, assuring adherence to the schedule even in the absence of the resident advocate. Minutes of these meeting will be recoded and actions required if any, will be actioned by the Person in Charge and the Centre's management team, in a timely manner, January 2024.
• When completing the annual review, the Person in Charge will actively engage with the Residents, to ensure that the review accurately reflects the resident perspectives on the quality and safety of care in the Designated Centre. This will be completed on 31st July 2024.

The provider will endeavour to ensure that the Risks identified within the Fire Risk Assessment are completed within the specified timeframes.
Amber Risks to be completed by February 2025 (12 months) and Green Risks (18 months) to be completed by August 2025.
The Provider is currently working with the HSE Estates Department in developing the scope of works required. Once this is completed the project will go to tender in line with the HSEs National Financial Regulations.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
The provider will come into compliance with Regulation 24: Contract for the provision of services as follows;

• The Designated Centre's Resident Contract has been updated to clearly indicate ;
That there is no fee charged for additional services provided by the HSE – 5th February 2024).
• The level of reimbursement available for Residents in the event of damage to their property
Is now included in the Residents contract -5th February 2024.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The provider will come into compliance with Regulation 31: Notification of incidents as follows;

• The Person in Charge submitted a retrospective NFO3, in respect of an incident which occurred in May 2023 on the 16th January 2024.
• The Person in Charge will ensure that all notifications are submitted to the Authority, via the Provider Portal, within the required timeframes.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The provider will come into compliance with Regulation 34: Complaints Procedure as follows;

• The Person in Charge and the Management team have reviewed the Designated Centre's complaints policy to ensure that the policy meets the requirements of SI: 628, which came into effect on the 1st March 2023. The Designated Centre's complaints policy now clearly sets out the review officers name and contact details and that the review officer will write to the complainant with the result of the review.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The provider will come into compliance with Regulation 17: Premises as follows; • External painting contractor has assessed the area where the roof leaked and penetrated the walls of one corridor. Remedial works to repair and paint same commenced and was completed on the 29th February 2024. • The Maintenance Department has been notified of ceiling tiles which are damaged and require repair or replacement. This will be completed by 30th April 2024.	

Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: The provider will come into compliance with Regulation 27: Infection Control as follows; • Spare clean, cleaning trolley is now stored in appropriate storeroom. • A full review of all storerooms within the Designated Centre, has been carried out by the Person in Charge, the Management Team, the Health & Safety Representative and the General Operative. Items no longer required in the Designated Centre have been removed and disposed of appropriately. • Communication has been issued to the maintenance department, who have sourced an external contractor who came to the Designated Centre on 19th February 2024 to review the storage requirement of the Designated Centre. Email communication of the 29th February 2024 from the external contractor, informing the Person in Charge that materials required have been ordered, however there can be a lead in time of up to seven weeks for delivery of materials. Proposed date for commencement of works 1st April 2024 & proposed date of completion on the 15th April 2024. This will ensure that items are no longer stored on the floor in the storeroom, therefore allowing for floor surfaces to be cleaned adequately.	

• A clinical waste bin was placed in the sluice rooms, on the day of inspection- 12.01.2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The provider will come into compliance with Regulation 28: Fire Precautions as follows;

• Following discussions and clarifications with the independent Fire Safety Consultant a revised Fire Safety Risk Assessment has been issued (dated Feb 2024) received by HSE Estates 01/03/2024. See attached.
• HSE Estates submitted a Capital submission applying for funding to address deficiencies, which has been approved on Thursday 29/02/2024.
• HSE Estates will now have to enter into a process to procure a designer to develop a schedule of works/detailed design and a tender package. Once this is completed, HSE Estates will then have to procure a contractor to complete these works in accordance with the National Financial Regulations.
• Unfortunately it is impossible to set timelines as we won't be in a position to dictate a programme for these works until a suitable contractor has been appointed. HSE Estates will endeavor to procure the designer in the coming weeks to commence the project.
• These works will then have to be completed in a phased controlled manner on the basis that this is a live environment, where the care and dignity of the Residents must take priority at all times.
• The Maintenance Department has been notified of holes in ceiling tiles, located along the corridor of one unit. This will be completed by 30th April 2024.
• The Registered Provider Representative has linked in with the Maintenance Department in relation to PAT testing of electrical appliances within the Designated Centre. An external contractor is being sourced to review and provide costing for same- 30th April 2024.

The provider will endeavour to ensure that the Risks identified within the Fire Risk Assessment are completed within the specified timeframes.
Amber Risks to be completed by February 2025 (12 months) and Green Risks (18 months) to be completed by August 2025.
The Provider is currently working with the HSE Estates Department in developing the scope of works required. Once this is completed the project will go to tender in line with the HSEs National Financial Regulations.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The provider will come into compliance with Regulation 9 : Residents Rights as follows; • The key of the door to the communal garden on the ground floor is now securely attached to the door with a chain and is accessible to Residents at all times. • The Healthcare Assistant roster has been reviewed to incorporate a designated Healthcare Assistant to provide meaningful activities in line with Residents interests and capacity. This is clearly identified on the staff roster from 10:00 to 16:00hrs daily. These hours are replaced on the roster utilizing regular agency staff. This commenced January 15th 2024. • Records of meaningful activities for Residents are recorded in the activity section of the EpicCare electronic records system. In addition a HealthCare Assistant activity record has been put in place to record and monitor meaningful activities provided by HealthCare Assistant in the units dining and sitting rooms each afternoon, Monday – Sunday inclusive. These records are kept in the activity folder at the Nurses station in each unit and are available to the inspector on request. • A schedule of Formal Resident meetings has been completed for 2024 and this has been provided to the inspector on the day of inspection, assuring adherence to the schedule even in the absence of the resident advocate. Minutes of these meeting will be recoded and actions required if any, will be action by the Person in Charge and the Designated Centre's management team, in a timely manner, January 2024. The PIC has convened a Resident Forum meeting on January 11th, 2024 attended by the resident advocate, with the subsequent meeting slated for March 7th, 2024. This will ensure that Residents are provided with an effective forum to provide feedback and be involved in decision about the organisation of the Designated Centre.	

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	15/01/2024
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.	Substantially Compliant	Yellow	15/03/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service	Not Compliant	Orange	31/03/2024

	provided is safe, appropriate, consistent and effectively monitored.			
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Orange	30/07/2024
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Substantially Compliant	Yellow	05/02/2024
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	15/03/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting	Not Compliant	Orange	31/03/2025

	equipment, suitable building services, and suitable bedding and furnishings.			
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	31/03/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/03/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2025
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Orange	31/03/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	16/01/2024
Regulation 34(2)(f)	The registered provider shall ensure that the complaints	Not Compliant	Orange	15/01/2024

	procedure provides for the provision of a written response informing the complainant of the outcome of the review.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	15/01/2024
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 residents.	Not Compliant	Orange	15/01/2024
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.	Not Compliant	Orange	07/03/2024