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:	Holy Ghost Residential Home
Name of provider:	Holy Ghost Hospital Board of Trustees
Address of centre:	Cork Road, Waterford
Type of inspection:	Unannounced
Date of inspection:	04 July 2024
Centre ID:	OSV-0000591
Fieldwork ID:	MON-0037125

About the designated centre

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

The Holy Ghost Residential Home is a single-storey purpose built centre that includes various renovations and extensions which have taken place over the years to enhance the living spaces for residents. It contains 60 single bedrooms with full en-suite bathrooms. Communal accommodation consists of a large communal sitting room called the concourse. A large dining room is located beside a well-equipped kitchen and a second sitting room is across the corridor. Other communal areas includes a fully furnished oratory, a library, a comfortable furnished foyer, a smoking room and a hairdressing room. There are also additional seating areas along some corridors. There is an enclosed garden in the centre of the building and other outdoor spaces are available including walkways at the front of the building.

The Holy Ghost is a residential setting catering for residents to live independently with supportive care. The emphasis is on home-style living where each resident has their own room/living space. The Holy Ghost residential home does not provide 24-hour nursing care but a registered general nurse is responsible and accountable for the daily running of the home. This supportive independent care model is reflected in the staffing structure which is household, catering and caring staff as in the community setting.
The centre is located in Waterford city in close proximity to the city centre and to public transport networks.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	58

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 4 July 2024	09:20hrs to 17:40hrs	Aisling Coffey	Lead
Friday 5 July 2024	07:50hrs to 14:00hrs	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 Holy Ghost Residential Home. The residents described the centre as a "home from home" and informed the inspector, "it's lovely here". Residents were highly complimentary of the staff and the care they received. One resident told the inspector that when it came to the staff, "you could have a laugh with them", while other residents described the staff as "the best" and outlined how kindly they were treated. The feedback captured the person-centred approach to supported living seen in the centre. 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.

This unannounced inspection took place over two days. On both days, the inspector spoke with residents, staff, and visitors to gain insight into the residents' lived experiences in the centre. The inspector also spent time observing the environment, interactions between residents and staff, and reviewing a range of documentation.

The centre is a large single-storey premises in a quiet cul-de-sac in Waterford, close to many shops, transport links, and other amenities. The main entrance lobby was attractive and welcoming, with comfortable furnishings, decorative features, and information on the services available. Internally, the centre's design and layout supported residents in moving throughout the centre, with wide corridors and sufficient handrails to accommodate residents with mobility aids. Photographs of residents and staff enjoying group activities and outings were displayed on the walls of the centre's corridors. There were multiple communal areas for residents to enjoy, including the chapel, visitor room, meeting room, library, lounge, and dining room. These areas were bright and spacious, featuring recently purchased comfortable armchair seating, attractive furnishings, and domestic style features, such as large decorative clocks and antique radios, providing residents with a homely environment. The main communal area was the concourse, a seated area where four wings of the centre intersect and where residents congregated to chat and watch television. While the concourse was a large open-plan area, the provider had installed screens in one section, creating a quieter and private seating area.

Bedroom accommodation consists of 60 single bedrooms. Each bedroom has en-suite facilities, including a shower, toilet, and wash hand basin. All bedrooms throughout the centre had a television, call bell, wardrobe, seating, and locked storage facilities. Residents personalised their bedrooms with photographs, artwork, lamps, soft furnishings, religious items, and ornaments. The size and layout of the bedroom accommodation were appropriate for resident needs.

While there was an onsite laundry used for domestic purposes, residents' clothing was laundered offsite by their families. A limited number of clinical handwash sinks were available in the centre for staff use. Staff informed the inspector that sinks within residents' en-suite bathrooms were dual-purpose and used by both residents and staff for hand hygiene. Hand sanitiser dispensers were conveniently located in corridors to facilitate staff compliance with hand hygiene requirements further.

There was an internal garden in the centre, which was clean, tidy, and pleasantly landscaped. The garden had raised flower beds, potted plants, hanging baskets filled with flowers, and water features.

There was a relaxed and unhurried atmosphere in the centre, and staff were seen responding to resident requests promptly and respectfully. Residents were up and dressed in their preferred attire and appeared well-supported. Residents watched television, read the newspaper, enjoyed the enclosed garden area, and chatted 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. Other residents were attending a local day centre in the city. While the inspector did not observe any activities on the first inspection day, multiple residents informed the inspector about the range of entertainment available in the centre, including sing-songs, dancing, bingo, card games, and outings facilitated on the centre's bus. On the second inspection day, a local band attended the centre to perform live music.

Residents had access to local and national newspapers, radios, and television. There were arrangements in place for residents to access independent advocacy services. Roman Catholic mass was celebrated in the centre on Tuesday and Saturday and broadcast on television five days per week. The centre's chapel provided a space for prayer and quiet reflection. The room had an altar, religious statues, and the stations of the cross. The provider had arrangements to support residents of other denominations practising their faith and maintaining contact with their religious leaders as required.

Residents could receive visitors in communal areas or in the privacy of their bedrooms. During the inspection days, multiple families and friends were observed visiting inside or spending time with their loved ones in the centre's garden. The inspector spoke with several visitors. Without exception, each visitor expressed their satisfaction with the quality of care provided to their relatives living in the centre and the communication between staff and families.

Lunchtime at 12.45pm was observed to be a sociable and relaxed experience, with all residents choosing to eat in the dining room. Residents sat in their preferred seats and spoke with their friends over lunch. Meals were freshly prepared onsite 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 meal and dessert was offered, and ample drinks were available for residents at mealtimes and throughout the day. Residents spoke positively to the inspector about the food quality, quantity and variety. The inspector observed breakfast on the

second day of the inspection and similarly noted it to be a relaxed, unhurried, pleasant experience for the residents.

Internally, the centre was pleasantly decorated and generally in good repair. However, some areas for repair were evident externally, for example, in several areas where the plaster had been removed from the walls. The provider informed the inspector that they knew of this maintenance need and planned work to address it in the coming weeks. While the centre was generally clean and tidy, staff practices in managing storage were reviewed, and some improvements were needed as outlined under Regulation 27: Infection control.

A number of residents in the centre chose to smoke. While the centre had a smoking room for residents containing protective equipment, such as a call bell, ashtrays, fire blanket and fire extinguishers, the inspector observed a cigarette box containing extinguished cigarette butts in the centre's internal garden.This area did not have the necessary protective equipment to support residents to smoke safely and protect them in the event of a fire. This and other fire safety matters are 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, the inspector found that more robust management and oversight systems were required to ensure that the service provided to residents was safe, appropriate, consistent, and effectively monitored.

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. While the provider had progressed with most aspects of the compliance plan following the last inspection in June 2023, this inspection found commitments made concerning managing behaviour that is challenging outstanding. This inspection demonstrated deficits in the overall governance and management of the service, with several findings impacting the quality and safety of service provision for residents. Actions were required by the provider to address areas of Regulation 5: Individual assessment and care plan, Regulation 10: Communication difficulties, Regulation 25: Temporary absence or discharge of residents, Regulation 27: Infection control, Regulation 28:

Fire precautions and Regulation 31: Notification of incidents. 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 concerning medication administration and management practices in the centre and urgent assurances were sought regarding Regulation 6: Healthcare, Regulation 16: Training and staff development and Regulation 23: Governance and management. 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.

The Holy Ghost Hospital Board of Trustees is the registered provider. The board's membership is comprised of a number of volunteers. The board chairperson represented the provider for regulatory matters and was present on the first day of the inspection. The secretary to the board is called the superintendent and is present in the centre several days per week. The provider had a clearly defined management structure, and staff members were clear about their roles and responsibilities. While the centre does not provide 24-hour nursing care, a registered general nurse is the person in charge. The person in charge works full-time in the centre, is responsible for the overall governance and reports formally to the board of trustees at monthly board meetings. The person in charge is supported onsite by an assistant manager, nurses, carers, catering, household, and administration staff. Deputising arrangements are in place. The centre is a supported care home for residents with low-dependency care needs. It is registered on the basis that the residents do not require full-time nursing care in accordance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Should a resident's care needs increase, they are supported to source alternative accommodation, usually a nursing home.

Communication systems were in place to ensure clear and effective communication between the person in charge and the board of trustees. There were monthly board meetings where the person in charge reported to the board on key issues within the centre, such as occupancy, temporary discharge, incidents, health and safety concerns, training requirements, finance and premises issues. Within the centre, there were quality management staff meetings chaired by the chairperson of the board and the person in charge. At these meetings operational matters concerning the daily care of residents were discussed, including incidents, accidents, safeguarding, clinical documentation, infection prevention and control, clinical audit and health and safety issues.

There were systems in place to monitor the quality and safety of care delivered to residents. The provider had records of accidents and near misses occurring in the centre. It was noted that each incident was investigated and a quality improvement plan identified. The provider had an audit schedule covering areas such as premises, environmental hygiene, medication management, nutrition, hand hygiene, and health and safety. Notwithstanding this good practice, this inspection found that the management and oversight systems in place needed to be significantly more robust

to effectively identify deficits and risks in the service and drive quality improvement. This will be discussed under Regulation 23: Governance and management.

The provider had completed the annual review of the quality and safety of care delivered to residents for 2023. The inspector saw evidence of the consultation with residents and families reflected in the review.

The inspector reviewed past and future rosters and found the staffing and skill mix rostered were appropriate to meet the low-dependency care needs of the centre's residents and aligned with its model of care. Although the centre does not provide 24-hour nursing care, the rosters found, there was generally a registered nurse in the centre on a 24-hour basis three days per week and at night the remaining four days of the week. However, there was also an occasion where no registered nurse was in the centre for more than 24 hours. At night, two staff members were on duty from 8.00pm to 7.30am. One of these two staff members slept from midnight to 6.00am in a designated bedroom in the centre. Given the size and layout of the designated centre, assurance was required that the provider had robustly tested the adequacy of the night-time staffing levels to ensure a safe and timely evacuation in a fire emergency. This will be discussed further under Regulation 28: Fire precautions.

While staff had access to a range of training programmes to support them in their respective roles, such as training in fire safety, safeguarding vulnerable adults from abuse and infection prevention and control, training concerning the management of behaviour that is challenging had not been undertaken in the centre, which is a repeat finding from the 2023 inspection. Furthermore, significant risk was identified due to gaps in training and supervision structures concerning medication administration and management practices. While staff supervision structures were in place in the centre, these structures had not been effective at ensuring staff implemented local policies in practice concerning medication administration and management. These findings will be discussed under Regulation 16: Training and staff development.

Regulation 14: Persons in charge

The provider had proposed a new person in charge following the retirement of the previous person in charge. A review of information supplied to the Office of the Chief Inspector of Social Services indicated that the proposed person in charge is an experienced nurse and manager with the required knowledge, experience and qualifications for the role.

Judgment: Compliant

Regulation 15: Staffing

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 16: Training and staff development

There was insufficient managerial oversight of staff practices concerning medication administration and management, as evidenced by the following findings:

- Non-nursing staff administering medication, including insulin, did not have training or an assessment of their competency to perform this role safely.
- There were no documented supervision or oversight systems to monitor non-nursing staff administrating medication.
- The provider's staff supervision structures had not identified that staff were not implementing local policies on medication administration and management in practice.

The provider had made a commitment in the June 2023 compliance plan to deliver training in managing behaviour that is challenging by January 2024, however this training had not been delivered, despite documentary evidence reviewed by the inspector confirming that staff had been supporting residents with behaviour that is challenging.

Judgment: Not compliant

Regulation 23: Governance and management

The management systems in the centre were not sufficiently robust to ensure the service provided was safe, appropriate, consistent, and effectively monitored, as evidenced by the findings below:

- The oversight systems in place to ensure individual assessments and care plans were completed correctly, and care plans were developed that accurately reflected the residents' care needs needed to be more robustly monitored, as detailed under Regulation 5.
- The systems for recognising statutory notifications that need to be notified to the Office of the Chief Inspector of Social Services had not ensured that required notifications had been made.

- Management systems failed to ensure that medication administration and management practices were undertaken by suitably trained and supervised staff and guided by the provider's medication management policies.
- The centre's oversight systems required review as they had not identified risks found during the inspection in areas such as falls and nutrition.

The inspector observed one discrepancy between the floor plans and what they observed on the inspection day. The visitor sleepover room was located where bedroom 33 was on the floor plans.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of the records related to incidents in the centre showed that three incidents in which residents required immediate hospital admission for injury assessment after a fall in the centre had not been notified to the Office of the Chief Inspector of Social Services within the required time frames.

Judgment: Not compliant

Quality and safety

While inspectors observed kind and compassionate staff treating residents with dignity and respect, enhanced governance and oversight were required to significantly improve the quality and safety of the service provided to residents. Robust action was required concerning non compliance in individual assessment and care planning and healthcare. Other areas requiring improvement included communication difficulties, temporary absence or discharge of residents, fire safety, infection control, and premises.

The person in charge had arrangements in place for assessing residents before admission into the centre. Upon admission, person-centred care plans were developed based on validated risk assessment tools. These care plans were reviewed at regular intervals, not exceeding four months. Notwithstanding these areas of good practice in care planning, some gaps were observed concerning the assessments and care plans, which will be outlined under the regulation.

Several residents were using communication aids to enable them to communicate effectively. Staff were knowledgeable about the communication devices used by residents and ensured residents had access to these aids to enable effective communication and inclusion. However, there were gaps in recording these

communication needs in the residents' care plans, which will be discussed under Regulation 10: Communication difficulties.

Records of residents transferred to and from the acute hospital were reviewed. The inspector saw that where the resident was temporarily absent from the 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. Staff ensured all relevant information was obtained from the hospital and placed on the resident's record. Notwithstanding this good practice, assurances were required that the transfer of residents from the centre was carried out in line with the requirements of the regulation, which will be discussed under Regulation 25: Temporary absence or discharge of residents.

The centre's interior was generally clean on the inspection day. The person in charge had completed a review following a recent COVID-19 outbreak. Within the review, relevant protocols and guidance were documented as having been adhered to, and learning was identified in the event of a future outbreak. The provider was due to train a staff member to take on the infection prevention and control link practitioner role. Notwithstanding these good practices, some areas for improvement were identified concerning storage practices to ensure compliance with the National Standards for Infection Prevention and Control in Community Services (2018).

Concerning fire precautions, the provider had completed works identified in the provider's fire safety risk assessment dated November 2022 to improve fire safety. Improvements included attaching door closers, reviewing all fire doors and fire hatches, installing further fire detection and enhancing emergency lighting around the premises. Preventive maintenance for fire detection and fire fighting equipment was conducted at recommended intervals, and staff had undertaken mandatory fire safety training. Four fire drills had taken place since the last inspection in June 2023. However, further assurances were required to ensure night-time staffing levels were adequate to facilitate a safe and timely evacuation in a fire emergency. Notwithstanding the improvement works undertaken, some further actions were also required to ensure that residents and staff were adequately protected in a fire emergency. These findings are set out under Regulation 28: Fire precautions.

Regulation 10: Communication difficulties

Residents identified as having communication difficulties did not have their communication requirements recorded in a communication care plan as required by the regulation.

Judgment: Substantially compliant

Regulation 17: Premises

Overall, the premises' design and layout met residents' needs. The centre was inviting and pleasantly decorated. There were several comfortable communal areas for residents and visitors to enjoy, in addition to a well-maintained internal garden. Regarding painting and maintenance works, it was evident that the provider had prioritised residents' bedroom and bathroom accommodation. The provider had a schedule of works to address areas of repair required externally.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were complimentary about the quality and quantity of food in the centre. Food was freshly prepared and cooked onsite. Choice of main course was offered to residents, and options not on the menu were available if a resident chose this. The food menu was displayed in the dining room. Food was attractively presented. There was adequate supervision and discreet assistance at mealtimes. Fresh drinking water was available to residents throughout the day. Records reviewed found residents had access to dietetic and speech and language therapy, and any changes to a resident's diet were being implemented. There were written communication systems between nursing and catering staff to ensure that dietary needs prescribed by healthcare professionals were followed.

Judgment: 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. It was not possible to verify the transfer of relevant information about the resident from the centre to the receiving hospital, such as the reason for transfer,

current health status, medical diagnosis, and medications, as copies of these records were not kept in the centre and available for review. This information is integral to ensuring that the hospital is aware of all pertinent information and can provide the resident with the most appropriate medical treatment.

Judgment: Substantially compliant

Regulation 27: Infection control

While the provider had systems and processes in place to manage and oversee infection prevention and control practices within the centre, and the environment was generally clean and tidy, storage practices 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), for example:

- Clean and dirty equipment were stored alongside each other in the centre's store rooms. There was no identifiable mechanism to determine which equipment had been cleaned before it was provided to a resident.
- Open personal protective equipment, such as face masks, were stored in the sluice room, presenting a risk of cross contamination.
- Items for religious services were being stored in a communal toilet and bathroom.
- Storage of domestic waste required review as the volume of waste was noted to have exceeded the capacity of the waste storage containers.
- Objects and boxes stored on the floor of storerooms throughout the centre impacted the ability to clean the area effectively.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While significant work had been undertaken to protect residents against the risk of fire, the oversight of fire safety within the centre required review to ensure residents and staff were adequately protected in a fire emergency.

Precautions against the risk of fire required review, for example:

- The inspector observed the storage of a large volume of combustible items, such as clothing and books, directly under a large fuse box in the sacristy lobby. The inspector confirmed this storage had not been risk-assessed and deemed safe.
- While the provider was undertaking weekly checks of the means of escape in the centre, there were no further daily or weekly fire safety checks recorded

on matters such as the fire alarm panel, fire extinguishers, emergency lighting or fire doors.

Fire containment measures in place required review as the inspector observed the following:

- A small sample of fire doors did not close fully when released.
- One fire door closer had been disengaged and required repair.

While the registered provider had made arrangements for staff in the centre to receive training in evacuation procedures, further robust assurances were required to assure the provider that residents could be evacuated in a safe and timely manner in the event of a fire emergency, particularly at night, when there were two staff on duty. For example:

- In November 2023, a simulated night time evacuation drill of the largest compartment, which contained 32 bedrooms, occurred. This drill recorded an evacuation time of 6 minutes for a full compartment evacuation, aligned with the provider's evacuation strategy. However, the records indicated that only five residents were evacuated during this drill, while there were 32 bedrooms in the compartment.

Improvements were also required concerning the recording of these drills to assure the provider that residents could be evacuated in a safe and timely manner in the event of a fire emergency, for example:

- A simulated drill involving 11 staff in January 2024 did not record the number of residents evacuated or where they were evacuated to.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required concerning individual assessments and care plans to ensure that each resident's needs were comprehensively assessed and an appropriate care plan was prepared to meet these needs, for example:

- A sample of four resident risk assessment tools examining areas such as the risk of falls or malnutrition were inaccurately scored, underestimating the resident's risk factors. This meant a robust care plan to mitigate these risks and enhance resident comfort and safety was not developed.

Care plans were not always reviewed and updated following a change in the resident's condition or after a review by a healthcare professional, for example:

- Two residents who had fallen did not have their falls care plan updated after these falls.

- One resident who had a choking incident did not have their nutrition care plan updated to reflect the incident.
- One resident who had been prescribed modified consistency fluids and had specialist recommendations made by a speech and language therapist regarding mealtime support to enhance their safety while swallowing did not have these recommendations recorded in their care plan.
- One resident who was experiencing visual decline and had been smoking in their bedroom, contrary to the centre's policies, did not have their risk assessment updated to reflect this risk, nor did they have a smoking care plan to guide staff on supporting them to smoke safely.

Action was also required to ensure consultation with the resident and, where appropriate, their family when care plans were revised, as required by the regulation.

Judgment: Not compliant

Regulation 6: Health care

The health of residents was promoted through ongoing medical review and timely access to a range of external community and outpatient-based healthcare providers such as chiropodists, dietitians, physiotherapy, occupational therapy, speech and language therapy and specialist nursing services. The records reviewed showed evidence of referral and review by these healthcare services for the residents' benefit.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	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	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant

Compliance Plan for Holy Ghost Residential Home OSV-0000591

Inspection ID: MON-0037125

Date of inspection: 05/07/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Medication Management –
• All Social Care and Care staff have received certified training on the Safe Administration of Medication.
• All Social Care and Care staff have received certified training on Diabetes.
• All Social Care and Care staff have received safe administration of medication training by the assigned Pharmacy to the service.
• Insulin Training for Social Care and Care Staff trained to administer Insulin - This will be completed by November 2024.
• Diabetic Residents will continue to liaise with the Diabetic Clinic for review of self-administration practices and competencies. Insulin dependent residents will continue to be encouraged to self-administer daily insulin as normal with supervision from staff.
• Medication Administration Policy & Procedure has been reviewed and adapted to the service provided and is accessible to all staff.
• All Nursing staff have updated the Medication Management Training on HSELand.
• Following the training, all staff will receive Mandatory Competency Assessments to be completed before the end of September 2024 which will be recorded in personal files.
• Monthly Audits of Medication / Medication Trolley will continue.

The provider has committed to completing certified training for all staff in Managing Behaviour that is Challenging. This training will be delivered by the 30th September 2024.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• To provide a more robust monitoring system for all assessments and care planning as detailed under Regulation 5 - the provider has sourced an advanced Software system specifically tailored for the Residential Service. This system will support staff to update and implement person centered plans for each resident which will strengthen all care needs.
• The PIC has access to the HIQA Portal now following an issue and going forward will document and Notify the Office of the Chief Inspector of Social Services of all required notifications.
• The APIC will also have access to the HIQA Portal in the event of the PIC being on leave.
• Current management and provider reviewed the Medication Administration Policy & Procedure, which has now been updated and specifically tailored to the Residential Service we provide.
• All Social Care and Care staff are trained and certified to administer and support residents to take their daily medication.
• Regular competency assessments are in place and audits are conducted monthly by the PIC.
• All care plans are currently under our quarterly review process. For those residents specifically vulnerable to issues regarding Falls and Nutritional changes will be on continuous assessment going forward.
• Risk Assessments have been updated and will be additionally reviewed following any concerns raised.
• A full implementation of a Care monitoring system for individualized assessments and care plans will in place January 2025.

Under Regulation 23: Floor Plans have been rectified and changed back to the original placement. Rm 29 = Bedroom & Rm 33 = Visitors Sleepover Room.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The current PIC has full knowledge of the requirement of Regulation 31: therefore, going forward will submit all relevant information through the Portal and Notify the Office of the Chief Inspector of Social Services of all required notifications.
• The APIC will also have access to the Portal in the event of the PIC being on leave.
• All staff will be made aware of the importance of reporting and documenting any incidents, accidents or falls regardless of their status within the service.
• During Residents meetings – Residents will also be encouraged to come forward to

inform staff of any unwitnessed falls they may experience.
• Open Communication reinforced for all with management support to comply with the regulation.

Regulation 10: Communication difficulties	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication difficulties:
• All residents with visual, hearing and or communication difficulties have been identified and Communication care plans are under review. Keyworkers will inform the PIC or APIC of relevant information required for follow treatments / appointments.
• Barthel Assessments identified communication needs.
• Discussions with residents and preference on appointments discussed.
• Communication Care plans developed and reviewed quarterly and updated as required.
• Whilst waiting for the Software system to be implemented, a revised record will be kept in the Summary of Needs for each resident and Property list will be reviewed to include all glasses & hearing aids.

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:
• All transfer information will be duplicated prior to transfer of any resident to the Hospital. Medication charts will be included. This information will be stored into the residents file. This is the standard protocol however the new software package will automatically record and save any information prepared for transfer therefore providing a history of admission and discharges.
• All staff are aware that this is protocol.
• Transfer information will include the following in formation, Name, DOB, NOK & Contact details. Medical History, general baseline, Current health status and Covid Vaccinations. Any relevant information.
• During a longterm absence – all updated information will be documented in the Daily notes as received.
• Step by Step guidelines will clearly outline the process for staff.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Senior staff Nurse nominated to take on the role as Infection Prevention Control Lead.
• Senior staff nurse to be trained as IPC before the 30th October 24.
• IPC Lead will monitor, support and audit infection control practices within the service and report directly to the PIC.
• All Cleaning and Multitask staff will receive a refresher certified training every 3 yrs or as required by 30th October 2024.
• All staff to complete Infection control training on the HSELand by 30th October 2024.
• All staff to review and sign the Infection Prevention Policy & Procedure.
• All clean equipment will be placed with a clean sticker and dated before being issued for use to any resident.
• All PPE Equipment is stored in the allocated areas and removed from the Sluice Shelf to reduce the risk of cross contamination.
• Items for the Religious service has been relocated and stored in the Oratory.
• Storage of domestic waste – The level of service from the Waste Management company was increased. Access for the company to collect the waste agreed therefore they will no longer have issues collecting at the planned times.
• All store-rooms have been cleared out with no boxes placed on any floors. Staff have been informed that this practice is not acceptable. Weekly Health and Safety walk arounds will allow the PIC to monitor and maintain this practice.
• Additional storge will the sought for PPE for easy immediate access.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Based on the items brought to the attention of the Provider in the Inspection Report
1. Storage of Combustible Items: Signage to be placed adjacent to all fuse box and other electrical installation cupboards to state that no storage of combustible items is allowed in these areas. Staff will also be reminded of this at the quarterly Quality Improvement and Consultation meetings.
2. Smoking: A sign will be placed to remind residents and visitors that there is no smoking allowed in the internal garden area.
3. Fire Doors: Daily checks will be carried out on fire doors to ensure that they are unobstructed, not wedged open and that heat seals are not damaged or missing.
4. Fire Doors connected to the Fire Panel and Alarm system will receive good working order maintenance every three months by a competent person
5. Fire Alarm and Fire Panel tested weekly as well as checking the hold-open device on the fire doors

6. Fire Extinguishers are maintained and certified annually.
7. Emergency Lighting continues to be certified quarterly.
8. Fire Panel and Fire Alarm continues to be certified quarterly.
9. Emergency Exit Signs checked for bulb operation monthly.
10. Fire Drills and simulated fire-drills increased to four times per year and as required if needed.
11. Fire Drill Report details to be improved to show details such as:
- the pre-drill objective
- the fire scenario simulated
- the date and time of the fire drill
- the safe compartment evacuation time
- the actual time taken for the evacuation drill
- a comparison of the safe time versus the actual time of the drill
- the number of residents or simulated residents evacuated
- the name and numbers of staff who participated in the drill
- any lessons learned.
- recommendation for any reasons to reduce the fire-drill time.
- Educate residents on the importance and support them in participation of all drills.
- Discuss with night staff and re-evaluate the pressure points, timings and identify areas for improvement on each drill especially in the largest compartment.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

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:
• For all Risk assessments and Care planning, a full person-centered approach will be implemented which will include the resident and family members if appropriate. The plans will centre around the residents and their needs in life.
• All Risk Assessments are under review for each resident which will identify changing need – Care plans with actions will be developed to progress forward in providing and enhance the level of comfort and safety for each resident.
• On commencement of a new software package – All assessment results will directly lead forward to highlight concerns resulting in an action plan for each resident.
• In-house training for all staff will highlight the value of assessments and strengthen the care provided.
• The current PIC will ensure all follow ups with / for residents are in line with best practice and the same will be documented accordingly.
• For the resident with Visual decline and had an episode of smoking in the bedroom – Immediate care plans were developed and policies explained to the resident. The

provider met with the resident again to explain the seriousness of this matter and resident agreed that this would not occur again. The resident is fully aware that Smoking in a bedroom is not permitted at any time.
• In the event of a recurrence the Bord of Trustees will meet with the resident and family.

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 10(2)	The person in charge shall ensure that where a resident has specialist communication requirements, such requirements are recorded in the resident's care plan prepared under Regulation 5.	Substantially Compliant	Yellow	01/10/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Red	15/07/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Red	15/07/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe,	Not Compliant	Red	15/07/2024

	appropriate, consistent and effectively monitored.			
Regulation 25(1)	When a resident is temporarily absent 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.	Substantially Compliant	Yellow	01/08/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	31/10/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment,	Substantially Compliant	Yellow	01/09/2024

	suitable building services, and suitable bedding and furnishings.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	01/09/2024
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	01/09/2024
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	15/07/2024
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	Not Compliant	Orange	01/10/2024

	where appropriate that resident's family.			