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:	Unannounced
Date of inspection:	29 May 2024
Centre ID:	OSV-0000503
Fieldwork ID:	MON-0043757

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:	47

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 29 May 2024	08:20hrs to 17:45hrs	Kathryn Hanly	Lead
Wednesday 29 May 2024	08:20hrs to 17:45hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Inspectors met with and observed residents throughout the day of inspection. They spoke with three residents about their experience of living in the centre. Residents said that they never waited long for assistance when they required it. They complimented the food and the helpful and considerate staff. Staff were observed assisting and interacting with residents in a friendly, caring and respectful manner.

There was a high level of residents who were living with a diagnosis of dementia or cognitive impairment who were unable to express their opinions on the quality of life in the centre. However, those residents who could not communicate their needs appeared to be relaxed and enjoyed being in the company of staff. Staff and residents were seen to have good humoured banter throughout the day.

Visitors were observed attending the centre on the day of the inspection. Inspectors spoke with three family members who were visiting. Visitors spoken to were very complementary of the staff and the care that their family members received. Visitors confirmed that there was no booking system in place and that they could call to the centre anytime.

To the left of the main entrance was a large seating area. This was registered as a communal multi-purpose area and was used by visitors, staff and residents for group activities. On the morning of the inspection a group of staff from the adjoining primary care centre were gathered in this area of the designated centre. Inspectors were not assured that there was adequate oversight of this area to ensure that appropriate infection prevention and control measures were maintained at all times.

The centre was located in a two-story building which comprised the 29 bedded Illankirka Ward on the ground floor and the 27 bedded Illangrove ward on the first floor. The first floor was accessible via wheelchair-accessible ramps and a passenger lift.

The residents dining area on each floor included a kitchenette and small nurses station. Inspectors observed the dining experience on the ground floor at lunch time. The meal appeared appetising and well presented and the residents were not rushed. However, overall the dining experience was a not a pleasant social occasion for residents. Inspectors observed that several residents were seated on their own at bed tables in the dining room. Staff explained that this arrangement was commenced during the COVID-19 pandemic when an accessible communal dining table had been removed to facilitate social distancing and that the table had not been put back in place since.

Residents were supported to personalise their bedrooms, with items such as photographs and artwork to help them feel comfortable and at ease in the home. Overhead hoists were in place in all rooms to enable safe moving and handling.

However residents in some twin rooms were required to share a television, which did not facilitate individual residents to choose what they wanted to watch on television. The clinical hand washing sink within some twin occupancy bedrooms was positioned inside the privacy screen of one of the resident's beds. As a result access to the sink may be restricted to the other resident as they would need to enter the first resident's bed-space to wash their hands. Findings in this regard are presented under Regulation 9; Resident Rights.

While the centre generally provided a homely environment for residents, improvements were required to enhance this. For example, excessive infection prevention and control signage on display in communal and public areas throughout the centre took away from the homely feeling. This included COVID-19 physical distancing signage, transmission based precaution posters, personal protective equipment (PPE) posters and posters promoting the "skip the dip" campaign in the dining room.

Overall, the general environment including residents' bedrooms, communal areas and toilets were clean and well maintained with some exceptions. For example cobwebs were observed in the upper surfaces of the atrium at the reception and excessive dust was observed within some electrical panel presses. Minor cracks in the plaster were observed in the atrium ceiling. The décor and paintwork in some areas of the original parts of the building was showing signs of wear and tear.

Ancillary facilities generally supported effective infection prevention and control. Staff had access to dedicated housekeeping rooms for the storage and preparation of cleaning trolleys and equipment on each floor. Each floor also had two sluice rooms for the reprocessing of bedpans, urinals and commodes. These rooms were observed to be clean and tidy. However, a spray hose attached to an equipment cleaning sink within one sluice room posed a risk of cross contamination. The detergent for a bedpan washer on the ground floor was empty. This may have impacted the effectiveness of decontamination of equipment cleaned in this machine.

The main kitchen was clean and of adequate in size to cater for resident's needs. Toilets for catering staff were in addition to and separate from toilets for other staff.

Laundering of residents' clothing and used linen was provided by an external contractor and some residents chose to have their clothing laundered at home. Clothes were marked to ensure they were safely returned from the external laundry. However, several individual residents' manual handling slings were not clearly labelled with residents initials. Potential mix-ups posed a risk of cross infection.

Inappropriate storage practices were observed in rooms that contained ducting and ventilation systems where fire stopping measures had not been addressed. Inspection inspectors observed these rooms to contain a significant number of combustible items including bags of clothing. Findings in this regard are presented under Regulation 23.

Conveniently located alcohol-based product dispensers within bedrooms and along corridors and within resident bedrooms facilitated staff compliance with hand

hygiene requirements. However, barriers to effective staff hand hygiene were identified during the course of this inspection. There was a limited number of dedicated clinical hand wash sinks in the centre which meant that the sinks in the resident's en-suite bathrooms were dual purpose used by residents and staff.

The next two sections of the report, capacity and capability and quality and safety will describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

This was an unannounced inspection with a focus on infection prevention and control to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to follow up on the findings of the previous inspection of January 2024.

Overall inspectors found that the management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored were not sufficiently robust. This was a repeat finding. For example, progress with fire safety improvement works as per the centres fire safety risk assessment including the fire detection system, compartmentation, emergency lighting, fire stopping had not been progressed.

Additional fire safety risks were identified on the day of the inspection. For example, there was some ambiguity regarding whether the alarm was connected to the adjoining health centre, signage to external assembly areas was unclear and agency staff were unsure of local evacuation protocols. Several fire doors had large gaps underneath and around the perimeter. These risks had not been identified and addressed by the provider.

Inspectors also followed up on other elements of the provider's progress with completion of the actions detailed in the compliance plan from the last inspection. Inspectors found that the provider had improved some storage facilities and physical infrastructure through maintenance works that had been completed. The provider had also taken actions to ensure that there were sufficient staff available to support residents to engage in meaningful activities in line with their interests and capacities. However, this inspection found that further action was required to ensure full compliance with staffing, training, governance and management, infection control and resident rights.

The registered provider is the Health Service Executive (HSE). There had been an inconsistent and unstable organisational structure in this centre. Three different persons in charge had been in position over the past year. The management team consisted of a person in charge and three clinical nurse managers (CNMs) positions.

One of these CNMs had recently given their resignation and the third CNM2 clinical nurse manager post had remained vacant.

The majority of residents living in the centre had high dependency care needs. On the day of the inspection staff were providing care to 27 residents with maximum dependency care needs, seven residents with high dependency care needs, 11 with medium dependency and three residents with low dependency needs.

A large number of staff nurse and healthcare assistant posts also remained vacant. This issue had been escalated to senior HSE management within Community Health Organisation 1 (CHO1). Due to ongoing staff shortages there was a continued reliance on agency staff. The provider's 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. For example, on the day of the inspection an unfilled nursing shift was substituted by an additional healthcare assistant reducing the number of nurses avaialble to residents. Furthermore the oversight of agency staff allocations also required review to ensure agency staff were supervised and managed and to ensure that agency staff were allocated to work alongside the provider's own staff who were familiar with the resident's preferences, medical history and care plans.

The centre had access to maintenance support who were based off site. Maintenance requests were logged electronically via facilities management software. The person in charge confirmed that maintenance issues were generally addressed in a timely manner. However, the facilities management software did not not provide a status update when maintenance requests had been completed and closed which meant that the neither the person in charge or the provider had adequate oversight of maintenance that was carried out in the centre.

The provider had nominated four staff members to the roles of infection prevention and control link practitioners to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre. Staff also had access to training and support from infection prevention and control specialist advice and support as required.

There were sufficient numbers of housekeeping staff assigned to both floors to meet the needs of the centre on the day of the inspection. These staff members were found to be knowledgeable in cleaning practices and processes within the centre. The provider had a number of assurance processes in place in relation to the standard of environmental hygiene. These included cleaning specifications and checklists and colour coded cloths to reduce the chance of cross infection. Cleaning records viewed confirmed that all areas were cleaned each day. The majority of housekeeping staff had also attended a nationally recognised specialised hygiene training program for support staff working in healthcare.

Infection prevention and control audits were undertaken by nursing management and covered a range of topics including staff knowledge, hand hygiene procedures, environment hygiene and sharps management. High levels of compliance were consistently achieved in recent audits. However, these local audits had not identified

a number of infection prevention and control issues including oversight of equipment hygiene, clinical hand washing facilities highlighted which were identified by the inspectors on the day of the inspection.

The provider had a Legionella management programme in place. Water samples were routinely taken to assess the effectiveness of local Legionella control measures.

Surveillance of healthcare associated infection (HCAI) and multi-drug resistant organism (MDRO) colonisation was routinely undertaken and recorded on a dedicated monitoring form.

The centre had a comprehensive local infection prevention and control guideline which covered aspects of standard including hand hygiene, waste management, sharps safety, environmental and equipment hygiene. Infection prevention and control resources and guidelines were accessible to staff via the infection prevention and control online catalogue.

There was an ongoing schedule of training in place to ensure staff had relevant and up to date training to enable them to perform their respective roles. However not all staff had completed infection control training. Furthermore it was not clear what infection prevention and control training agency staff had received. In addition the inspectors found that the management of agency staff working in the centre did not ensure that they were effectively supervised. Findings in this regard are presented under Regulation 16; training and staff development.

Regulation 15: Staffing

The provider had failed to ensure sufficient staffing levels in the centre to meet the needs of the residents, and for the size and layout of the centre. For example;

- A clinical nurse manager post remained vacant for an extended period of time.
- A nursing shift had been substituted with an healthcare assistant shift on the day of the inspection.There was 3.0 WTE vacant post ,and a further 3.72 vacant due leave such as maternity and sick leave
- There were 6 vacant post of healthcare assistant and 4 vacant due to leave
- There was 2.4 vacant posts in housekeeping.
- Administrative duties were covered by agency staff.
- There was an over reliance on agency staff to cover shifts. For example on the day there were four agency nurses and six agency care staff working in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff supervision arrangements were not appropriate to protect and promote the care and welfare of residents. This was evidenced by:

- There were gaps identified in the infection prevention and control training records. For example; only 80% staff had received training in outbreak management.
- Agency staff did not receive a thorough induction when they came to work in the centre and there were no assurances that these staff were up to date with infection prevention and control training.
- Agency staff were not adequately supervised. For example two agency staff nurses were allocated to work together on the day of the inspection. One of these staff had not worked in the centre previously and was not familiar with the residents and their care needs.
- Agency staff did not demonstrate an appropriate awareness of the fire evacuation procedures in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

Systems for monitoring the quality and safety of the service required review to ensure the systems were consistently informing ongoing safety improvements in the centre. For example:

- The provider had failed to ensure that the staffing resources were in line with the centre's statement of purpose against which the centre was registered. This is detailed under regulation 15.
- Risk assessments in use in the centre were not robust and did not provide a good level of protection to residents. For example, a resident that had previously found to have scorch marks on his clothes was in possession of a cigarette lighter without supervision. Additionally, resident access to the first floor balcony had not been risk assessed.
- There was no time bound action plan to address risks in relation to fire detection, fire containment and fire doors throughout the centre, which were identified to the provider though their own fire safety risk assessment (FSRA) commissioned June 2023 ,report dated Feb 2024 . As a result the inspectors identified the same risks on the day of this inspection.
- Additional fire safety risks identified on the day of the inspection, including the absence of directional signage to external assembly points, inappropriate storage in an electrical room and plant room, poor external emergency lighting and inappropriate wedging open of fire doors had not been identified by the provider. In addition agency staff working in the centre were unaware of evacuation procedures in the event of a fire emergency. There were

differing views as to which was the largest compartment therefore it was unclear if residents could be evacuated safely. There was no procedures in place should a fire occur in the healthcentre and it s potential impact on residents accommodated in the designated centre.The provider's oversight of the staff resources, the physical environment in the centre and infection prevention and control facilities and practices did not ensure the risk of further outbreaks of infections were minimised. These findings are set out under Regulation 27.

- Management systems for the oversight for the maintenance of the premises was found to be ineffective. The facility management software did not not provide a status update when maintenance issues had been completed.
- The provider had introduced a tagging system to identify equipment that had been cleaned. However this system had not been consistently implemented at the time of inspection. For example, several items of shared equipment had not been tagged after they had been cleaned by staff. Inspectors also found that the tag to alert staff that an item of equipment had been cleaned was not removed when the equipment was used which created the risk that other staff would think the equipment had been cleaned after use and was safe to use with another resident. There were no guidelines in the use of this system and staff reported that they had not received any training prior to its implementation.
- The oversight of staff rosters was not robust and did not give a clear record of staff on duty. For example some rosters reviewed by the inspectors only had the staff member's first name documented.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed two contracts for the provision of services and found that these contracts did not clearly indicate the following:

- Fees to be charged for additional services.
- A contract for a resident that had been admitted in April had not been signed by the resident or their representative.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of notifications found that the person in charge of the designated centre notified the Chief Inspector of outbreaks of any notifiable infection as set out in

paragraph 7(1)(e) of Schedule 4 of the regulations, within three working days of their occurrence.

Judgment: Compliant

Quality and safety

Overall, inspectors were assured that residents living in the centre enjoyed a good quality of life. However significant focus and resources were now required to ensure that the national standards for infection prevention and control in community settings were maintained to protect residents from future outbreaks and that adequate fire safety precautions were put into place in a timely manner.

Inspectors found that care was person centred. There were no visiting restrictions in place. Visits and social outings were encouraged and facilitated. Residents had access to religious services and mass took place in the centre every Monday. Staff confirmed that that resident voting in the upcoming local and European elections would be facilitated.

There was a focus on social interaction led by the activity co-ordinators on each floor and residents had daily opportunities to participate in group or individual activities. Residents had access to local and national newspapers every day. However, the provision of one television set in twin and triple bedrooms did not afford each resident personal choice regarding their television viewing and listening.

Residents were complimentary of the home cooked food in the centre. A group of residents attended the dining rooms for their meals while the some residents chose to have lunch in their bedrooms. There were adequate numbers of staff available to assist residents at meal-times. Inspectors observed residents being assisted with their meals in a respectful and dignified manner. However, improvements were required in the dining experience for residents using the ground floor dining room.

Residents had daily access to a medical officer as well as specialist treatment and expertise in line with their assessed needs. There was evidence of appropriate referral to and review by health and social care professionals to speech and language therapists, chiropodist and tissue viability as required. There was a low reported incidence of wounds including pressure sores within the centre. Physiotherapy, occupational therapy services were based in the adjoining community health centre.

The National Transfer Document and Health Profile for Residential Care Facilities was used when residents were transferred to hospital. This document contained details of health-care associated infections and colonisation to support sharing of and access to information within and between services.

Resident care plans were accessible on a computer based system. There was evidence that the care plans were reviewed by staff at intervals not exceeding four months. Care plans viewed by inspectors were generally person-centred. However, a small number of care plans reviewed were not adequately detailed to guide care delivery in relation to residents' preferences or needs.

The premises were generally designed and laid out to meet the needs of the residents. Bedrooms were personalised and residents had ample space for their belongings. However the layout of some twin bedrooms impacted on residents' right to privacy and dignity. Findings in this regard are presented under Regulation 9; Resident's Rights.

The centre had experienced nine outbreaks over the previous year which included COVID -19, gastroenteritis outbreaks and other respiratory outbreaks. Several potential contributory factors were identified on the day of the inspection which increase the risk of further outbreaks. For example;

- An outbreak report was produced by the person in charge in January 2024. This found that staff sickness patterns were not effectively monitored and this resulted in the failure to detect and manage the outbreak in a timely manner.
- Rates of staff influenza vaccine uptake in 2023 was below the national uptake target of target of 75%. COVID vaccine uptake records also revealed a marked reduction compared to the previous seasons.
- The reliance on agency staff may also have been a contributory factor to previous outbreaks. Agency staff often work in multiple settings and may not be familiar with residents baseline health, which can delay the identification and management of symptoms indicative of an infectious outbreak. Furthermore agency staff on the day of the inspection confirmed that they had not received any form of structured induction.
- Ongoing use of communal areas by staff from the health centre posed a risk of cross infection particularly during periods of high community transmission.
- Limited access to dedicated clinical hand washing sinks may have impacted effective hand hygiene and contributed to the outbreaks.

Prescribers had access to relevant laboratory results required to support timely decision-making for optimal use of antibiotics. A review of resident files found that clinical samples for culture and sensitivity were sent for laboratory analysis as required.

Inspectors also identified some examples of antimicrobial stewardship practice. Monthly monitoring of a minimum dataset of healthcare associated infection (HCAI), antimicrobial resistance (AMR) and antimicrobial consumption was undertaken through Community Healthcare Organisation (CHO) area 1. There was a low level of prophylactic antibiotic use within the centre, which is good practice. Staff had received training on the "skip the dip" campaign which aimed to prevent the inappropriate use of dipstick urine testing that can lead to unnecessary antibiotic prescribing which does not benefit the resident and may cause harm including antibiotic resistance. However discussions with staff during the inspection found that this initiative had not been embedded in practice. Findings in this regard are

presented under regulation 27.

Regulation 11: Visits

There were no visiting restrictions in place. Staff and residents confirmed that visits were encouraged and facilitated in the centre.

Judgment: Compliant

Regulation 17: Premises

The registered provider provided premises which were appropriate to the number and needs of the residents living there. The premises were clean, well maintained and conformed to the matters set out in Schedule 6 Health Act Regulations 2013.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The national transfer document was incorporated into the centre document management system. Copies of transfer letters were kept in resident's files.

When residents returned from the hospital, the inspector saw evidence that relevant information was obtained upon the residents' readmission to the centre.

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. For example;

- The centre had experienced nine outbreaks between May 2023 and February 2024. Several potential contributory factors were identified on the day of the inspection which increase the risk of further outbreaks. For example; a delay

in the identification and early rapid response to outbreaks impacted effective infection prevention and control.

- There was a continued reliance on the use of dipstick urinalysis for assessing evidence of urinary tract infection. This was contrary to national guidelines which advise that inappropriate use of dipstick testing can lead to unnecessary antibiotic prescribing which does not benefit the resident and may cause harm including antibiotic resistance.
- A range of safety engineered needles were not available. However, inspectors saw evidence (used needles recapped in the sharps disposal bin) that needles were recapped after use. This practice increased the risk of needle stick injury.
- Individual glucometers for monitoring blood sugars were not available. This posed a risk of cross contamination.
- There was a limited number of dedicated clinical hand wash sinks in the centre and the sinks in the resident's rooms and en-suite bathrooms were dual purpose used by residents and staff. Outlets of a number of sinks in housekeeping were corroded.
- Used wash-water was emptied down residents' hand wash sinks and basins were rinsed in the residents' and wash sinks which posed a risk of cross contamination.
- A programme of high dusting was required in the main foyer. Cobwebs were observed on windows and ledges.
- Actions from a recent environmental health officer report had not been progressed.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Overall, the standard of care planning was good and described person centred and evidenced based interventions to meet the assessed needs of residents. However, however further action is required to be fully compliant. For example:

- There were no residents with confirmed or suspected COVID-19 infection in the centre on the day of the inspection. However, all residents had generic COVID-19 care plans in place.
- A resident's with an elbow wound did not have a care plan to guide wound care and management.

Judgment: Substantially compliant

Regulation 6: Health care

A number of antimicrobial stewardship measures had been implemented to ensure antimicrobial medications were appropriately prescribed, dispensed, administered, used and disposed of to reduce the risk of antimicrobial resistance. For example monthly monitoring of a minimum dataset of healthcare associated infection (HCAI), antimicrobial resistance (AMR) and antimicrobial consumption was undertaken through Community Healthcare Organisation (CHO) 1. Monthly reports reviewed included breakdown and benchmarking nationally and within CHO1. The most recent report (Quarter 1 2024) showed low levels of both therapeutic and prophylactic antibiotic use relative to other HSE centres throughout the region. This initiative provided ongoing assurance to management in relation to the quality and safety of services, in particular the burden of HCAI and AMR in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

The design and layout of some of the multi-occupancy bedrooms within the designated centre impacted on residents' right to privacy and dignity. For example,

- Privacy screens did not extend fully around the beds in a number of twin bedrooms.
- Some residents in twin bedrooms did not have individual choice of television viewing and listening as only one television was provided in these bedrooms.

The dining experience required review to ensure all residents were facilitated to have a sociable dining experience. Residents on the ground floor dining room were observed having their meals on bed tables lined up in a row separate to the residents seated at dining tables.

Clothing belonging to deceased residents was stored in black bags awaiting collection by family members. The use of refuse bags can be seen as disrespectful and undignified for the deceased and their families.

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	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Virginia Community Health Centre OSV-0000503

Inspection ID: MON-0043757

Date of inspection: 29/05/2024

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: Compliance with Regulation 15: Staffing will be achieved by the following actions:

1. A review of the Centre's management team has been completed. This review has resulted in a Clinical Nurse Manager II and Clinical Nurse Manager 1 being available to both units within the Designated Centre (25.06.24). The area Director of Nursing will assist and provide support to the PIC in respect of management and clinical issues. (16.09.24). All recruitment paperwork for the remaining vacant CNM II position have been approved by senior management and have been forwarded for derogation and recruitment by National HSE. The area Director of Nursing will be based in the Designated Centre to support the PIC until the CNM II is recruited permanently (16.09.24).

2. A detailed review of the staffing and staff Rosters within the Centre has been completed (03.07.24).This review has resulted in all vacant posts in an interim capacity being covered with regular agency staff. The vacant 6.25 staff Nurse Posts are currently being covered by Agency staff Nurse, who are all registered Nurses on the Live Nurse register of Nurses in Ireland and are suitably qualified to provide care which meets the assessed needs of the Residents. The vacant Health Care Assistant posts are being filled by regular agency staff. All agency HCA's working in the Designated Centre have completed FETAC level 5 in healthcare or equivalent and suitably qualified to provide care which meets the assessed needs of the Residents. The 2.5 vacant housekeeping posts are currently being filled by regular agency staff. The required paperwork for the recruitment of the vacant posts have been resubmitted and signed by HSE management. These posts have been requested for derogation by National HSE.
3. The above process will provide consistency and continuity to residents. This process is in place since the 08/07/24. The register provider and the Person in Charge will continue to monitor and review rosters and skill mix as to be assured that the above process is implemented in full.
4. The Register Provider and the Person in Charge have developed an induction programme/checklist for all agency staff recruited within the Centre. This will ensure that

all staff are aware of Policies and Procedures within the Centre.
5. All agency staff within the Centre are provided and facilitated to attend all HSE mandatory training.
6. The above process provides assurance to the register provider and the person in charge that all staff working within the Centre have the required knowledge and skills in line with their roles and responsibilities
7. The Person in Charge and the Clinical Nurse Managers will ensure on a daily basis that there is a mix of both HSE and agency staff working within the Designated Centre. This will be monitored by the Register Provider during site visits to the Centre.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Person in Charge will ensure Compliance with Regulation 16- Training and staff development by implementing the following actions:

1. All staff will have completed the IPC Outbreak Prevention and Management Training on HSELand by the 31/07/24. This will be fully completed by all staff (including those employed via Agency)
2. The Provider Representative and the Person in Charge will continue to provide oversight of Staff Training and development in the Centre by continuous monitoring and review of the Centre's Training Matrix.
3. The Register Provider and the Person in Charge have developed an induction programme/checklist for all agency staff recruited within the Centre. This will ensure that all staff are aware of Policies and Procedures within the Centre.
This will be completed and signed by the staff member and the Ward Manager / Senior Staff Nurse carrying out the Induction. This process will be monitored by the Register Provider during site visits to the Centre.
4. A review of the Centre's management team has been completed by the Person in Charge and the Register Provider. This review has resulted in a Clinical Nurse Manager 2 and Clinical Nurse Manager 1 being available to both units within the Designated Centre. This will ensure appropriate supervision of all staff.
5. The Clinical Nurse Managers on each unit in conjunction with the Person in Charge will ensure that staff rosters provide the appropriate staffing and skill mix to safely meet the needs of the residents
6. The Registered Provider Representative and the Person in Charge have undertaken a review of the Clinical Oversight and Governance of all staff working in the Designated Centre (including Agency Staff). Following this review the Person in Charge and / or their Deputy (CNMII) will carry out Daily Governance Walkabouts in the Centre and will complete a Governance record of same to include observation of Residents Wellbeing, Resident Engagements / Activities, Person Centered moments / staff engagement, Person-Centered Language and Environment, Residents Meals, Safe Environment – IPC

practices and environment, Safe Environment – Health & Safety, Medication Management and General Observations. Actions required are clearly identified and actions taken recorded
7. The Provider Representative and the Person in Charge have reviewed the IPC practices within the Designated Centre. Following this review IPC is a standing agenda item at the Centre's daily Safety Pause which is attended by all staff including Agency staff rostered for duty. Records of the daily Safety Pause are maintained in the Person in Charge Office. IPC is also a component of the daily Quality Care walkabouts carried out in the Centre by the PIC
8. All staff within the Centre are required to complete the HSEs mandatory training in respect of IPC. All staff are to have completed same by the 31/07/2024
9. The Provider Representative and the Person in Charge have reviewed the governance and oversight of agency staff awareness of Fire Evacuation Procedures in the Designated Centre. Following this review the Person in Charge has introduced a Detailed Fire Induction Checklist for all new staff working in the Designated Centre. This record will be signed by the staff member and the Manager providing the Induction.
10. All staff working within the Centre will attend all HSEs mandatory staff training
11. All staff within the Centre will be included in fire drills within the Centre
The above processes will ensure that all staff are aware of the fire practices to be followed within the Centre
12. The Register Provider will provide oversite and ensure that all staff within the Centre are compliant with mandatory training. The Register Provider during site visits will engage with staff as to ensure that they are aware of the Fire Precautions and other practices within the Centre. This process will provide assurance to the Register Provider

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Compliance with Regulation 23- Governance and management will be achieved by the following actions-

1. A review of the staffing provision within the Centre in line with the Statement of Purpose has been completed. The Register Provider and the Person in Charge will continue to monitor and review staffing and staffing processes implemented within the Centre.
2. Risk assessments within the Centre have been reviewed to ensure that they are robust and provide an adequate level of protection for residents.
3. An updated individual robust risk assessment has been completed for a Resident whom was previously found to have scorch marks on their colthing and who was in possession of a cigarette lighter without supervision and who likes to smoke independently (04.07.24). The risk assessment identifies risk associated with independent smoking but also allows for the residents right to positive risk take while

also taken account of the residents own will and preference.

4. A risk assessment is now in place regarding Resident access to the first floor balcony, this was completed on 04.07.24.
5. A review of the Fire Safety Risks in relation to Fire Detection, Fire Containment and Fire Doors in the Centre as identified through Fire Safety Risk Assessment for the Designated Centre has been completed.

• HSE Estates Fire Department have engaged an Architect, Fire Engineer, Quantity Surveyor and PSDP to review and oversee the Fire Safety upgrade works required in the Designated Centre. A full review of the Designated Centre will be undertaken and a scope of works developed. The aim of this project is to determine all defects as noted in the Fire Risk Assessment, agree solutions and complete all remedial works to ensure fire safety compliance. Once a scope of works has been developed, a tender will be issued to suitable contractors. These works will include resolving compartmentation issues, outstanding fire-stopping, any deficiencies to the mechanical & electrical services, etc.

Timeline:
• Design team has been appointed – July 2024,
• Design team undertaking first survey – 25th July 2024,
• Develop schedule of works/detailed design and tender package – 27th September 2024,
• Procure and appoint an External Contractor – 25th October 2024,
• Works on site (due to nature of the project and the fact that works will be carried out in a live environment, works will be undertaken and completed on a phased basis) – Plan to complete project in line with Fire Safety Risk Assessment by 28th February 2025.

Expert External Contractor completed the remediation of existing fire doors as per HSE 6 point fire door check in the Designated Centre in May 2023.

External Contractor carry out 6-monthly regular inspections of the fire doors in the Designated Centre. On completion of their inspections they issue the report of their findings to the HSE Maintenance Team. The HSE Maintenance team carry out the minor remedial/repair works, while the External Contractor complete any other outstanding items on the list. External Contractor carries out the repairs.

In order to strengthen the Governance and Management of Fire Safety in the Designated Centre, an External Contractor has been secured to carry out monthly inspections of Fire Doors in all Designated Centres in Cavan Monaghan. On completion of their monthly inspection, a report of required works will be issued to the Person in Charge and repairs will be actioned in a timely manner. Inspection Reports and Repair records will be maintained by the Person in Charge.
Works to upgrade the existing Fire Alarm System to include the toilet areas is now completed on 11th July 2024

A review has been undertaken of the existing assembly point signage. Additional signage shall be erected at the exits/stair discharge points. Signage will also be raised in places

where there is the possibility occupants may be unable to see the signage in the event of an obstruction. The signs will also be reflective and visible in darkness.
Supplier has confirmed new delivery and completion date of 26th July2024.

A review of the Centre's Fire Policy to include the Procedure to follow should a Fire occur in the Primary Care / GP area of the Health Care Centre. This is implemented as of the 04/07/24.

Inappropriately storage items have been removed from the electrical room and plant room. This will be monitored by the Person in Charge during daily Quality Care Walkabouts and by the provider during site visits. Commenced 8th of July 2024.

The external Contractor has reviewed the external emergency lighting on the 11th July 2024.The Expert External Contractor will complete required works to the external emergency lighting by 30th August.

The Provider Representative and the Person in Charge have reviewed the systems and oversight for the maintenance of the Designated Centre. A detailed Maintenance Schedule has been drawn up and implemented in the Centre as of the 01/07/24.

The Registered Provider has liaised with the Maintenance Manager seeking review of the current maintenance software to provide a status update when issues have been actioned and complete. In the interim the Person in Charge will maintain a written record of all actions completed and date of completion.

The Provider Representative and the Person in Charge have reviewed the IPC practices within the Designated Centre. Following this review IPC is a standing agenda item at the Centre's daily Safety Pause which is attended by all staff including Agency staff rostered for duty. Records of the daily Safety Pause are maintained in the Person in Charge Office. IPC is also a component of the daily Quality Care walkabouts carried out in the Centre by the PIC / CNMII. (8th July 2024). There are 4 IPC link practitioners working in the Centre, who will provide guidance to staff in relation to IPC standards.
6. IPC Outbreak Prevention and Management Training on HSELand will be completed by all staff (including those employed via Agency) working in the Designated Centre by (31st July 2024).
7. The register provider and the person in charge have reviewed the process in place to identify the tagging of "clean equipment". The process for the implementation of this system is explained to all staff as part of the induction process and the person in charge and the provider have developed a guideline for all staff on the use of the system.
8. The Provider Representative and the Person in Charge have reviewed the oversight of staff rosters. All rosters now provide the full name and surname of all staff rostered for duty in the Designated Centre. This ensures that the Centre has a clear record of staff on duty in the Designated Centre. This has been implemented as of the 01/07/24
9. The register provider during site visits will review governance and management systems within the Centre as to ensure systems are implemented and robust.
10. The Register Provider and the Person in Charge have continuous meetings to discuss and review challenges within the Centre as to implement robust quality improvement plans

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 Register Provider will come into Compliance with Regulation 24- Contract for the provision of services by implementing the following actions-
1. The Person in Charge has reviewed all residents contracts of care to ensure that all contracts how clearly identify the Fees to be charged for additional services.
2. The Person in Charge has introduced a new monitoring system in which all contracts of care are located within the Person in Charge office. This process will ensure that the Person in Charge has the oversite to ensure that all residents within the Centre have up to date fully signed contracts of care.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The Register Provider will ensure compliance with Regulation 27- Infection Control by the implementation of the following actions:

1. The Person in Charge and the management team have provided education sessions to all staff at the daily safety pause alerting staff to the systems of Covid 19 as to assist in the early identification of systems which will result in an early and rapid response to outbreaks
2. All staff will have completed the IPC Outbreak Prevention and Management Training on HSELand by the 31/07/24. This will be fully completed by all staff (including those employed via Agency)
3. Additional training has been provided to all staff on the "skip the dip" initiative. The "Skip the Dip" initiative is discussed at daily safety pauses within the units and at staff and team management meetings. The "Skip the Dip" initiative is discussed at all staffs induction as to ensure that all staff are aware of the "Skip the Dip" initative.
4. The Person in Charge has ordered safety engineered needles for use within the designated centre. All staff have been made aware not to recap needles and the dangers associated with same.
5. The Person in Charge on the safety walk around is reviewing all sharp boxed as to ensure that the recapping of needles has ceased. This is further reviewed by the Provider as part of the onsite visits to the centre
6. Individual glucometers for monitoring blood sugars are now avaialbe for all residents

whom require regular blood sugar monitoring. As part of the Pre Assessment Process the Person in Charge will be aware of any resident whom requires regular blood sugar monitoring and will ensure that on admission this residents has access to there own individual glucomenter.
7. The Register Provider, the Person in Charge, the Infection Prevention and Control team in conjunction with the maintenance/estate team reviewed the number of dedicated clinical hand wash sinks in the centre. As part of this review it has been identified that a number of additional sinks are required. The placement of these sinks have been guided by the expertise of the IPC and maintenance team. Additional sinks will be fitted by the 31st December 2024.
8. Used wash-water practices within the centre have been reviewed as to ensure the appropriate disposal of used water. This process has been communicated to all staff. The Clinical Nurse Managers and the Person in Charge will provide supervision to all staff and ensure that the appropraite processes are in place
9. A programme for the high dusting in the main foyer has been implemented. High dusting in this area will be completed by 31st December 2024.
10. All actions from a recent environmental health officer report have been actioned.

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:
The Register Provider will ensure compliance with Regulation 5- Individual assessment and care plan by implementing the following processes-

1. All residents care plans have been reviewed within the Centre ensuring that care plans are specific and individual to residents needs and requirements
2. All residents whom have a wound have an evidence based clinical care plan in place to guide wound care and management
3. The Person in Charge has implemented a wound monitoring system within the designated centre. This monitoring system will inform the Person in Charge of any resident with a wound within the centre. The Person in Charge will review and ensure that any resident with a wound has an individual care plan.
4. The Person in Charge and Register Provider have implemented the "Link Nurse Tissue Viability Programme" as part of this process the link nurse completes monthly tissue viability audits. These audits review compliance with care plan implementation for those residents whom have a wound. Findings of these audits are reviewed at team meetings and quality improvement plans are developed and implemented as required.
5. The Provider Representative during site visits will review the monitoring process in respect of wound management and will review residents care plans whom have a wound as to ensure that they have an up to date clinical care plan which will guide wound care and management.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Compliance with Regulation 9 - Residents rights will be achieved by implementing the following actions:

1. The Register Provider and Person in Charge have reviewed all residents bed spaces as to ensure each residents privacy and dignity is maintained. The External Contractor attended the Designated Centre on 9th July 2024 to further review the Privacy Screens and additional Privacy screens will be fitted by the external contractor by 31st October 2024.
2. Additional televisions have been ordered for residents in twin bedrooms. This will ensure that all residents have access and choice of television viewing. This will be implemented by the 31/10/24.
3. The Person in Charge has carried out a review of the dining experiene. Following this review the dining room furniture has been reviewed and new tables have been introduced. This allows for residents to engage in a more sociable and enjoyable dining experience.
4. End of Life personnel belonging bags are in place within the Centre. Following the death of a resident their belongings are stored in these specific bags. This is in line with the units end of life policy.
5. The Register Provider as part of there site visits to the Centre will review residents dining experience as to ensure it is a sociable and plesant experience for the residents.
6. Following the Death of a resident in the Designated Cenre, the Person in Charge will monitor the storage of residents property as to ensure that residents belongings are stored in the appropriate end of life bags.

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	08/07/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/07/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	02/07/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	08/07/2024

	effective delivery of care in accordance with the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	28/02/2025
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	01/07/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	31/07/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment	Substantially Compliant	Yellow	01/07/2024

	referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
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	31/10/2024
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	31/10/2024