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:	Midleton Community Hospital
Name of provider:	Health Service Executive
Address of centre:	The Green, Midleton, Cork
Type of inspection:	Unannounced
Date of inspection:	08 August 2024
Centre ID:	OSV-0000579
Fieldwork ID:	MON-0044534

About the designated centre

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

Midleton Community hospital is a 42-bed facility predominantly for the care of the older persons; however it is registered to care for any person over the age of 18 years, both male and female. The hospital provides 24-hour nursing care provided by a team of doctors, managers, staff nurses, multi-task attendants (MTAs) and other staff members. Residents have access to a wide range of services including physiotherapy, podiatry/chiropody, speech & language therapy (SALT), dietitian, optical, dental and hairdressing. The multi-disciplinary team works together to provide holistic care for residents.All religious denominations are facilitated and we have close links with the local clergy. There is a chapel on site. The catering department provides nutritious meals which are tailored to meet the different dietary requirements of each resident. There is an activity programme in place for residents' social needs ranging from art therapy, music, external activity providers, visits by local schools/choirs, gardens on site, day trips, movie afternoons and excursions to the nearby farmers' market.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

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
Thursday 8 August 2024	09:00hrs to 17:40hrs	Mary O'Mahony	Lead
Thursday 8 August 2024	09:00hrs to 17:40hrs	Niall Whelton	Support

What residents told us and what inspectors observed

The overall feedback from residents was that Midleton Community Hospital was a nice place to live in and residents felt their rights were respected. Staff promoted a person-centred approach to care and were observed by the inspectors to be kind and respectful towards residents. This was an unannounced inspection, by two inspectors of Social Services, from the Health Information and Quality Authority (HIQA), one of whom had expertise in fire and estates management. The inspectors met and spoke with all residents, and with six residents in more detail, who said they were very happy, and "at home" in the centre,. They were content with the care, the accommodation and meals in the centre. Three family members also met with inspectors and echoed the positive comments of residents.

The front building had been temporarily closed, due to recent flooding in the local town of Midleton. The renovations of the front building are now completed and the provider (HSE) had applied to reopen the beds, for those residents who had been temporarily accommodated in either, St Mary's Ward, in Heather House which is another HSE centre, and in the upstairs, back building. St Mary's ward, in the downstairs back building, had been reconfigured to accommodate six of those residents in two bedrooms. The unused large physiotherapy room in St Mary's ward, had been converted into an additional dining and sitting room. Residents living in this unit told the inspector that they were looking forward to returning to the front hospital. They had been facilitated to go down to see the improvements and said they were impressed with the decor and the high quality furnishings.

Midleton Community Hospital is located in the centre of the busy town of Midleton. The Health Service Executive (HSE) was the registered provider for Midleton Community hospital. The centre consisted of two buildings, the front and back buildings, accessible to each other across a back garden and furnished patio area. Bedroom accommodation consists of single, twin, triple and four bedded rooms. Renovations had been undertaken, in the last number of years, to improve the quality of life of residents, while awaiting completion of a new building on site. The new building had progressed to near completion, and the person in charge stated it was due to be finished at the end of the year, or early next year.

Inspectors met with the person in charge on arrival in the centre. Following an introductory meeting, inspectors were accompanied on a walkabout of the front and back building. The front hospital building, which was currently unoccupied, had been renovated to a very good standard, with high quality furniture and fittings. Toilet areas had been widened to ensure accessibility for residents with diverse needs. The inspectors observed that there were overhead hoists in the two multi-occupancy bedrooms. However, the screens in these bedrooms were quite cumbersome, which was addressed in the quality and safety dimension of the report under, Regulation 17: premises. Care had been taken with the decor, to ensure it was modern, and suitable for those residents who would be returning to take up their previous accommodation. The inspectors saw that the management of fire safety had been

comprehensive and certification was made available, stating that fire safety works were completed and approved.

The back building has been reconfigured and the hallways and toilets were now wider and more accessible to residents. In the back building residents were seen in the 'garden room' doing an activity with an external facilitator. A group of residents were seen spending time in another small sitting room, reading, while others were out walking with members of the activity team. Dining tables and chairs had been provided in the communal rooms and residents were seen to dine at these tables during the day of the inspection. They told inspectors that they enjoyed the sociability of mealtimes. All residents now had double wardrobes and said they had enough space for their clothes and possessions. The person in charge explained that she encouraged relatives to continue to bring in personal items from home, to make their bed spaces more homely. Photographs and drawings were displayed in the bedrooms along with other memorabilia. Labelled, personal clothes were seen to be returned from the laundry in clear plastic bags. Residents informed the inspectors that they were happy with the service available and said that delicate items were sent to a specific launderette. There had been issues with laundry earlier in the year, due to an external event, which was since resolved. These complaints were documented and made available for inspection purposes. The minutes of residents' meetings, and a number of survey results reviewed, confirmed the positive comments made to the inspectors, about residents' satisfaction with life in the centre.

Photographs of recent celebrations were displayed, and interactions between staff and residents indicated that staff had a very warm relationship with residents, the community and families. Inspectors observed a large group of residents being accompanied to the on-site church, for mass in the afternoon. Inspectors found that residents had good levels of social contact, with the person in charge, with the activity personnel, the hairdresser, the staff, and their visitors. They were seen to be informed and to enjoy the conversations about the renovations and the activity of the builders, on the adjacent site. Residents told inspectors that their choices were generally respected, in relation to visits, meals, bedtimes, access the local ''green'' area, daily papers, mobile phones, the use of headphones and computers. Inspectors reviewed documentation which confirmed that when a resident stated that they wanted to go to bed at a time of their own choosing, this was respected.

Care plans and strategies were in place to support those with challenges to communicate effectively. Visitors confirmed that there was good communication with staff. Community involvement was evident, fund raising by ''the friends of Midleton hospital'' was continuing. Staff and residents said that, staff members, the local community, the builders and the ambulance personnel, had been very supportive, on the evening and night of the flood, and throughout that period. By way of example, some staff had stayed on site that night until 01.30, to ensure all residents from the front hospital were safe, and relocated to new accommodation.

The next two sections of the report present the findings of this inspection, in relation to the governance and management arrangements in place in the centre,

and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

On this inspection, inspectors found that, in general, the governance and management arrangements, required by regulation to ensure that the service provided was well resourced, consistent, effectively monitored and safe for residents, were well defined. A number of areas of good practice were observed: inspectors found that there were comprehensive audit and management systems set up in the centre, ensuring that good quality care was delivered to residents. Nevertheless, areas such as premises, aspects of fire safety, infection control, and the directory of residents, required action, in order to comply with regulations.

The registered provider for the centre was the Health Services Executive (HSE). The general manager acted as the named person representing the HSE, for the purposes of regulation and registration, and attended the feedback meeting at the end of the inspection day. The provider had applied to renew the registration of the front building and had complied with the requirements of the regulations in relation to this process. They had applied to register 33 residential beds, between the two buildings, a reduction of nine beds. The care team in the centre was comprised of the person in charge, four clinical nurse managers (CNMs), a team of nurses and health-care staff, as well as administrative, catering, household and maintenance staff. Complaints management and key performance indicators (KPIs) such as falls, restraint and antibiotic use, were reviewed and discussed at these meetings. The information for the annual review of the quality and safety of care for 2023 had been collated. The audit schedule was set out at the beginning of the year and aspects of residents' care including the judicial use of antibiotics (antimicrobial stewardship), were audited monthly. Clinical audit was being carried out in areas such as medicine management, wounds and infections.

The service was well resourced and the provider was generally responsive to findings on inspection. Many findings were addressed on the day, or shortly afterwards. However, as described under Regulation 17, aspects of the premises required further action, to comply with Schedule 6 of the regulations. While a new building was due to open in early 2025, there were currently 23 residents residing in the existing centre, which meant that their privacy, dignity, comfort, accessibility and safety, had to be assured for the remaining months in the "older" buildings. The training matrix indicated that staff received mandatory, and appropriate training, appropriate to their various roles. Internal and external trainers were employed to deliver manual handling training, dementia care, safeguarding and infection control training. This meant that staff were informed on best evidence-based practice and were aware of the most up to date information, on aspects of residents' care. Staff handover meetings, and team meetings, ensured that information on residents' needs was effectively exchanged between the staff groups. Information, seen in

individual communication sheets, provided evidence that relevant information was passed between day and night staff. Copies of the appropriate policies, standards and regulations, were accessible to staff.

Where restraints, such as bedrails, were used, they were risk assessed and used in line with national policy. Residents exhibiting responsive behaviour (how residents with dementia respond to changes in their environment or express any distress) were well supported. Staff were observed to respond appropriately to such residents, including the use of a clinical assessment tool to describe the behaviour. However, action was required to ensure best practice in the promotion of residents' safety and free movement, related to access to outdoors, as highlighted under Regulation 17, in this report.

Inspectors found that records required by Schedule 2, 3 and 4 of the regulations were available for inspection purposes. A sample of staff personnel files were seen to be correctly maintained. Vetting disclosures, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016, were in place for all staff, prior to commencement of work in the centre. There was a comprehensive complaints management system in place. This was described in more detail under Regulation 34: complaints.

Regulation 16: Training and staff development

Records showed that there was good oversight of staff training needs;

Inspectors were assured that the registered provider had appropriate staff supervision arrangements in place to ensure that care delivery was appropriately monitored and delivered. Mandatory training was up to date for all staff. Additional, appropriate, training was available in, end of life care, gerontology, resuscitation and infection control procedures. There were satisfactory arrangements in place for the ongoing supervision of staff, through CNM presence on each unit, and through the induction, probation and performance review process.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents required review and action, as follows:

The required details, as set out in Schedule 3, part 3, of the regulations, were not entered in the directory for all residents, for example, the name and address of the next of kin, the name and address of residents' GPs, the name of the admitting hospital or other, as well as cause of death, where known.

Judgment: Substantially compliant

Regulation 21: Records

The records required to be maintained in each centre under Schedule 2, 3 and 4 of the regulations were available to inspectors and they were securely stored.

Staff files were well maintained and contained the regulatory documents.

Judgment: Compliant

Regulation 22: Insurance

Evidence was made available which indicated that the centre was appropriately insured .

Judgment: Compliant

Regulation 23: Governance and management

Some management systems pertaining to the oversight of fire safety and risk management and premises issues, required action, to ensure the service was safe and appropriately and effectively monitored:

This was evidenced by:

Regulation 28

- Fire safety issues to be addressed such as: the need to provide assurance that fire-stopping had been completed on some walls and ceilings, where gaps around pipes had not been sufficiently sealed (in order to prevent the spread of smoke and fire).
- Some fire safe doors required repair and adjustment. (A number of these issues were addressed during the inspection.)
- An inappropriate, door holding mechanism, was in use on one toilet door.
- These findings were highlighted in more detail under regulation 28: Fire safety

Regulation 17:

Additionally, issues requiring action, related to premises works and privacy and dignity, were detailed under regulation 17: Premises.

For example,

- the challenges of living in multi-occupancy wards.
- accessibility of toilets for use by wheelchair users.

Regulation 27:

- Infection control issues, related to storage of equipment.

Regulation 19:

- Maintenance of the directory of residents.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Complaints were well managed in the centre.

There was a comprehensive complaints policy in place and this was displayed at the entrance to the designated centre. Residents and families were made aware of the complaints policy and knew how to make a complaint if they wished to do so. Records of complaints were well maintained and investigated in line with the centre's complaints policy. These records were reviewed by the inspectors.

Residents informed the inspectors that they were advised to make a complaint if they were unhappy. The person in charge stated that they would be supported and said that senior management team members had been trained in complaints management.

Judgment: Compliant

Quality and safety

Overall, residents in Midleton Community Hospital were found to be supported to have a good quality of life which was respectful of their wishes and choices. Residents spoken with were complimentary of the staff, the care and their access to relatives and visits. While findings on this inspection demonstrated good compliance

with the regulations inspected, some improvements were required in relation to premises, infection control, and fire safety, in this dimension of the report.

Inspectors were assured that residents' health-care needs were well met. There was weekly access to the general practitioners (GPs), who were described as supportive to staff, and residents. This attention was evidenced by the medical notes, in residents' files. The pharmacy fulfilled their duties, as outlined in the regulations for the sector. Specialist services were accessible, as described under Regulation 6: Health-care. A comprehensive assessment was carried out for each resident before admission, which supported the development of an individualised, care plan.

In recent years, the registered provider had invested in upgrading sections of the premises, which consisted of two separate buildings from the "old workhouse" era. Due to the complexities of making this old building suitable for the modern era, and residents' privacy and dignity needs, the provider had invested in building a 50 bedded, purpose-built, premises, on the same grounds as the existing hospital. Residents and relatives said they were looking forward to the fact that they would all have private, fully en-suite, bedrooms in the new build, which was due for completion, late in 2024 or early 2025. The front building had been newly, and carefully, renovated following the recent flooding and was now ready for occupation. Actions, which were required in relation to premises, were detailed under regulation 17.

There were good systems of fire safety management and oversight. The designated centre comprised old buildings, which by the configuration and layout, created ongoing challenges to fire safety management in the centre. Fire safety upgrades in recent years had greatly improved the layout, and significantly improved the safety of residents. The centre was subdivided into fire compartments, which allowed effective progressive horizontal evacuation. There was an active construction site adjacent to parts of the designated centre, which impacted the means of escape from some exits. The interim arrangements put in place ensured that adequate escape was available, and this was under ongoing review. Actions required in relation to fire precautions are detailed under regulation 28.

The front building was finished to a high standard and the inspectors saw appropriate documentation which confirmed the renovations were completed to an appropriate standard.

The centre was observed to be very clean, and staff were seen to adhere to good hand hygiene protocol, however, some actions required under this regulation were described under regulation 27: Infection control.

A safeguarding policy provided guidance to staff, on recognising and responding to abuse. Staff spoken with demonstrated an appropriate awareness of their safeguarding training and their related responsibilities. Finances were managed in line with the HSE private, personal, property policies and procedures.

Residents' nutrition and hydration needs were met. Residents praised the choice of meals on offer and expressed praise for the chef. Daily menus were available on each table. Individual food preferences and dietetic requirements, such as, gluten

free diet or modified diets were respected. However, in the evenings, as found on previous inspections, the dining tables were not utilised to their full extent, with a large number of residents served their tea in their bedrooms. The person in charge stated that this will be addressed, and noted that there will be improved dining facilities in the new building.

Inspectors found that, in general, residents were free to exercise choice on their daily routine. A number were seen to go out with family, a group visited the "village green" by the town, and others attended mass and went for walks outside with staff. It was evident that residents were consulted about the running of the centre, formally, at residents' meetings, and also through the daily interactions with staff and family members. Kind and attentive moments, were witnessed, between staff and residents, during the inspection. However, further support, particularly around regular external access, was required. The person in charge stated that risk assessments will be carried out by staff and the physiotherapist. Following these, individual key fobs, for entering and exiting the building, will be made available to some residents.

Regulation 10: Communication difficulties

Residents who had communication difficulties, or special communication requirements, were seen to have these recorded in their care plans and were observed to be supported to communicate freely.

Residents were also facilitated to access additional supports, such as, assistive technology to assist with their communication

Judgment: Compliant

Regulation 12: Personal possessions

There were adequate arrangements in place for the management of residents' personal possessions.

Each resident had sufficient space for storing personal possessions, including a double wardrobe and a bedside locker, with a lockable drawer.

As regards furnishing the newly renovated front building, the person in charge stated that an additional eight, lockable, bedside lockers will be transferred with the residents, who will be relocated to the front building, from the back building.

Where there were limitations on the placement of furniture next to residents' beds in some rooms, this will be addressed under Regulation 17: premises.

There were effective systems in place for the return of residents' clothing and bed linen, following laundry in an external service. This service had resolved a number of issues with damaged laundry, following a fire at the external service. These complaints and concerns had been documented and were made available for review by the inspectors. The satisfaction of residents and relatives was recorded. Residents had been appropriately compensated, and the person in charge stated that the service was under constant review and audit, to ensure that an effective service was maintained.

Judgment: Compliant

Regulation 17: Premises

Not all aspects of the premises complied with the requirements of Schedule 6 of the regulations for the sector, and regulation 17: Premises:

An immediate action was given to the provider, to address the accessibility issues, in relation to the available toilet space in St Mary's Ward.

A near miss incident had occurred and appropriate action had not been taken, to ensure accessibility and privacy for a wheelchair dependent resident, using the toilet. (A responsive and effective action was taken by the provider on the days following the inspection and the toilet in now accessible and safe for use, independently, by a wheelchair user.)

- The wall mounted, telescopic, folding screens were difficult to manoeuvre around individual beds, in the four bedded, multi-occupancy rooms, in the front building. Their design and movement was cumbersome and heavy, meaning that a staff member would have to support a frail older adult to move them around the bed, if individual privacy was required for reading, visiting or sleeping. Four mobile screens were available, to supplement the fixed screen and increase the available private bed space, when staff were required at both sides of the bed, or a specialised chair was needed in the space, to seat a resident using the overhead hoist
- The overhead hoist was noisy when moved across the ceiling, and this would undoubtedly be disturbing to other residents, if used during the night for any resident
- The design and layout of the four bedded rooms meant that it was difficult for all four residents to see one of the two large screen TVs, or watch their favourite programme, without their bed being repositioned, or disturbing others.
- The sitting/ dining room for the four residents, in each of the four-bedded rooms, was located at the end of the room. This meant that staff, relatives and other residents, had to pass by residents' private bed space, to access this. Some contingency measures had been put in place, however, a risk assessment was required to ensure that sufficient controls were in place, to

protect those who were confined to bed, or choose to spend a day in bed, from intrusion by others. This was also an issue of concern in the back building, upstairs, where there was no barrier except a curtain, between some bed spaces and the hallway, where staff, relatives and residents passed by, all day

- There was no screening on all windows in the four bedded rooms in the front building to protect residents privacy . (Appropriate screening was sourced and applied to all windows immediately following the inspection.)
- The security and safety and accessibility for residents, when walking outside, and in the side gardens, required review and risk assessment, as the grounds led out to a rough surface in one area, and car parking areas, in all directions
- In the twin bedrooms, in the front building, it would be difficult for both residents to access the sink, due to the location of the sink at the end of one bed, and lack of available space to mobilise. (The person in charge reconfigured the beds in one room, and this made the sink more accessible to both.)
- In addition, in these bedrooms space was limited for a bedside chair, without blocking the wardrobe from opening or to enable clear access to the wardrobe.
- In the rear building the configuration of the privacy screens in the three bedded rooms in St. Mary's did not maintain privacy within the residents' bed space.
- Flooring in the sitting /dining room in St Mary's ward was damaged, which would impede effective cleaning.

Judgment: Not compliant

Regulation 27: Infection control

Some actions were required to ensure that the centre complied with infection control guidelines and best practice;

For example:

- The timber shelving in the linen storage cupboard was not a suitable material for deep cleaning purposes.
- A large number of laundry trollies were stored in the residents' bathroom, restricting access to the toilet and bath.
- The housekeeping cupboard was small, and as a consequence, when the housekeeping trolley was stored there, it blocked access to the hand washing sink.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Some action was required to ensure adequate precautions against, and protect residents from, the risk of fire, for example;

- There was a vacuum cleaner stored in an escape stairwell; stairways should be kept free of storage and obstructions.
- A storeroom in the rear building had an electrical panel in the corner of the room. There was storage adjacent and this created a risk of fire.
- The person in charge arranged for this storage to be immediately removed. Furthermore, a risk assessment is required by a competent person to determine appropriate controls for staff to implement to keep this area safe.

In the chapel, there were two side exit doors leading to the outside; assurance was required from the provider that where residents were in varying types of wheelchairs, that appropriate means of escape was available. The person in charge committed to completing drills in this area to ensure adequate means of escape.

The inspectors reviewed fire drill records and personal emergency evacuation plans (PEEPs) for residents. Regular fire drills took place and simulated various scenarios; the reports would benefit from more details, including where the simulated evacuation was to lead to. Similarly, the PEEPs would benefit from more detail, to include supervision requirements and how many staff were required to assist each resident.

Overall, the building had good fire containment measures in place. Some deficits were noted to fire door sets, including gaps and doors that did not fully close. The provider had already arranged for a full review of fire doors in the centre and this was actively being addressed during the inspection, with contractors on site. There was some fire sealing required to the electrical room in the rear building, where wires and pipes penetrated the fire-rated ceiling.

Additional detection of fire was required in the corridor in St. Mary's, to ensure adequate detection of fire.

Fire safety systems, including the kitchen suppression system, emergency lighting and fire detection and alarm system were being serviced at the appropriate intervals; however the certificate/confirmation for annual inspection and testing of the emergency lighting system was not available for review. This was forwarded following the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care plans had been developed to support staff to meet the needs of residents:

A comprehensive assessment was seen to be carried out to assess residents' health, personal and social care needs, prior to admission. Care plans were person-centred to each resident and were underpinned by appropriate, clinical, risk assessment tools.

A review of each care plan was carried out at intervals, not exceeding four months, or when necessary.

Judgment: Compliant

Regulation 6: Health care

Health care was well managed in the centre.

Two general practitioners (GP's) attended the centre on a regular basis. Residents' medications were reviewed as part of the medical consultation. The pharmacist and staff engaged in ongoing monitoring and auditing of medication management practices.

The care of any pressure wound was seen to be carried out, in line with professional guidelines from the tissue viability nurse (TVN), and the GP. Pressure relieving mattresses were in use for any vulnerable resident and one, relevant, care plan reviewed contained photographs of a pressure wound, indicating that incremental healing was taking place.

Residents had access to specialist services such as psychiatry of old age, palliative care professionals, chiropody, external dental care, speech and language therapists (SAL,T), occupational therapy (OT), geriatrician, dietitian and optical assessments.

Several residents had specialist chairs and the suitability of the chairs had been assessed by the OT.

The physiotherapist attended when required, to support residents with their mobility, for post falls assessment and to give advice on the use of suitable equipment, as part of the falls prevention programme.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors spoke with the majority of residents throughout the day. They said that they were happy in the centre and felt their rights and choices were respected, for example, in relation to food choice, visiting local shops, and activity involvement.

Residents reported that they felt safe in the centre and they attributed this to their familiarity with staff. Most staff members had an understanding of residents' backgrounds and interests.

Visitors and residents confirmed that they were treated with dignity by staff and by the person in charge.

Residents had access to social outings, activity provision by an external provider each day, gardening, religious services, external and internal musicians and celebrations with family.

Residents felt that they could raise concerns about aspects of care in the centre and they felt that support was available from staff. A review of minutes of residents' meetings evidenced that, residents were informed about changes, and where residents made suggestions for improvement, these were acted upon.

Activities, in general, were meaningful and interesting. Residents praised the choice on offer, as well as the staff leading the programme, who were mainly part of an external activity group.

Where the age, era and layout of the premises impacted in a negative way on the right to privacy, and safe external access, this was addressed under Regulation 17: premises.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Midleton Community Hospital OSV-0000579

Inspection ID: MON-0044534

Date of inspection: 08/08/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: • The directory of the residents has been updated to include a comprehensive set of information as set out in Schedule 3, part 3. • We will maintain an up-to-date directory of residents by ensuring that all required admission details are gathered and documented promptly upon arrival of new residents as per HSE Admission policy.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • In response to fire safety concerns, all identified issues were promptly assessed and addressed. Gaps in fire stopping on some walls and ceilings and around pipes were rectified. These areas were inspected, sealed, and officially signed off by the Fire Seal Company on 22nd August 2024. • In response to the fire-safe doors, the fire seal company inspected and repaired all fire-safe doors in the hospital. The work was completed on August 16, 2024. • The inappropriate holding mechanism was immediately discontinued upon identification during the inspection. A risk assessment was conducted, and appropriate control measures were put in place. The resident's toilet was refurbished into a wheelchair-accessible toilet to facilitate accessibility and privacy for the resident.	

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• MCH acknowledges the concerns about the design and movement of the privacy screens, as residents will need assistance to move them. To address this issue, we will assess the placement of privacy screens to ensure they are easily accessible and movable. The privacy screen provider will visit to assess the screens for solutions that residents can easily manoeuver. The risk assessment will be reviewed regularly to mitigate any further identified risk.

• MCH acknowledged the concern about the noise generated by the overhead hoist when moved across the ceiling, which undoubtedly disturbs other residents if used during the night for any resident. To mitigate this issue, the following measures are in place:
The equipment provider was contacted on 09.08.2024 for immediate maintenance and inspection to identify and address any mechanical issues causing the noise and explored with the servicing company for a dampening solution. The staff have been instructed to move the overhead hoist gently to reduce operational noise.

• Additional televisions were installed on 20.08.2024. Each resident in the four bedded rooms has a television and Bluetooth headphones.

• The privacy of the residents in the multi-occupancy bedrooms was reassessed to ensure they are protected from intrusion by others. Control measures in place are as follows:
o Privacy screens are drawn around the resident's space during personal care or rest.
o The dining/day room in each of the four-bedroom rooms is accessible to residents and staff only as much as possible.
o Two separate sitting rooms are available to receive visitors.
o Clear signage is placed inside the room and on the door to remind staff, visitors, and residents to respect the privacy of all individuals in the room.
o Staff awareness of the importance of the resident's privacy in shared spaces is increased and reminded to all staff at daily meetings.

• Privacy film in the resident’s bedroom lower window was installed on 13th August 2024.

• A security fence and gate were installed in the side garden of the front building on 23rd August 2024. Appropriate signage has been put in place to ensure the safety of the residents, including slow-down and wheelchair users. The HSE Maintenance has committed to undertaking a risk assessment for the footpath alongside the garden. In the interim, residents will be supervised when outside the garden area.
• Regarding the concern about the sink's location and the limited space to move around in the twin bedroom, MCH will thoroughly assess the potential residents who can be accommodated in the twin bedroom. This ensures that the room setup meets their needs

and promotes their well-being. Priority will be given to residents who are fully dependent on their care, ensuring their complex needs are fully met.

• Additional privacy screens were installed in St Mary's ward on 23.08.2024 to maintain privacy within the resident's space.

• MCH will improve the cleaning procedure to address the damaged floor, ensure thorough dirt removal, and effectively monitor the area's cleanliness. Funding to replace the flooring has been approved and the works are due to progress in the coming weeks, with a proposed completion date of 31.11.2024.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
- On August 13th, the timber shelving inside the linen room was replaced with mobile chrome wire shelving, which is suitable for deep cleaning.

- All the laundry trollies will be immediately removed from the resident's bathroom and relocated to a designated storage area that does not restrict access to bathroom facilities.

- An alcohol dispenser was installed by the entrance wall of the housekeeping cupboard, and a hand wash sink was available inside the visitor's toilet, which is about 10 feet apart.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
- A cleaning storage room is available on the floor, and staff were reminded to store all cleaning equipment appropriately when it is not in use.

- The Estate Fire and Safety Officer has committed to conducting a risk assessment on the electrical panel inside the storage room, and any recommendations will be immediately implemented. In the meantime, a local risk assessment was carried out. The following control measures were put in place: Access to the storage area is restricted to management personnel only, a minimum clearance of 5 feet is maintained around the electrical panel, a CO2 fire extinguisher is placed near the storage room, regular inspection of the electrical panel by a competent person is conducted, and materials in

the storage area are organized and stored away from the electrical panel, with flammable materials (chemicals) kept out of the room.

- Fire evacuation drills were performed at the church, which involved the evacuation of various types of wheelchairs and scenarios. The exit route on the right side of the church, which brings you directly outside, and the escape route through the entrance of the church were established as the two primary escape routes. MCH will endeavor to conduct a regular fire drill in this area.

- Simulated fire evacuation drill reports will include where the end point of the simulated evacuation, which will be communicated to the staff during the drill.

- The personal evacuation plans (PEEPS) for residents were updated with additional information on the residents' assistance requirements for day and night scenarios.

- On 22nd August, 2024 the Fire Seal Company assessed and sealed off gaps in the fire-rated ceiling on some wires and pipes inside the electrical room in the rear building.

- An additional smoke detector was installed in the corridor in St Mary’s ward on 23rd August, 2024.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/10/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	30/09/2024
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.	Substantially Compliant	Yellow	22/08/2024
Regulation 27	The registered provider shall ensure that	Substantially Compliant	Yellow	30/09/2024

	procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
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.	Substantially Compliant	Yellow	15/10/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	23/08/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	22/08/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons	Substantially Compliant	Yellow	30/09/2024

	working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	22/08/2024
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 designated centre and safe placement of residents.	Substantially Compliant	Yellow	30/09/2024