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:	Mount Carmel Supported Care Home
Name of provider:	Mount Carmel Community Trust CLG
Address of centre:	Prologue, Callan, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	20 March 2024
Centre ID:	OSV-0000546
Fieldwork ID:	MON-0039576

About the designated centre

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

Mount Carmel Supported Care Home was opened in 1985. The centre is part of the local community and in 1982 the site on which the centre was built was donated by the local Parish and it is run by a Board of Management made up of local people and their representatives. The registered provider is Mount Carmel Community Trust Limited. The centre provides residential services to low dependency residents over 65 years. (Any deviation from this age range would be recommended by the Manager and approved by the Board of Management). The centre provides long-term and respite care for residents who are mainly capable of living independently and who require minimal assistance in a home-from-home environment. All residents are admitted following an assessment by the person in charge and a team of social and health care professionals. If residents develop a higher level of dependency and additional care is required; they will be provided with the necessary support in seeking other more suitable forms of accommodation. There is a day care facility that provides services for up to a maximum of 12 clients. The total capacity of the centre is for 20 residents. It is a single story building located on the main street of Callan, in a quiet area within walking distance of all local shops and amenities. All bedrooms are single with five having en-suites with shower toilet and hand basin. There is approximately 18 staff working in the Centre. The centre is funded by a grant from the Health Service Executive (HSE), resident's fees, fundraising and some staff provided by a An Foras Áiseanna Saothair (Training and Employment Authority also known as FÁS) and Tús which is a community work placement scheme providing short-term working opportunities for unemployed people.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	19

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 20 March 2024	09:15hrs to 18:20hrs	Aisling Coffey	Lead

What residents told us and what inspectors observed

The consistent and enthusiastic feedback from all residents who spoke with the inspector was that they greatly liked living in the centre and considered themselves "very happy" to call Mount Carmel their home. The residents were highly complimentary of the staff and the care they received. Visitors who spoke with the inspector provided equally positive feedback describing how "delighted" they were that their loved one was living in the centre as the residents were "so well looked after". When the inspector asked a resident if they felt they could make a complaint or raise a concern, the resident laughed and said, "Sure, I run the place". This feedback captured the person-centred approach to supported living seen in Mount Carmel Supported Care Home and how the residents felt ownership of their routine and accommodation and were involved in the day-to-day running of the centre more broadly. Staff were knowledgeable about the residents' needs, and it was clear that staff and management were striving to provide the best care and promote residents' independence in their day-to-day lives. The inspector observed warm, kind, dignified and respectful interactions with residents and visitors throughout the day by staff and management.

The inspector arrived at the centre in the morning to conduct an unannounced inspection. The inspector signed in at the entrance. The inspector was greeted by the person in charge and the assistant manager. Following an introductory meeting with the person in charge, the assistant manager accompanied the inspector on a tour of the premises. During the day, the inspector had the opportunity to speak with most residents and talk in more detail to five residents and two visitors to gain insight into their lives in the designated centre. The inspector also observed interactions between staff and residents and reviewed documentation.

Mount Carmel Supported Care Home is a single-storey building in the town of Callan, County Kilkenny. The centre is located within walking distance of the local shops and amenities. The centre is registered to offer long-term and respite residential care to residents with low-dependency care needs. There were 19 residents accommodated in the centre on the day of the inspection, with one resident in hospital. The model of care supports residents who are predominantly independent with self-care but require minimal assistance to maintain their well-being. Should a resident's needs increase, they are supported to source alternative accommodation. The centre shares its grounds with eight bungalows offering independent living accommodation to older persons, which the same provider manages. Within the centre, a day centre facility operates two days per week for six people, offering meals and activities. This model helps the residents living in the centre to maintain their friendships and connections with the local community. Residents of the centre were seen to engage with their friends in the bungalows and spoke of how they also enjoyed interacting with their friends in the day centre. Some residents had moved from the bungalows to the centre and informed the inspector that their familiarity with the residential service made the transition easier.

The centre is a single-storey premises accessed through an entrance lobby. Visitors and callers to the centre signed the visitor book located in the reception area. On the inspection day, residents and visitors were seen coming and going as they pleased. The person in charge informed the inspector that the front door is locked at 9:00 pm, at which point residents can enter the centre by ringing the doorbell. Internally, the centre's design and layout supported residents to move around the centre as they wished, with wide corridors, sufficient handrails, and comfortable seating set out in the various communal areas. These communal areas included a dining room, a day room, a prayer room and a daycare room. Residents were observed relaxing in the day room outside of mealtimes. This room was comfortable and pleasantly decorated with a working stove set within a marble-effect fireplace. This area had games, jigsaws, newspapers, and magazines for residents' enjoyment, as well as a large-screen television. There was a smoking room for residents who chose to smoke, while smoking was also observed to occur in two other undesignated external smoking areas. All 20 bedrooms are single occupancy. While five bedrooms have en-suite shower facilities, the remaining bedrooms have a wash hand basin.

All bedrooms seen contained a television, call bell, wardrobe, locker, seating and locked storage facilities. Residents had personalised their bedrooms with photographs, artwork, religious items, furniture and ornaments. The size and layout of the bedrooms were appropriate for resident needs. Roman Catholic mass is celebrated in the centre's prayer room six days per week. Residents commented favourably on having access to this facility. Outside of mass, the prayer room provided a space for prayer and quiet reflection. The room had an altar, stained glass windows, and displayed the stations of the cross. Outside the centre, there was a pleasantly decorated front garden containing flowers, shrubs, ornaments, and a large decorative mural composed by residents and staff as an art project facilitated by an artist. The garden also had comfortable outdoor seating, and residents and their visitors used the area throughout the day.

There was a relaxed and unhurried atmosphere in the centre. Residents were up and dressed in their preferred attire and appeared well cared for. Residents spent their time watching television, reading the newspaper, using the prayer room, and chatting with other residents and staff. Some residents informed the inspector they had appointments that day and were seen to leave the centre and return later. While the inspector did not observe any activities aside from mass taking place on inspection day, residents spoke of the outings they had gone on recently, including a visit to a local hotel to see a musician, and how they enjoyed activities such as quizzes and bingo that took place in the centre. While residents used their mobile telephones, the centre also provided access to a shared portable landline phone exclusively for resident use. Residents had access to national and local newspapers provided at no charge by local shops, televisions and radios. Residents had recently exercised their right to vote in the centre. There were arrangements in place for residents to access advocacy services. Residents could receive visitors in the centre within communal areas or in the privacy of their bedrooms. Multiple visitors were observed during the day. The centre had a minibus to facilitate resident appointments and outings, and four staff members drove this vehicle.

Residents ate in the centre's dining room or their bedrooms aligned with their preferences. Residents informed the inspector they could have breakfast when they liked, and the inspector observed residents taking breakfast at various times throughout the morning on the inspection. Residents also made toast and hot drinks in the dining room as they wished. Lunchtime at 1230pm was observed to be a sociable and relaxed experience, with 16 residents choosing to eat in the dining room. Meals were freshly prepared by the onsite chef, supported by a catering assistant, in the centre's kitchen. The menu choices were displayed on a whiteboard in the dining room, and the food served appeared nutritious and appetising. A choice of main course and dessert was being offered, and ample drinks were available for residents at both mealtimes and throughout the day. Later in the afternoon, freshly baked scones were being enjoyed in the day room. Residents commented positively to the inspector about food quality, quantity and variety.

While the centre was generally clean and in good repair, some areas required additional maintenance and cleaning to ensure the residents could enjoy a safe and pleasant living environment. These findings are discussed under Regulation 17: Premises and Regulation 27: Infection Control. In addition, the inspector observed that some of the fire doors in the building required review to ensure the provider's fire precautions were robust. This is discussed under Regulation 28: Fire precautions.

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

Capacity and capability

Notwithstanding the good care and support that residents were receiving in their daily lives, some of the provider's oversight arrangements required strengthening, such as fire safety, infection prevention and control, and the management of risks such as falls management. Improvements were also required in relation to policies, notification to the Chief Inspector, and care planning.

This was an unannounced inspection to monitor the ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 as amended and to review the registered provider's compliance plan arising from the previous inspection. The inspection also informed the provider's application to renew registration. While the provider had progressed with some aspects of the compliance plan following the last inspection in May 2023, this inspection found new issues of non compliance that demonstrated some gaps in the overall governance and management of the service. These findings are discussed under the relevant regulations in this report.

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

Mount Carmel Supported Care Home was established in 1985 to provide supported care for older people with low dependency care needs from the local and surrounding areas. The registered provider is Mount Carmel Community Trust Company Limited by Guarantee. The company is comprised of 11 directors who work in a voluntary capacity. The chairperson represents the provider for regulatory matters and attended onsite for feedback at the end of the inspection. The centre was granted registration under the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations, which stipulated that if the centre provided care to residents who do not require full-time nursing care, the person in charge is not required to be a registered nurse. The residents' medical needs are met by their general practitioner, and the residents can access the public health nurse and other primary care services. The centre also employs a registered nurse working 10 hours weekly for the exclusive benefit of the residents.

The centre had a clearly defined management structure, and staff members were clear about their roles and responsibilities. The person in charge works full-time in the centre, is responsible for overall governance, and reports to the board of directors. The person in charge is supported by a full-time assistant manager, a part-time nurse, a team of health care assistants, chefs, catering staff and a maintenance person. The assistant manager deputises for the person in charge. The healthcare assistants work in a multi-task capacity, undertaking household, laundry and care-giving duties. The staff complement was enhanced by additional staff members participating in a community work placement scheme run by the Department of Social Protection who provided additional caring and maintenance support. The inspector reviewed past and future rosters and found the staffing and skill mix were appropriate to meet the needs of the residents within the centre and aligned with its social model of care. The centre had a staff member working every night from 09:00pm to 07:45am.

Communication systems were in place to ensure clear and effective communication between the person in charge and the board of directors. The person in charge submitted a comprehensive report to the board outlining key issues within the centre, such as occupancy, temporary discharge, incidents, accidents, compliments, complaints, regulatory matters, resident feedback and premises issues. Within the centre there were house meetings and health and safety meetings held with staff and chaired by the person in charge. These meetings discussed operational matters concerning the daily care of residents and health and safety issues, such as fire safety and winter preparedness.

There were systems in place to monitor the quality and safety of care delivered to residents through an audit schedule covering areas such as cleaning audits, hygiene inspections, medication audits and audits of residents' folders, where care needs were recorded. The provider was completing the annual review of the quality and

safety of care delivered to residents. The inspector saw evidence of the consultation with residents and families to be reflected in the review. This inspection found that some areas of auditing needed to be more robust to effectively identify deficits and risks in the service and thereafter drive quality improvement. This will be discussed under Regulation 23: Governance and management.

While there was a suite of centre-specific policies and procedures to guide practice in the centre, four policies were not available, while the remainder had not been reviewed and updated in line with regulatory requirements. The inspector sought to review the directory of residents and found that while the centre held the required information, including date of birth, home address, admission date, and general practitioner details, this information was being held in multiple locations and needed to be amalgamated into one directory format as required by the regulations.

Five staff files reviewed by the inspector were found to be well maintained. These files contained all the necessary information as required by Schedule 2 of the regulations, including Garda Siochana (police) vetting, references and qualifications. The centre had an insurance policy concerning injury to residents and insuring against loss or damage to residents' property.

The centre displayed its complaints procedure at reception and in several communal areas. Information posters in respect of advocacy services to support residents in making a complaint were displayed. Residents and families said they could raise a complaint with any staff member and were confident in doing so if necessary. Staff were also knowledgeable about the centre's complaints procedure. The person in charge maintained a comprehensive record of complaints received, how they were managed, and the outcome for the complainant, including their level of satisfaction. Notwithstanding this good practice, some improvements were required to comply fully with the regulation, which will be outlined under Regulation 34: Complaints procedure.

Registration Regulation 4: Application for registration or renewal of registration

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

Judgment: Compliant

Regulation 14: Persons in charge

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

Judgment: Compliant

Regulation 15: Staffing

There was a well-organised staffing schedule in the centre. Based on a review of the worked and planned rosters, and from speaking with residents, it was evident that there was sufficient staff, of an appropriate skill-mix, on duty each day, to meet the assessed needs of the residents.

Judgment: Compliant

Regulation 19: Directory of residents

While the centre held the information required under Schedule 3, it was being held in multiple locations, including the nightly register and the resident admission sheet. The Schedule 3 information needed to be amalgamated into a directory format as required by the regulations.

Judgment: Substantially compliant

Regulation 21: Records

A review of five personnel files found evidence of identification, relevant qualifications and references. The inspector was assured that Garda Síochána (police) vetting disclosures, were in place for all directly employed staff and those on community work placement schemes run by the Department of Social Protection.

Judgment: Compliant

Regulation 22: Insurance

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

Judgment: Compliant

Regulation 23: Governance and management

Management systems in the centre required strengthening to ensure the service provided was safe, appropriate, consistent, and effectively monitored, as evidenced by the findings below.

- The registered provider was required to take action regarding fire safety management in the centre. Following the inspection, an urgent action plan requiring the provider to complete a number of actions with respect to the identified fire safety risks was issued. This is discussed further under Regulation 28: Fire precautions.
- The oversight of policies did not ensure that all of the Schedule 5 policies were in place and that the centre's policies and procedures were reviewed within the required regulatory timeframes.
- The systems for recognising statutory notifications that need to be notified to the Chief Inspector of Social Services had not ensured that required notifications had been made.
- The oversight systems to monitor care planning did not ensure that each resident had an up-to-date care plan to meet their identified needs. Furthermore, an audit identified that some residents did not have care plans in place, but this had not been acted on, and the inspector found the same findings during this inspection.
- The risk management systems were not fully effective. For example, improvements were required in fire safety, falls management and infection prevention and control. This had not been identified by the risk management systems being used.

Judgment: Not compliant

Regulation 3: Statement of purpose

An up-to-date statement of purpose included the information set out in Schedule 1 of the regulations.

Judgment: Compliant

Regulation 30: Volunteers

The person in charge confirmed that the centre does not have persons working on a voluntary basis. Should this position change, the person in charge understood the regulatory requirements for volunteers to have Garda Siochana (police) vetting, to receive support and supervision, and to have their roles and responsibilities set out in writing.

Judgment: Compliant

Regulation 31: Notification of incidents

The Chief Inspector of Social Services had not been notified of four notifiable incidents within the required time frames. For example:

- an incident where a resident required hospital assessment post-fall
- a possible safeguarding incident
- two occasions where the fire alarm had been activated in the previous 12 months

Judgment: Not compliant

Regulation 34: Complaints procedure

The centre's complaints policy and procedure required updating to meet the amendments to the regulations that had come into effect in March 2023 (S.I. 628 of 2022). For example:

- The centre's complaints procedure needed to reference a person as the complaints officer.
- There was no named review officer, nor were there associated timeframes for the review officer to issue their written response.
- The nominated complaints officer had not completed training to support them in their role of managing complaints. Evidence of this training was submitted after the inspection.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

While there was a suite of centre-specific policies and procedures, four policies, including risk management, responding to emergencies, and fire safety

management, were not available. The remainder had not been reviewed since 2015. Policies guide evidence-based practice and must be reviewed at intervals not exceeding three years as required by the regulations.

Judgment: Not compliant

Quality and safety

While the inspector found that residents were well cared for and were supported to live a fulfilled life in which their rights and independence were promoted, this inspection found that residents were not adequately protected in the event of a fire emergency or through the infection prevention and control measures that were in place in the centre. Improvements were also required in the management of falls and care planning processes, especially the involvement of residents in their care plans and reviews.

Concerning fire precautions, the centre has undergone building works in the past two years to improve fire safety. Preventive maintenance for fire detection and fire fighting equipment was conducted at recommended intervals, and staff had undertaken fire safety training. However, significant improvement actions were still required to ensure that the provider brought the centre into compliance with Regulation 28 and that residents and staff were adequately protected in a fire emergency. This was a particular concern at night when staffing levels were reduced to one staff member. These findings are set out under Regulation 28: Fire precautions.

The person in charge had arrangements in place to assess residents before admission into the centre. Upon admission, residents' care needs were evaluated. The centre used validated risk assessment tools, such as the Falls Risk Assessment Scale for the Elderly (FRASE) and the Malnutrition Universal Screening Tool (MUST). However, these risk assessments were not always accurately completed to reflect the residents' care needs, directly impacting the accuracy and effectiveness of the residents' care plans. The inspector also found care plan reviews did not document evidence of consultation with the resident and, where appropriate, their family, which is a regulatory requirement.

The health of residents was promoted through ongoing access to the residents' general practitioner and a nurse working in the centre 10 hours per week. Residents also had access to various community and outpatient-based healthcare providers such as chiropodists, dietitians, physiotherapists, occupational therapists, speech and language therapists, geriatricians and mental health services. Notwithstanding this good practice, the inspector found that a review of falls management in the centre was required to ensure that residents at risk of falls or who had had a fall had access to appropriate medical and specialist healthcare.

Inspectors reviewed records of residents transferred to and from the acute hospital. Inspectors saw that where the resident was temporarily absent from a designated centre in an acute hospital, relevant information about the resident was provided to the designated centre by the acute hospital to enable the safe transfer of care back to the designated centre. Upon residents' return to the centre, the staff ensured that all relevant information was obtained from the hospital and placed on the resident's record. Notwithstanding this good practice, the inspector was not assured that the transfer of residents from the centre was carried out in line with the requirements of the regulation as there were no records available of the information sent from the designated centre to the receiving hospital. This will be discussed under Regulation 25: Temporary absence or discharge of residents.

Staff were observed communicating appropriately with residents, including those residents who were living with a cognitive impairment. Inspectors found that residents with sensory needs had these communication needs documented during their assessment. For residents with hearing or visual difficulties, the documented assessment referred to their usage of hearing aids or glasses. The staff spoken to were knowledgeable about the communication devices used by residents and ensured they had access to them to enable effective communication and inclusion.

The premises were designed and laid out to meet the number and needs of residents. Residents' bedrooms were clean, tidy and personalised with items of importance to them, such as family photos, ornaments and sentimental items from home. With the exception of bedroom 17, which had paint peeling and staining on the roof, resident bedrooms were pleasantly decorated and in good repair. Residents had adequate space for storing their clothes, toiletries, and other belongings and displaying significant possessions. Each resident had access to lockable storage and call bell facilities. The centre had an onsite laundry for the laundering of residents' clothing and the centre's linen. While the centre's interior was generally clean on the day of inspection, the environment, storage and cleaning practices required review to minimise the risk of transmitting a healthcare-associated infection. This will be discussed under Regulation 27.

Residents had their rights promoted within the centre. Residents were consulted about and participated in the organisation of the designated centre. There was an active social programme where birthdays and other occasions were celebrated. There were regular day and night time outings to local events and venues. There were no restrictive practices in place. Residents came and went as they wished and lived their lives in accordance with their preferences. Residents could receive visitors in the centre, and it was evident that visitors were very welcome. Visitors and residents confirmed there were no restrictions on visiting. The centre had a comprehensive information guide for residents, which contained all regulatory requirements.

Regulation 10: Communication difficulties

The inspector found that residents identified with communication difficulties due to sensory deficits, had their communication needs documented on assessment. Staff were knowledgeable about the communication devices used by residents and ensured residents had access to these aids to enable effective communication and inclusion.

Judgment: Compliant

Regulation 11: Visits

There were no restrictions on visiting in the centre. There were suitable communal facilities indoors for residents to receive a visitor. Visits were also observed taking place outdoors in the garden areas.

Judgment: Compliant

Regulation 12: Personal possessions

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

Judgment: Compliant

Regulation 13: End of life

The person in charge had made arrangements to capture the wishes and preferences of residents concerning their care at the end of life. The inspector observed person-centred end-of-life care plans, which respected each resident's dignity and autonomy. The plans detailed the resident's preferences concerning care and comfort needs, addressing their physical, emotional, social, psychological, and spiritual needs and their religious preferences. These plans detailed the resident's preferences concerning the involvement of family and friends and the resident's preferred location for end-of-life care.

Judgment: Compliant

Regulation 17: Premises

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

- There was paint peeling and staining on the ceiling of bedroom 17.
- The seat coverings on some residents' armchairs, couches and pressure cushions were peeling and torn, meaning they could not be cleaned effectively.

Judgment: Substantially compliant

Regulation 20: Information for residents

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

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The inspector reviewed records of residents transferred from the centre to the acute hospital. However there was no evidence that a transfer document was completed for each resident transferred to hospital. As a result, the inspector was not assured that the required information about each resident was communicated to the receiving hospital. This information is integral to ensuring that the receiving hospital knows all pertinent information to provide the resident with the most appropriate medical treatment.

Judgment: Substantially compliant

Regulation 27: Infection control

While the centre was generally clean and tidy, some areas required attention to ensure residents were protected from infection and to comply with the National Standards for Infection Prevention and Control in Community Services (2018).

The oversight of cleaning practices required improvement, for example:

- The stainless steel food trolley and dresser in the dining room, which held crockery and condiments, were visibly dirty and required cleaning.
- The staff informed the inspectors that the contents of commodes, bedpans, and urinals were manually decanted into the sluice hopper before being placed in the bedpan washer for decontamination. The area around the sluice hopper was visibly dirty with brown staining. Decanting risks environmental contamination with multi-drug resistant organisms (MDROs) and poses a splash/exposure risk to staff. Bedpan washers should be capable of disposing of waste and decontaminating receptacles.
- Bed linen was observed being manually sluiced in a communal bathroom's wash hand basin. This practice increased the risk of environmental contamination and cross-infection.
- Cleaning equipment, such as the trolley, sweeping brushes, and dustpans, was visibly dirty. Cleaning equipment should be clean.

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

- There were no clinical hand sinks available for staff use within the centre. Sinks within residents' rooms and communal bathrooms were used for dual purposes by both residents and staff. This practice increased the risk of cross-infection.
- The current laundry layout required review to ensure a dirty-to-clean workflow without crossover to maintain a segregation of clean and dirty laundry. Facilities were also required to sort and distribute clean laundry.

Several storage practices posed a risk of cross-contamination, for example:

- A resident's perching stool was being stored in the sluice room.
- Linen was being stored on a wooden platform placed directly on the floor of a storage cupboard. In order to maintain the cleanliness of the linen, storage should be on slatted shelving or racking and be off the floor, with sufficient space under the lowest shelf to permit cleaning the floor underneath.
- A multipurpose outdoor storeroom contained clean and dirty items, presenting a risk of cross-contamination. Clinical equipment, including a podiatry chair, beds, and mattresses, was stored alongside clinical supplies such as incontinence wear and open personal protective equipment (PPE) such as facemasks. Dirty items, such as a hoover, were also stored in this room. A number of these items were being stored directly on the floor, impacting the ability to clean the floor effectively.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The oversight of fire safety management and systems to identify fire safety risks did not fully ensure the safety of residents in the event of a fire in the centre. Following the inspection, the provider was issued with an urgent action plan requiring them to take actions to address the findings set out below within the time frame specified by the Chief Inspector:

The registered provider had not taken adequate precautions against the risk of fire and provided suitable building services:

- Residents smoked in two undesignated outdoor smoking areas. These areas did not have protective equipment for the residents while they smoked. In the event of a fire, there were no fire blankets or fire extinguishers in this area. There were no accessible emergency call bells for the resident to summon assistance. There was no easily accessible first aid kit in any of the three smoking areas should the resident sustain a burn.
- Residents who chose to smoke did not have a risk assessment or associated care plan developed, to support them to smoke safely.

The registered provider had not made arrangements for maintaining means of escape:

- Transport wheelchairs were observed being permanently stored on the corridors along fire exit routes. This posed a potential obstruction on this horizontal escape route.

The registered provider did not make adequate arrangements for staff in the centre to receive training in evacuation procedures. While fire evacuation drills were taking place, further robust assurances were required concerning staff preparedness to facilitate safe and timely evacuation:

- Neither the fire action procedure nor evacuation maps displayed throughout the centre nor the four most recent fire evacuation drills referenced the locations of the centre's fire compartment boundaries.
- Of the four most recent fire drills reviewed by the inspector, all drills simulated the same horizontal evacuation to the day care room. No evacuation drills had simulated a horizontal evacuation to another point of safety or an evacuation to the assembly point outside the building which could affect staff preparedness in the event of a fire.
- Given the centre had one staff member on duty at night from 09:00pm to 07:45am, no simulated nighttime evacuation drill had been practised in the preceding 14 months to provide assurances of safe and timely evacuation during the period of lowest staffing.
- The fire action plan documented staff members' responsibility to ensure the closure of doors in the event of a fire, and this was observed as occurring in the records of the last four fire drills. However, given that no bedroom doors

had automatic door-closing devices, assurances were required that in the event of a fire evacuation at night, one member of staff would be able to close all doors whilst also evacuating the residents at the same time.

The registered provider had not made adequate arrangements to contain fire:

- Some doors in the centre were being held open with a hook, or with a door wedge, for example the kitchen door.
- The kitchen door did not have the features of a fire door, such as a cold smoke seal or intumescent strip.
- The majority of fire doors had their cold smoke seal painted, and the brushes were hard. This would impact the cold smoke seal's effectiveness in containing smoke.
- Not all fire doors were closing when released from its magnetic door closer, for example, the fire door outside the prayer room and a dining room door.

In addition to the actions identified in the urgent compliance plan further actions were required to ensure that there were adequate arrangements for evacuating all persons in the designated centre to a place of safety:

- The provider displayed floor plans in the residents' bedrooms to inform residents and their visitors about the evacuation procedures and routes to places of safety. However, four of the five documents reviewed by the inspector were incorrect, which could lead to confusion in an emergency.
- The provider had prepared personal evacuation plans for residents, but these plans did not record the supervision requirements of residents following an evacuation. This was important as a small number of residents were at risk of walking back into the building and leaving the assembly point.

There were some gaps in precautions against the risk of fire and in the provision of suitable building services:

- There was an open hatch from the kitchen to the dining room. There were no shutters or other closing mechanisms to halt the spread of smoke or fire from the kitchen into the resident's dining room.
- Paper records were being stored in an unregistered storage area in the attic.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required concerning individual assessment and care plans to ensure the needs of each resident are comprehensively assessed and an appropriate care plan was prepared to meet these needs. For example:

- The inspector reviewed a sample of residents' assessments and care planning documentation. While there was evidence of personalised and detailed

assessments and care planning for some residents, this was inconsistent. For example, on a number of resident's files, there was a "My Life Story Book" assessment tool, which had been left blank. Not completing this tool was a missed opportunity to record key information about the residents' identity, needs, preferences, history, lifestyle, priorities and achievements, which would, in turn, inform person-centred care.

- Two residents who had fallen did not have their falls risk assessment tools updated to reflect these falls. The risk assessments that were completed in the weeks after the falls incorrectly documented that the residents had no recent falls.
- One of the two residents did not have a falls care plan developed despite having fallen twice in three days and having been involved in another accident several days after the falls.
- The second resident had a falls care plan in place but it was not updated to reflect the factors contributing to their most recent fall.

In a sample of care plans reviewed, there was no written evidence of resident consultation regarding care plan reviews, as required by the regulations.

Judgment: Not compliant

Regulation 6: Health care

Notwithstanding the access residents had to a range of healthcare professionals, the clinical oversight and monitoring of injuries within the centre needed to be enhanced to ensure residents had access to appropriate medical and healthcare based on their assessed needs, for example:

- The inspector found that where a resident had fallen twice in three days and had been involved in another accident several days after the falls, there was no record on file of the resident being supported to access a medical review by their doctor nor a physiotherapy review following any of these incidents.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

No restrictive practices were implemented in the centre. The residents came and went from the centre as they wished.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors saw that staff were respectful and courteous towards residents. The provider had provided facilities for residents' occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. Residents had the opportunity to be consulted about and participate in the organisation of the designated centre through participation in residents' meetings. Residents' privacy and dignity was respected

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mount Carmel Supported Care Home OSV-0000546

Inspection ID: MON-0039576

Date of inspection: 20/03/2024

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: A directory of residents has been developed as of 03.04.2024, as noted in the report the information was there but not gathered in one Document but is now in a Residents Directory.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Following the issuing of an urgent action plan several actions were undertaken in response to the urgent plan. • An external company has been engaged to review all Schedule 5 policies in a timely fashion. • The PIC will ensure to review all incidents to determine if statutory notifications are to be taken. This will also be included in the PIC's monthly report. • The PIC will ensure on a regular basis (every 3 months) that residents care plans are reviewed with the resident to ensure that they are supported to live the life that they wish to live. • The PIC will review the use of risk management tools to ensure that issues identified will be addressed.	

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC will ensure that following recorded incidents and accidents that a determination will be made as to whether they are notifiable incidents. These decisions will be incorporated in the PIC's monthly report that is presented to the Board of Management.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
As part of the overall review of policies and procedures, the complaints procedure will be incorporated into review undertaken by an external Company and updated accordingly.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
All Policies and Procedures are to be reviewed by an external agency. An external company are to carry out this piece of work.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Centre's maintenance team systematically carry out painting and minor repairs throughout the Centre. The team will prioritize rooms identified in the report.

A review of all soft furnishings to be carried out and those not up to standard to be removed.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
As part of emergency hospital admissions, we supply a transfer document, which outlines existing diagnosis, medication prescribed, symptoms etc. This document is sent with the resident, if the resident has been referred to hospital via their GP, the GP will supply an admission letter.

A copy of the transfer document that we supply will now be kept on file as part of the recording keeping.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Following the inspection in March the following actions were undertaken to in response to the inspection:

• The items that were identified (stainless steel food trolley and dresser) are now included in the cleaning schedule and are included as part of the weekly audit undertaken by management.

• A review of the capabilities of our bedpan washer was undertaken and it was determined that it would facilitate the contents of bedpan etc being placed directly into it and hence minimizing the risk environmental contamination.

• Clothing, Bedlinen etc that are contaminated are to be placed in alginate bags at the source of the contamination to reduce the risk of environmental and cross contamination.

• Increased monitoring of existing cleaning equipment, ensuring that dustpans and brushes are clean.

• The issue of clinical hand sinks was raised at the previous inspection as were the doors.

It was decided to address the issue of the doors as an infection control issue. Installing the Clinical hand sinks is a financial issue.

• The dirty to clean flow process was re-instated in the laundry room. This was impeded when a domestic washing machine and dryer were installed to facilitate when the industrial washing and dryer were out of action. Both domestic machines have been removed and are in storage and an additional storage area for clean clothes has been installed.

• A slated shelving unit will be installed to remove any linen off the wooden floor.

• The multipurpose storage room has had an extensive declutter. A buildup of PPE from Covid has been removed to enable better storage. The floor of the areas has also been paid with floor paint to facilitate cleaning and additional shelving has been installed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Following the inspection in March 2024 and issuing of urgent compliance plan the following actions have taken place:

• Reduction of undesignated outdoor smoking areas to one at the main entrance to the Centre. The installation of an alarm system in the sole undesignated smoking area which can be used to alert staff in the event of a situation that requires staff involvement. The provision of a fire blanket and burns spray has been made available to the area. Also, appropriate fire extinguishers are located nearby in the event of an emergency.

• Risks assessments to be carried out all residents who identify as a smoker. The assessment included cognitive and physical elements.

• The folded wheelchairs were removed from the corridor as they were identified as a potential obstruction, and a structure was built to store the wheelchairs in the event of needing them. It must also be noted that a daily check of evacuation routes is undertaken by staff and any concerns are noted.

• While it was noted that provision of adequate arrangement for staff to receive training in evacuation was not meet it must be noted that training is provided on a 2 yearly basis by a suitable qualified tutor, the course includes:
o Refresher of Module 1
o Introduction to Fire Alarm Detection system
o Visual Risk Assessment and Practical Class
o Evacuation procedures and Practical
o Summary test / Evaluation

• Following the inspection we have identified the fire compartments boundaries on the floor maps and carried out a simulated night evacuation, which included complete evacuation of the building.

• As part of the evacuation procedure, bedrooms are checked and marked with chalk to signify that they are empty, this procedure starts with bedrooms nearest to where the fire has been identified. Regarding automatic door closing devices for bedrooms will be included in the Fire Risk Assessment to be carried out.

• Kitchen door on a hook for ease of entrance while presenting meals to residents have all been removed and doors that had issues with magnetic closers have been repaired.

• The doors that had the cold smoke seals compromised with paint following the repainting as part of addressing the infection control concerns are being addressed by the contractor who carried out the original work.

• Regarding incorrect floor signage on the back of bedroom doors, this was rectified and happened because the paint contractor had inappropriately replaced floor signage on wrong doors were rehanging the doors.

• The PEP's will identify if supervision is required, and the house fire safety instruction given to all new residents will now include instructions about not re-entering the building with specific instructions to do so by the Fire brigade staff or Mount Carmel Staff.

• Regarding other issues raised including the serving hatch, storage of documents in the attic, these have been included in the Fire Risk Assessment that we agreed to have carried out by a competent company. The assessment was carried out on the 18th of April 2024 by external company and we are awaiting the report and its findings and recommendations.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

• My Life Story Book is an assessment tool we introduced to help capture the social aspect of resident's lives, there may have been a timing issue in relation to been asked to participate in the assessment as we allow residents to settle in before carrying out this assessment. All residents are asked and encouraged to participate in the assessment but not all residents wish to engage in the assessment. We have after an initial decline to carry out the assessment go back to the resident a second time. We will ensure that all residents are asked at admission to participate in the My Life Story Book assessment.

• The PIC will ensure that following a fall the respective Fall Risk Assessment Tool will be updated and reflect any changes required. • In addition quarterly reviews will take place in conjunction with residents of their respective care plan requirements.

Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: It is always the policy following an incident such as a fall or slip that the resident is aided to seek medical review or assistance especially if following initial assessment by staff that further medical assessment is warranted. This has and can be done after-hours services such as Caredoc etc, if the resident declines this assistance it is noted in the care notes.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/05/2024
Regulation 19(1)	The registered provider shall establish and maintain a Directory of Residents in a designated centre.	Substantially Compliant	Yellow	30/04/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/04/2024
Regulation 25(1)	When a resident is temporarily absent	Substantially Compliant	Yellow	30/04/2024

	from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/04/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	28/03/2024
Regulation 28(1)(c)(i)	The registered provider shall	Not Compliant	Red	28/03/2024

	make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Not Compliant	Red	28/03/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	28/03/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the	Substantially Compliant	Yellow	28/03/2024

	designated centre and safe placement of residents.			
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.	Not Compliant	Orange	28/04/2024
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Not Compliant	Orange	28/04/2024
Regulation 34(2)(a)	The registered provider shall ensure that the complaints procedure provides for the nomination of a complaints officer to investigate complaints.	Substantially Compliant	Yellow	30/11/2024
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the request of a complainant, the decision referred	Substantially Compliant	Yellow	30/11/2024

	to at paragraph (c).			
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Substantially Compliant	Yellow	30/11/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	30/11/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	30/11/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's	Substantially Compliant	Yellow	30/04/2024

	admission to the designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/04/2024
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Substantially Compliant	Yellow	30/04/2024