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:	St Patrick's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Summerhill, Carrick on Shannon, Leitrim
Type of inspection:	Unannounced
Date of inspection:	08 March 2024
Centre ID:	OSV-0000661
Fieldwork ID:	MON-0033812

About the designated centre

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

The designated centre provides 24- hour care to 46 residents, male and female primarily requiring nursing and/or palliative care. Some have a diagnosis of dementia and others are young chronic sick persons under 65 years of age. The centre is made up of three units located on the ground floor of a two storey building which was formerly a hospital. Two of the units accommodating 14 residents in each are mainly for long term care and a specialist dementia unit (SDU) accommodates 18 residents. Three beds in the SDU are for residents requiring respite or assessment on a short-term basis and one designated bedroom is for residents receiving end of life care The aim of the centre is to provide a residential setting where residents are cared for, supported and valued within a care environment that promotes their health and well-being.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	40

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 8 March 2024	09:30hrs to 16:00hrs	Catherine Rose Connolly Gargan	Lead
Monday 11 March 2024	08:45hrs to 16:00hrs	Catherine Rose Connolly Gargan	Lead
Thursday 7 March 2024	10:00hrs to 16:30hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

This inspection was an unannounced inspection carried out over three days. The inspectors met with many residents, staff and members of the centre's management team and the manager representing the provider. Inspectors observed that residents were supported by staff to make independent choices about their daily lives and to enjoy a good quality of life in the centre.

Overall feedback from residents regarding the service they received and their quality of life in St Patrick's Community Hospital was positive. and were very complimentary in their feedback regarding their satisfaction with the standard of care provided. Residents spoken with were also happy with the standard of environmental hygiene.

There was a relaxed atmosphere within the centre as evidenced by residents moving freely and unrestricted throughout the centre. On the day of the inspection communal areas throughout the centre were adorned with colorful St. Patrick's Day decorations. Residents told the inspectors they were happy, content and very comfortable living in the centre and that staff were kind caring and always attentive to their needs. Residents comments included 'we get the best care here' and 'staff are very kind and thoughtful'.

The inspectors observed that residents' accommodation was arranged into three units on ground floor level. The first floor in the premises was not part of the designated centre and was being utilised by the acute hospital services to provide step-down services for patients. Both the designated centre and the acute hospital services shared a common entrance and foyer area and access was controlled by reception staff. This was an improvement from the last inspection in the centre.

Residents' accommodation was divided into three separate units; the Monsignor Young Dementia Unit, the Dr McGarry Unit, and the Sheemore Unit. Each unit was linked into the main circulating corridors. Although, each unit operated independently with assigned staff, efforts were being made to encourage residents in Dr McGarry and Sheemore units to integrate with each other including joining the social activities taking place in these units.

Inspectors observed that residents in the dementia unit were facilitated to enjoy fulfilling and meaningful lives. Staff had a very good knowledge of each resident's individual life story, the significant people in their lives, their care needs and preferences and their usual routines. Staff were observed to be gentle, kind and respectful towards all residents but especially residents with dementia and residents were observed to respond positively to these person-centred staff interactions with them. The Monsignor Young Unit dementia unit offered residents a safe continuous walking space around the unit for those who were walking with purpose. This circulation area was well laid out with several points of interests along the way for

residents to stop and look at or engage with. Many of the residents had a background in farming and the environment was designed to capture their interests.

For example, there were pictures of cattle and sheep displayed along the walls. This was continued into the resident's outdoor space with a full size sheep, a cow and a calf models outside grazing in the garden. Raised flower beds with hand trowels were available for any of the residents with an interest in gardening in the a courtyard area. The doors were unlocked to these outdoor areas and residents could go in and out as they wished.

The inspectors observed that residents on Sheemore and Dr McGarry units had unrestricted access to safe outdoor areas. The provider had ensured the community garden area adjacent to the Sheemore unit was safe and secure for residents since the last inspection. Access through the garden by members of the public was now controlled by staff. The inspectors also observed that the provider had developed a second small courtyard area for residents on the Dr McGarry unit since the last inspection and both outdoor areas off Dr McGarry unit were available to residents. Both areas had colourful outdoor seating, large potted plants and outdoor ornaments in them. Some residents were seen enjoying these outdoor spaces on the days of the inspection.

The inspectors were told by some residents that they went on regular outings to the local town and other areas of interest in the centre's wheelchair accessible bus or with their family and friends. Inspectors were told that assessments and work was ongoing to support one resident to return to live in the community. Meaningful and varied social activity programmes tailored to residents interests and capacities were facilitated by staff in each unit. Residents in the dementia unit were observed enjoying a lively singing session led by a visiting musician. Many of the residents in the other two units were interested in arts and crafts and they were supported to enjoy this activity.

The inspectors observed that many of the residents liked to start their day with Mass streamed from a local church on the televisions in the sitting rooms. There was also a large church on site which was accessible to residents through the staff dining room. Although the inspectors were told that some residents liked to go to the church and that residents could avail of refreshments in the staff dining room if they wished, no residents were observed visiting the church or having refreshments in the staff dining room on the days of this inspection.

The inspectors observed that renovations were completed in Sheemore and Dr. McGarry units to upgrade the environment and facilities including wall and floor surfaces, finishes and furnishings. The furnishings and surfaces in these units readily facilitated cleaning and added colour to the residents' lived environment. However, the inspectors observed that the décor and surfaces in much of the Monsignor Young dementia unit environment was showing signs of wear and tear. The centre's management confirmed that renovations in this area to include painting and furniture replacement were scheduled to commence in the coming weeks. Despite

the infrastructural issues identified, overall the general environment and residents' bedrooms, communal areas and toilets, bathrooms inspected appeared visibly clean.

While the centre provided a mostly homely environment for residents, further improvements were required in respect of premises and infection prevention and control, which are interdependent. For example, surfaces and finishes including wall paintwork, wood finishes and flooring in two pharmacy/ clinical rooms were worn and as such did not facilitate effective cleaning. The janitorial unit with one housekeeping room had not been plumbed and extensive damage to the paintwork was observed within the main laundry. Barriers to effective hand hygiene practice were also observed during the course of this inspection. Findings in this regard are further discussed under Regulation 27: Infection control.

The inspectors observed that ancillary facilities generally supported effective infection prevention and control. The infrastructure of the on-site laundry supported the functional separation of the clean and dirty phases of the laundering process. Staff on each unit also had access to a dedicated housekeeping room for storage and preparation of cleaning trolleys and equipment and a sluice room for the reprocessing of bedpans, urinals and commodes. These areas were well-ventilated, clean and tidy. There was a dedicated "pharmacy"/ clinical room for the storage and preparation of medications, clean and sterile supplies and dressing trolleys on each unit.

The inspectors observed that painting and decoration had been used to support residents in identifying key areas. Colour coding and vinyl prints were used to identify toilet doors and bedroom doors to support residents with orientation and way finding in all three units. Memorabilia familiar to residents such as dressers, crockery, tea-sets, ornaments, flower pots and other items were used in the communal areas to create a homely and comfortable environment for residents.

Residents were complimentary about the quality of the food they were provided with and their comments regarding the food included 'better than the Ritz' Residents confirmed that they always had a choice of menu. While, residents meals were observed by inspectors to be well presented, highly modified consistency meals were served in bowls and although the modified consistency vegetables, meat and potatoes were served separately, they were only identifiable by colour. The centre's management told the inspectors they were researching use of shaping moulds to improve the presentation of modified consistency meals for residents.

Many residents had personalised their bed areas with their family photographs and other personal items. Residents told the inspectors that liked their bedrooms and that their 'bed was cosy and comfortable'. Residents also told the inspectors that they decided when they went to bed and when they got up each morning.

Residents told the inspectors that they felt safe and secure in the centre and that they would speak to a staff member or their relatives if they had any concerns or were dissatisfied with any aspect of the service they received.

The next two sections of the report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance with the regulations are set out under each section.

Capacity and capability

This inspection found that care and services provided for residents were generally well managed and ensured that residents received services and care to meet their assessed needs. Notwithstanding the significant fire safety and refurbishment works completed in the Sheemore and Dr McGarry units, progress was slow with completing refurbishment works in the Monsignor Young unit to improve the lived environment for the residents living with dementia. Furthermore, the findings on the last inspection in June 2023 were repeated on this inspection regarding the provider's inadequate oversight of fire safety in the centre to ensure that non-compliance was identified and addressed in a timely manner.

This announced inspection was completed to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors also followed up on the actions the provider had committed to take in their compliance plan following the previous inspection in June 2023 and on the statutory notifications and other information received since the last inspection. The provider had applied to the Chief Inspector for renewal of the registration of St Patrick's Community Hospital and this application was reviewed as part of this inspection.

The registered provider of St Patrick Community Hospital is the Health Service Executive (HSE) and the service manager representing the provider attended the inspection. As part of a national provider network the service benefits from access to and support from the HSE national resources such as community health organisation management teams (CHO) resources and expertise, staff training and development, clinical practice development, finance and information technology.

The designated centre's local management structure consisted of a person in charge supported by an assistant director and clinical nurse managers on each of the three units accommodating residents.There had been a change of person in charge in February 2024 and the new person in charge had previously worked in the role from October 2022 to June 2023. In the absence of the person in charge this inspection was facilitated by the assistant director of nursing (ADON).

There were established governance and management processes in place with oversight of key areas in clinical care and support services for the residents. Resident’s feedback was sought through resident meetings and questionnaires and this feedback was used to informed quality improvement plans including and an annual review of the quality and safety of the service.

Inspectors identified some examples of good antimicrobial stewardship. For example, the volume, indication and effectiveness of antibiotic use was monitored each month. There was a low level of prophylactic antibiotic use within the centre, which is good practice. Staff also were engaging with the "skip the dip" campaign which aimed to prevent the inappropriate use of dipstick urine testing that can lead to unnecessary antibiotic prescribing which does not benefit the resident and may cause harm including antibiotic resistance. Nursing staff had also completed online antimicrobial stewardship training.

However, accurate surveillance of multi-drug resistant organism (MDRO) colonisation was not undertaken. A review of acute hospital discharge letters and laboratory reports found that staff had failed to identify a small number of residents that were colonised with Extended Spectrum Beta-Lactamase (ESBL) and Vancomycin-resistant Enterococci (VRE). As a result accurate infection prevention and control information was not recorded in this residents care plans to effectively guide and direct their care. Findings in this regard are presented under regulation 27; Infection control.

Infection prevention and control audits covered a range of topics including environmental hygiene and hand hygiene. The high levels of compliance achieved in recent audits was reflected on the days of the inspection.

The provider had mostly ensured there was adequate numbers of staff available with appropriate skills to ensure that residents' needs were met. However, night-time staffing required further review to ensure there was adequate numbers of staff available in two of the three units to meet residents' needs. A small number of staff vacancies were being filled at the time of the inspection. Inspectors observed there were sufficient numbers of housekeeping staff to meet the needs of the centre on the day of the inspection. Records reviewed by the inspectors showed that staff had appropriate Garda vetting in place before they commenced working in the designated centre.

The person in charge had a system in place to monitor staff training and all staff were facilitated to complete mandatory training and a programme of professional development training to ensure that they had the necessary skills and competencies to meet the complex needs of residents. The inspectors' observations of staff practices and discussions with staff gave assurances that they were familiar with residents' needs. However improved supervision of staff was necessary on one unit to ensure staff were available in the communal rooms to assist and monitor residents with their needs.

Inspectors found that that there were clear lines of accountability and responsibility in relation to governance and management for the prevention and control of healthcare-associated infection. The person in charge had nominated three staff members to the roles of infection prevention and control link practitioners to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre. Staff also had access to onsite training and

support from infection prevention and control specialist advice and support as required.

Records were held securely and records that were required to be held in the centre were made available to the inspector for the purpose of this inspection.

Arrangements for recording accidents and incidents involving residents in the centre were in place and were notifications as required by the regulations were notified to the Health Information and Quality Authority within the specified timeframes.

The centre's policies and procedures had been updated and were accessible to all staff working in the centre.

Regulation 14: Persons in charge

A new person in charge commenced in this role on 26 February 2024 and their qualifications and experience met the requirements of the regulations. The new person in charge had previously worked in this role in the designated centre from October 2022 to June 2023.

Judgment: Compliant

Regulation 15: Staffing

Although, there sufficient staff available each day, The inspectors were not assured that the numbers of staff available each night in Dr McGarry and Sheemore units were adequate to meet residents' assessed needs. This was evidenced by the following findings;

- Five residents in Sheemore unit and eight residents in Dr McGarry unit were assessed as needing two staff to assist them with their personal care and repositioning needs while in bed. This meant that when the two staff available in each unit at night were providing care for these residents there were no staff available on the unit to respond to the other residents' needs for assistance.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Although, there were sufficient numbers of staff available on the day of the inspection the inspector found that staff on Dr McGarry unit were not appropriately deployed and supervised to ensure they were available at all times in the communal sitting/dining room. The inspectors found that the residents in this room were left for long periods throughout the day of the inspection with no staff available to respond to their needs for care or supervision.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents in the centre was maintained and included all information pertaining to each resident as specified by the regulations.

Judgment: Compliant

Regulation 21: Records

Records as set out in Schedules 2,3 and 4 were kept in the centre and were made available to the inspector. Records were stored securely and the policy on the retention of records was in line with regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

The provider had failed to provide sufficient resources to ensure that the refurbishment works project was completed as scheduled. As a result there were a number of repeated non compliances for Regulation 17.

Night time staffing levels between 20.00hours and 08.00hours also needed to be reviewed to ensure the current staffing resource met the needs of all residents and that residents did not have to wait for care staff to be available.

Systems in place to monitor the quality and safety of the service did not identify:

- fire door checks were not being carried out effectively.
- daily fire checks of all evacuation routes were not identifying obstructions
- the procedure for cleaning and tagging of used equipment was not consistently implemented by staff
- recommended hand hygiene practices were not consistently followed by staff.

- the environmental audits did not ensure that the centre was well maintained in all areas.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of residents' contracts of care were reviewed by the inspectors. Each resident's contract document was signed and dated and outlined the terms and conditions of their accommodation, bedroom details and the fees to be paid by each resident.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of accidents and incidents involving residents in the centre was maintained. Notifications and quarterly reports were submitted within the timeframes specified by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

A centre-specific complaints policy was in place and had been updated in line with recent legislative changes. The complaints policy identified the person responsible for dealing with complaints and included a review officer, as required by the legislation. A summary of the complaints procedure was displayed and was included in the centre's statement of purpose document.

Procedures were in place to ensure all expressions of dissatisfaction with the service were recorded, investigated and the outcome was communicated to complainants without delay. Agreed actions to address the issues raised were implemented.

Access for residents to advocacy services to assist them with making a complaint was in place and residents were informed about this service.

Residents knew who they could talk to if they had a complaint and that they could access advocacy services to support them if needed.

An appeals process was in place if a complainant was not satisfied with the outcome of the investigation of their complaint.

Complaints received were reviewed with the provider representative as part of the centre's governance and management process.

Judgment: Compliant

Regulation 4: Written policies and procedures

The centre's policies and procedures were undated within the last three years but the inspectors found that the centre's fire policy in relation to the frequency and procedure for checking of fire doors was not implemented in practice on this inspection to ensure that all fire doors in the centre were operating as required.

Judgment: Substantially compliant

Quality and safety

Overall, residents were provided with good standards of nursing and health care in line with their assessed needs and residents rights were respected with the exception of actions needed to ensure residents' privacy in the Monsignor Young and Dr McGarry units. Care and supports were informed by residents' needs and usual daily routines. However more focus and resources were now required to make the improvements that were required to bring the centre into compliance with the regulations and to ensure that the resident's on all units could enjoy a safe and pleasant lived environment.

There were no visiting restrictions in place and public health guidelines on visiting were being followed. Signage reminded visitors not to come to the centre if they were showing signs and symptoms of infection.The provider continued to manage the ongoing risk of infection while protecting and respecting the rights of residents to maintain meaningful relationships with people who are important to them

A review of a recent outbreak report found that the outbreak was identified, managed, controlled and documented in a timely and effective manner. Staff spoken with were knowledgeable of the signs and symptoms of infection and knew how and when to report any concerns regarding a resident.

Staff were observed to consistently apply standard precautions to protect against exposure to blood and body substances during handling of sharps, waste and used linen. Care was provided in a clean and safe environment that minimised the risk of transmitting a healthcare-associated infection. Appropriate use of PPE was observed

and all staff were bare below the elbow to facilitate effective hand hygiene practices.

The provider also had a number of effective assurance processes in place in relation to the standard of environmental hygiene in the centre. These included cleaning specifications and checklists, and colour coded cloths to reduce the chance of cross infection. Cleaning carts were equipped with a locked compartment for storage of chemicals and had a physical partition between clean mop heads and soiled cloths. All areas and rooms were cleaned each day and the environment appeared visibly clean. Housekeeping staff and multitask attendants had also attended (or were scheduled to attend) a nationally recognised specialised hygiene training program for support staff working in healthcare.

Inspectors identified some examples of good practice in the prevention and control of infection. The provider had introduced a tagging system to identify equipment that had been cleaned but inconsistencies in the tagging system meant that inspectors were not assured that all equipment had been cleaned after use.

There were a limited number of clinical hand wash sinks dedicated for staff use. Sinks within residents' rooms were dual purpose used by both residents and staff. This practice increased the risk of cross infection. A portable clinical hand wash sink had been installed on one unit. This unit was not connected to the main sewer system which placed staff at risk of handling contaminated waste water when emptying the removable waste water receptacle. The removable clean water receptacle was refilled in the sluice room which also posed a risk of cross contamination.

Notwithstanding the significant fire safety works that had been carried out by the provider in recent years this inspection found that some of the provider's fire safety processes did not ensure residents were adequately protected from risk of fire. The inspectors' findings are discussed under Regulation 28: Fire precautions.

Residents were provided with good standards of nursing care and timely health care to meet their clinical needs. Residents' records and their feedback confirmed that they had timely access to their general practitioners (GPs), specialist medical and nursing services including psychiatry of older age and allied health professionals as necessary. However, their access to physiotherapy services was limited to urgent and post falls referrals which did not ensue all residents who needed this service had access. Residents' care plans were detailed and reflective of their individual preferences and wishes regarding their care and supports. Care plans were for the most part, regularly updated and residents or, where appropriate, their families were consulted with regarding any changes made. Residents' food and nutrition needs were met.

Actions had been taken by the provider since the last inspection to ensure residents' social care programme supported them to continue to enjoy activities that interested them in line with their individual capacities.

Residents were encouraged and supported to personalise their bedrooms. However, the layout of some residents' bedrooms in the Monsignor Young unit did not ensure

that they could maintain control of their clothing and possessions. The inspectors were informed that provider was progressing a refurbishment programme and works were completed on Sheemore unit and Dr McGarry units. Inspectors were told that the works were due to recommence which was delayed. Works in the Monsignor Young dementia unit were planned to commence in the weeks following this inspection. In addition further actions were necessary to ensure the residents' living environment was kept in a good state of repair and that effective cleaning could be achieved in all parts of the centre.

Residents' meetings were regularly convened and issues raised needing improvement were addressed. Residents had access to local and national newspapers, radios and televisions.

The provider had comprehensive procedures in place to protect residents from abuse including procedures in place to control and prevent unauthorised persons from entering the designated centre via a courtyard/garden area predominantly used by residents in Sheemore residents.

There was a positive approach to care of residents predisposed to experiencing episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). A minimal restraint environment was promoted and the procedures in place were in line with the national restraint policy guidelines.

Regulation 10: Communication difficulties

Residents with communication difficulties were supported to communicate freely and staff were aware of their needs. The inspector found that each resident's communication needs were regularly assessed and a person-centred care plan was developed for those residents who needed support with communications. The inspector observed that where it was needed, assistive equipment was available for residents to support their communication needs.

Judgment: Compliant

Regulation 11: Visits

There were no visiting restrictions in place and visitors were observed visiting residents on the centre on the day of inspection. Residents told the inspectors that their visitors were welcomed and facilitated in the centre. Residents were able to meet with their visitors in their bedrooms or in a private area in each of the units as they wished.

Judgment: Compliant

Regulation 12: Personal possessions

A number of residents in the multiple occupancy bedrooms in Monsignor Young unit could not maintain control of their clothing and possessions as their wardrobes were located in a neutral space outside their immediate bed spaces and their clothing and possessions could be accessed by other residents in these bedrooms.

Furthermore, many of the residents in this unit either did not have a locker available in their bedroom or where available, the locker was located along an opposite wall and not by residents' beds to facilitate them to access their possessions as they wished.

Judgment: Substantially compliant

Regulation 13: End of life

Staff provided end of life care to residents with the support of the residents' general practitioner.The centre had established good links with the community palliative care team and this service was available to support residents as needed. An up-to-date policy was available to inform staff on the centre's procedures to ensure residents' end -of-life needs were met.

The inspectors reviewed a sample of residents' care plans and their end-of-life physical, psychological and spiritual care and their wishes and preferences regarding where they would like to be at end of lives were established and regularly updated. This gave residents opportunity to be involved in and to make decisions regarding their end-of-life care while they were well. A pain assessment and monitoring tool was in use by staff to ensure any pain experienced by residents was managed. Pain medications were administered as required and monitored to ensure effectiveness.

Single rooms were available for end of life care and relatives were supported to be with residents during this time. Overnight facilities and refreshments were available to residents' family members and friends during end-of-life care.

Judgment: Compliant

Regulation 17: Premises

The designated centre did not conform to all of the matters set out in Schedule 6 of the regulations. For example;

- Although storage areas were better organised with storage segregation in place, inappropriate storage of residents' assistive equipment was found again on this inspection. For example, inspectors observed storage of a hoist in a communal shower/toilet in Sheemore unit.This inappropriate storage hindered residents' safe access to the bathroom facilities and reduced the floor space available to them in this room.
- Grab rails were not in place on both sides of a toilet in a communal shower/toilet used by residents. This finding did not promote residents' independence and safety and is repeated from the last inspection.
- Paint was damaged/missing on a number of bedroom doors, doorframes and on wall surfaces in some residents' bedrooms and on walls along a number of the corridors but particularly in Monsignor Young unit. This meant that these surfaces could not be effectively cleaned. This is a repeated finding from the last inspection.
- Appropriate and secure storage of large waste collection bins was not in place. The inspectors observed large hazardous and non hazardous waste collection bins located along the external walls around the perimeter of the premises including along the pedestrian route from the car park to the designated centre.
- A shower hose was not fitted in a communal shower in Monsignor Young unit. This finding did not ensure that residents could use this facility if they wished.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with a varied diet and they confirmed that they enjoyed their meals and could have alternatives to the hot meal menu options offered if they wished. Residents' special dietary requirements were effectively communicated to catering staff and dishes were prepared in accordance with residents' individual preferences, assessed needs and the recommendations of the dietician and speech and language therapists. Fresh drinking water, flavoured drinks, milk, snacks and other refreshments were available at mealtimes and throughout the day.

A small number of residents preferred to eat their meals in their bedrooms and their preferences were facilitated. Residents were provided with discreet assistance as needed and staff were observed to encourage residents with drinking fluids throughout the day. There was sufficient staff available to provide timely assistance to residents in the dining rooms and in their bedrooms at mealtimes.

Judgment: Compliant

Regulation 27: Infection control

The registered provider had generally ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship but some action was required to be fully compliant. For example;

- Accurate surveillance of MDRO colonisation was not undertaken. There was some ambiguity among staff and management regarding which residents were colonised with MDROs. As a result accurate information was not recorded in several residents' care plans and appropriate infection control and antimicrobial stewardship measures may not have been in place when caring for these residents.

Equipment and the environment was generally managed in a way that minimised the risk of transmitting a healthcare-associated infection, however further action is required to be fully compliant. This was evidenced by;

- Hand hygiene facilities were not in line with best practice. The portable hand washing sink in use did not support effective hand hygiene practices.
- The janitorial unit within one housekeeping room was not plumbed. Inspectors were informed that mop buckets were prepared within the sluice. This posed a risk of cross contamination.
- Surfaces and finishes within the pharmacy rooms that contained medications, clean and sterile supplies such as needles, syringes and dressings were worn and poorly maintained. This posed a risk of cross-contamination.
- Paintwork within the main laundry was damaged and peeling.
- The system to identify that equipment had been cleaned after use had not been consistently implemented at the time of inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The Provider did not have effective arrangements in place to ensure residents' safe evacuation and that they were protected from risk of fire. This was evidenced by the following findings;

- Effective containment of fire and smoke in the event of a fire in the centre was not assured. The inspectors found that there were gaps in a number of fire doors. This is a repeated finding from the last inspection
- A fire door on a corridor to Sheemore unit was damaged in a number of areas and efforts had been made to fill holes and damage to the surface of the door with filling. Assurances were not available regarding effectiveness of this

fire door in the event of a fire in the centre and the inspector's finding had not been identified and addressed by the provider as committed to in the compliance plan from the last inspection.
- Weekly checks of the fire doors in the centre as part of the fire safety management system and in accordance with the centre's fire policy had not been completed. The procedure that was in place where a six monthly fire door check was completed could not be relied on to ensure the effective operation of the fire doors at all times.
- An external fire exit route from Sheemore unit was partially obstructed by a chair placed in the exit route and had not been identified in the daily checks that fire exits were not obstructed. The chair was removed immediately. This is a repeated finding from the last inspection.

The provider could not be assured that residents' evacuation needs would be met in the event of a fire in the centre. For example, the inspectors found the following from a review of the records of the simulated evacuation drills completed in n the centre since the last inspection:

- the evacuation drill records did not correlate with the same information recorded in the fire safety management register
- it was not clear that all available staff in the centre at the time of the simulated emergency evacuation drills participated in the drill to ensure effective and timely evacuation of residents in the event of a fire in the centre.
- the inspectors were not assured that residents' personal emergency evacuation assessments were referred to and used to inform the simulated emergency evacuation drills
- the records of the simulated emergency evacuation drill information available did not provide assurances that staff supervision for residents post their evacuation had been considered as part of the evacuation procedure. At the time of this inspection, the inspectors confirmed that many of the of the residents in the centre would require supervision post evacuation to ensure their safety.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Notwithstanding the high standard of residents assessments and care plan documentation, inspectors found that actions were necessary to ensure that a small number of residents' care plans were accurately updated with the recommendations made by the speech and language therapy specialist. This finding did not ensure that this pertinent would be communicated to all staff to guide residents' effective care delivery.

Judgment: Substantially compliant

Regulation 6: Health care

The inspectors found that residents did not have access to a physiotherapy specialists outside of post fall assessments and urgent need. This arrangement did not ensure residents had adequate access to a physiotherapy service to support their rehabilitation and independence.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Staff maintained a positive and supportive approach in their care of a small number of residents who were predisposed to experiencing episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were facilitated to attend training to ensure they had up-to-date knowledge and skills to effectively care for residents with responsive behaviours.

The person in charge and staff were committed to minimal restraint use in the centre and their practices reflected the national restraint policy guidelines. There was minimal use of full-length bedrails and alternatives to this restrictive equipment were assessed and used in consultation with individual residents and their representatives to support residents' security and independent with repositioning when resting in bed.

Judgment: Compliant

Regulation 8: Protection

The centre had policies and procedures in place to protect residents from abuse. Staff spoken with were knowledgeable regarding recognition and responding to abuse. Staff were aware of the reporting procedures and clearly articulated knowledge of their responsibility to report any concerns they may have regarding residents' safety. Residents confirmed to the inspectors that they felt safe in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' privacy was not assured due to an unprotected clear glass window in the door of a multiple occupancy bedroom in Monsignor Young unit. Wide gaps were evident in the doors of a number of the communal shower/toilets in Monsignor Young and Dr McGarry units. As a result, residents, visitors and staff walking past these rooms would be able to see into the rooms when individual residents were carrying out personal activities. These findings were addressed on the days of this inspection.

Judgment: Substantially 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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Patrick's Community Hospital OSV-0000661

Inspection ID: MON-0033812

Date of inspection: 11/03/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
To ensure compliance with Regulation 15 Staffing the Registered Provider and person in charge will:

- On the 20/03/2024 the Registered Provider and Person in Charge completed a staffing at night review
- This review focused on the prevalence of incidents at night on all units within the designated center
- Following this review of staffing at night within the designated center, it has been determined that there is no increase in prevalence of incidents at night on the ground floor units. It has also been determined that the current allocation of staff safely meets the clinically assessed needs of all residents within the designated center.
- This will be kept under review by the Registered Provider on an ongoing basis
- If at any point the Person In Charge requires additional resources/ staffing this will be supported by the Registered Provider and put in place immediately
- The Person in Charge completes a daily and weekly review of staff rosters to ensure that the number and skill mix of staff provided is appropriate to ensure that the residents assessed care needs are met to a high standard.
- The person in charge or deputy review this supervision on a daily basis on their safety walk arounds to ensure adequate supports are in place for residents
- For any vacant positions agency staff are providing cover in these posts,
- There are currently no funded vacant positions within the centre which are not staffed.
- All necessary recruitment proceses have been completed pending the HSE recruitment pause being lifted.
- The Registered Provider will continue to monitor staffing, resources and the supervision of residents on an ongoing basis to ensure that the services provided are safe and meet the assessed needs of all residents within the centre.
- This will continue to form part of the provider meetings, compliance visits and inspections

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
To ensure compliance with Regulation 16(1) (b): Training and Development The Person in charge will:

Compliance will be met by:
- The Registered Provider and Person In charge completed a review of staff allocation within the designated Centre on the 20/03/2024 to ensure staff are available to provide activities and supervision for all residents
- Staff are now allocated to provide activities and supervision to residents throughout the center. This is documented daily on all units in the allocation of staffing book held on each unit
- Staff are allocated on a daily basis to provide supervision at all times in communal rooms. This is in place from 20/03/2024
- This is monitored on an ongoing basis by the Person in Charge or their deputy
- Each unit has clinical supervision in place and a Clinical nurse manager 11 has clinical oversight on each unit ensuring high standards of care and supervision are in place, all units are staffed 24/7 with trained nursing staff who are supported by experienced Health care assistants
- This is further supported by the Person In Charge / designate carrying out safety checks on a daily basis at different times across the designated center to ensure adequate supervision is in place at all times
- The Registered Provider and Person In Charge have completed a review of all incidents within the designated centre and have also reviewed staffing and the allocation of staffing as part of this review. This determined that adequate staffing was in place at the time of incidents .15 minute safety checks were in place for residents and a number of residents have 1:1 supervision in place as determined by their clinical need
- The Registered Provider will continue to monitor staffing and resources on an ongoing basis to ensure that the services provided are safe and meet the assessed needs of all residents within the centre. This will continue to form part of the provider meeting and Compliance visits and inspections
- The Person In Charge / Designate reviews staff allocation on a daily basis including staff who are supervising to ensure resident safety and supervision is maintained.
- The Registered Provider reviews the training of staff on a monthly basis at the Older persons residential governance meetings and also during provider meetings and compliance visits to the designated center
- A robust training plan is in place for all staff in the center and the center is supported by the Practice development coordinator Sligo/ Leitrim in respect of staff training and development

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure Compliance with Regulation 23(a) Governance and Management the Registered Provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

To ensure Compliance with Regulation 23(c) Governance and Management the Registered Provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Compliance will be met by:

- The Registered Provider, HSE Fire Safety Officer and Person in Charge have reviewed the Fire safety management system within the designated center on 19/03/2024.
- Following the fire safety review, Additional fire door checks are carried out during weekly fire drills and records are maintained in the Fire Register as and from 19/03/2024.
- The Registered Provider and Person in Charge have reviewed any outstanding environmental upgrade works on 20/03/2024. Following this the maintenance Program has been reviewed and updated to ensure that the designated center is well maintained. The Registered Provider will monitor this on an ongoing basis
- The Registered Provider is working in conjunction with HSE estates and HSE maintenance to ensure that any outstanding refurbishment works are completed without further delay.
- The Registered Provider in conjunction with the Person In Charge now reviews the schedule of refurbishment works weekly to ensure that these are completed on time if any delays are identified these are discussed with HSE Estates and HSE Maintenance to ensure that a maintenance action plan is in place to address this
- The fire exit routes in each unit are formally checked twice daily on the Fire exit escape sheet.
- Additional safety walk a round's are now being completed by the Person in Charge to ensure there is full compliance with clear evacuation routes. In the absence of the Person in charge this is completed by ADON/CNMS/Senior nurses.
- A new maintenance system for fire doors has been implemented as and from 29/04/2024 to ensure any fire door remedial works are completed in a timely manner.
- If any fire door is identified as being faulty a maintenance system is currently in place to ensure remedial works are reported and completed. This process will continue to ensure the fire safety is maintained.
- The Person in Charge and Registered Provider have reviewed the cleaning of equipment practices within the designated center on 22/03/2024.
- Following this review a comprehensive cleaning schedule is in place for all equipment which ensures that equipment once cleaned is tagged with an 'I am Clean' IPC labels.
- 100% of staff have completed Hand Hygiene training within the designated center.

- Hand hygiene practices are currently being monitored by the Person in Charge through observational hand hygiene audit to ensure compliance. If any practices are observed that are not in compliance with hand hygiene practices these are discussed with staff and staff are supported to attend training
- Additional practical hand hygiene training sessions have been arranged and will be completed in June 2024
- There are currently 4 Infection prevention and control link nurses within the designated center who are supporting practice with onsite training and IPC audits.
- The center is supported by the Infection prevention and control team and Public Health department they provide onsite support, training, winter ready visits and outbreak management supports.
- The Registered Provider and Person In Charge have completed a review of both staffing and of all incidents within the designated centre and have reviewed the allocation of staffing as part of this review.
- This review has focused on ensuring that adequate supervision is in place for residents including 15-minute safety checks and also 1:1 supervision for those residents with complex needs.
- Following this review and on examination of Key performance indicators of quality care it is felt that the staffing levels in place are appropriate to ensure the assessed needs of the residents is met to a high standard.
- The Person In Charge completes a daily and weekly review of staff rosters to ensure that the number and skill mix of staff provided is appropriate to ensure that the residents assessed care needs are met to a high standard.
- If at any point the Person In Charge or deputy require additional resources this will be supported by the Registered Provider and put in place immediately
- The Person In Charge has introduced a staff allocation and staff breaks template which provides details of the staff assigned to care for residents and include the name of the staff assigned to provide 1:1 supervision to residents. Staff that provide 1:1 supervision are provided with a detailed handover of the residents care needs, routines and preferences to include social activities etc.
- Staff are advised to engage with the resident in preferred activities both within and outside the unit. This includes walking outside of the unit and spending time in other communal areas within the centre and spending time in the many attractive garden areas. Staff assigned 1:1 supervision do not leave the resident unattended at any time and are relieved by another staff member for breaks etc. The details of that staff member are also documented on the staff allocation / staff breaks template
- The Registered Provider reviews and monitors all areas of governance and management within the designated centre on an ongoing basis as part of their governance and compliance visits and meetings as the Provider.
- This encompasses staffing, resources, Infection prevention and control, fire safety and all areas pertaining to Quality, risk and patient safety.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: To ensure compliance with Regulation 4 (1): Written policies and procedures the RRegistered Provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in schedule 5. Compliance will be met by: - The Person in Charge in consultation with Registered Provider has reviewed, updated and implemented the Fire Safety management policy on the 19/03/2024 to ensure that it includes the frequency and procedure for checking of fire doors within the designated center.	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: To ensure Compliance with Regulation 12(a): Personal Possessions: The Person In Charge shall, in so far as is reasonably practical, ensures that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions Compliance will be met by the following : 1. The Person in Charge and Registered Provider have completed a review of resident's multi occupancy bedrooms on 19/03/2024 including the layout within the designated center to ensure all residents have access to their personal possessions and lockers. 2. Customized Wardrobes with lockable lockers inside and bedside lockers had been ordered for the Monsignor Young Unit prior to inspection. Fitting of these wardrobes commenced on the 01/05/2024.This will ensure residents have a safe place to store personal belongings and their possessions close to their bed space. This will be completed by 15/05/2024. 3. A reconfiguration of all residents bedrooms has been completed by the Person in Charge to ensure all residents have access to their lockers 19/03/2024.	
Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure compliance with Regulation 17(2): Premises: 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

Compliance will be met by :

- The Registered Provider and Person in Charge have reviewed any outstanding environmental upgrade works on 20/03/2024. Following this the maintenance Program has been reviewed and updated to ensure that the designated center is well maintained. The Registered Provider will monitor this on an ongoing basis
- The Registered Provider will as part of the ongoing governance and management arrangements within the center ensure that the providers meetings/ visits and compliance visits will focus on ensuring that sufficient resources are provided to ensure the remaining refurbishment works are completed without delay.
- The Registered Provider as part of their oversight ensures that an onsite monthly visit is completed including an environmental and safety walk around to review the premises and ensuring that it is appropriate and adequately maintained and in compliance with Regulation 17. If areas for improvement have been identified these will be actioned without delay This is in place from April 16th 2024
- The Registered Provider is working in conjunction with HSE estates and HSE maintenance to ensure that any outstanding refurbishment works are completed without further delay.
- The Registered Provider in conjunction with the Person In Charge now reviews the schedule of refurbishment works weekly to ensure that these are completed on time if any delays are identified these are discussed with HSE Estates and HSE Maintenance to ensure that an action plan I sin place to address this
- The provider representative will ensure that a safety walk around continues to be completed as part of all visits and that an ongoing cyclical maintenance Programme is in place and actioned.
- The Registered Provider and Person in Charge have completed a review of storage of equipment in all units within the designated center on 19/03/2024
- Following this review designated storage areas have been identified for assistive equipment when not in use. This will be reviewed and monitored on a Daily basis by CNMs on unit and ADON/DON on daily during walk around on units. This is in place from 19/03/2024.
- The Registered Provider and Person in Charge have reviewed the communal bathroom identified on inspection as requiring upgrade. on the 19/03/2024
- Following this review the flooring was replaced in this bathroom on the 16/04/2024.
- The Occupational therapist completed an assessment of this bathroom on 25/03/2024 and identified and ordered assistive grab rails to support resident safety. This will be completed by 15/05/2024.
- A shower head has been ordered for this bathroom and has been fitted on the 10/05/2024.
- Prior to inspection the Registered Provider and Person in Charge had identified that a Programme of painting for the Monsignor Young Unit was required and a painting contractor had been appointed
- Painting commenced on Monsignor Young unit on the on 21/03/2024. This was completed on the 20/05/2024. Residents were consulted with regarding colour choices

for the unit
- The Registered Provider, Person in Charge and HSE Maintenance manager have reviewed the large waste collection storage area on 29/02/2024 prior to the inspection. Following this review a Contractor Completed an onsite site assessment on the 01/05/2024 and work will be completed by 30th September 2024.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
To ensure compliance with Regulation 27: Infection control: 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.

Compliance will be met by:

- The Registered Provider has reviewed all Infection prevention and control practices within the designated center and has discussed the Findings from the inspection with the HSE IPC team
- The Registered Provider commissioned an Infection and control review of the designated center. This was completed on the 29/04/2024 with IPC and the Person in charge.
- The Registered Provider and the Person in charge have reviewed surveillance of MDRO within the designated center. As and from 15/03/2024 the residents identified with MDRO colonization have had their care plans updated to reflect best practice.
- The Person in Charge has developed a template which captures MDRO concerns. This has been implemented from 30/04/2024.
- The Portable Stainless steel Hand Wash basin in Monsignor Young unit has been removed on 20/03/2024 following advice from IPC team Following IPC review it was determined that there were sufficient hand hygiene sinks in practice to support staff to safely practice hand hygiene.
- Staff also have access to hand gel at the point of care throughout the center to ensure hand hygiene is practiced as per the WHO five moments for hand hygiene
- The Janitorial unit in Monsignor Young Unit will be plumbed and ready to use by the 15/05/2024.
- The IPC Team have reviewed the Pharmacy rooms in Sheemore, Dr.Mc Garry and Monsignor Young Unit on 29/04/2024. Following this, a maintenance Programme has been identified to upgrade these rooms. This will be completed by 30 August 2024
- The Person in charge has reviewed the laundry facility following the inspection. Painting in the Laundry will be completed by 30/05/2024.
- The Registered Provider and Person in Charge have reviewed the cleaning of equipment practices within the designated center on the 22/03/2024. Following this review a comprehensive cleaning schedule is in place to ensure that for all equipment

which ensures that equipment once cleaned is tagged with an "I am Clean" label. This is in place from 22/03/2024.
- "I am clean" advice posters are displayed in all units following IPC review on 29/04/2024. Staff are also reminded about the label use through safety pause to ensure consistency of use.
- The Registered Provider and Person in Charge have completed a review of storage of equipment in all units within the designated center on 19/03/2024
- Following this review designated storage areas have been identified for assistive equipment when not in use. This will be reviewed and monitored on a Daily basis by CNMs on unit and ADON/DON on daily during walk around on units. This is in place from 19/03/2024.
- The Registered Provider and Person in Charge have reviewed the communal bathroom identified on inspection as requiring upgrade. On 19/03/2024
- Following this review the flooring was replaced in this bathroom on the 16/04/2024.
- 100% of staff within the center have completed hand hygiene training.
- A shower head has been ordered for a bathroom identified during the inspection and this was completed on 03/05/2024.
- Prior to inspection the Registered Provider and Person in Charge had identified that a Programme of painting for the Monsignor Young Unit was required and a painting contractor had been appointed
- An ongoing Programme of IPC audits is in place within the designated center with robust time bound quality improvement plans as required in place and reviewed by the Registered Provider and PERSON IN CHARGE
- The Registered Provider will continue to monitor all aspects of IPC within the designated center including any notifiable diseases , staff training , outbreak reviews and share learning post same
- The Registered Provider will review and monitor all aspects of IPC within the designated center on an ongoing basis and as part of the governance and compliance arrangements in place to ensure that the center is in compliance with Regulation 27.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
To ensure compliance with Regulation 28(1)(c)(iii)
The Registered Provider shall make adequate arrangements for testing fire equipment.
To ensure compliance with Regulation 28(1)(c)(ii)
The Registered Provider shall make adequate arrangements for reviewing fire precautions.
To ensure compliance with Regulation 28(2)(I)
The Registered Provider shall make adequate arrangements for detecting, containing and extinguishing fires.
To ensure compliance with Regulation 28(3)
The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated center.

Compliance will be met by the following:

- The Registered Provider, HSE Fire Safety Officer and Person in Charge have reviewed the Fire safety management system within the designated center 18/03/2024.
- Following the fire safety review, Additional fire door checks are now carried out during weekly fire drills and records are maintained in the Fire Register as and from 18/03/2024.
- All identified gaps in Fire doors have subsequently been repaired on 19/03/2024 following review by the HSE fire Officer.
- All fire doors are fit for purpose and effective in the event of a fire
- A new maintenance system for fire doors has been implemented as and from 29/04/2024 to ensure any fire door remedial works are completed in a timely manner.
- If any fire door is identified as being faulty a maintenance system is currently in place to ensure remedial works are reported and completed. This process will continue to ensure the fire safety is maintained.
- The Registered Provider ensures that a Fire maintenance contract is in place within the designated center and that as per the HSE fire safety handbook 6 monthly fire door checks are completed on all doors. This was last completed on 31/12/2023 and any remedial works also completed (All fire sealing products are tested on fire doors).
- The next scheduled 6 monthly fire door check will be June 2024
- As part of the weekly fire door inspection the Person in Charge or deputy review all fire doors within the designated center to ensure they are compliant with fire standards , if any door is identified as not being compliant this is escalated to HSE maintenance immediately .
- The Registered Provider as part of their onsite visits also reviews fire doors and all aspects of fire safety within the designated center.
- The fire exit routes in each unit are formally checked twice daily on the Fire route escape sheet and any issues rectified immediately.
- The Fire Safety checklist has been updated and amended from HIQA fire safety guidance and implemented from 01/05/2024.
- Additional safety walk around are now being completed by the Person in Charge to ensure there is full compliance with clear evacuation routes. In the absence of the Person in charge this is completed by ADON/CNMS/Senior nurses. This is in place from 15/03/2024.
- An annual Fire safety training Programme is in place to ensure all staff attend Fire safety training on an annual basis.
- Monthly Simulated Fire Drills for Day and night are carried out in the designated center to support staff with knowledge and skills to safely evacuate the residents. Shared learning takes place on all units after these simulations
- The Person in Charge has reviewed the Fire Drill record and amended with clear lines of authority and accountability at all levels for fire safety.
- Staff are identified at individual, team and service levels with information from HSE fire safety register and adapted guidelines from HIQA fire safety handbook. Roles and duties at the time of evacuation and staff supervision for residents post their evacuation are clearly documented in the reviewed fire drill sheet. This is practiced during fire drills from 11/04/2024.
- The Registered Provider and Person in Charge have reviewed the Personal Emergency Evacuation sheets for each resident on 11/04/2024 and has ensured that it is completed on admission and updated as required or at least 4 monthly. This document is used for

evacuation drills to ensure the staff are assisting the residents safely.
- The Registered Provider and Person in charge have consulted with the HSE fire officer in respect of the door on a corridor to Sheemore unit. This door is not a fire door as determined by the HSE Fire Officer. It has been removed from magnetic release system from the 27/03/2024 as it is not a Fire door and has been repaired.
- An external competent Contracted Fire maintenance team support all aspects of the Fire safety system within the designated center. They also complete 6 monthly fire door checks. These were completed on 31/12/2023 (All fire sealing products are tested on fire doors). The next scheduled 6 monthly check will be June 2024
- An annual check of all firefighting equipment is being completed annually. Last check completed in March 2024.
- Detection and Fire alarm system are serviced quarterly by an external fire maintenance company. This was completed on the 14/02/2024
- The Registered Provider as part of their due diligence and ongoing compliance support visits will ensure that all aspects of fire safety checks are effective and completed on time
- Fire safety and management will continue to form part of the Provider Compliance visits and inspection.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
To ensure compliance with Regulation 5 (4) The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Compliance will be met by the following :

- The person in charge has completed a full review of residents care plans within the designated center following this review Care plans were updated to ensure the care plans accurately reflected the individual care needs of each resident. This was completed on the 15/03/2024
- The recommendations made by speech and language therapists have been updated to accurately reflect the person centered care needs of residents this was completed on the 15/03/2024.
- Following this review the Registered Provider reviewed the updated care plans and each resident has a detailed plan of care which is informed by a comprehensive assessment of their healthcare and psychosocial needs
- The residents care plan is updated 4 monthly or more frequently as indicated or if a change in the resident care needs has been identified.
- An audit plan is in place within the designated centre of which care plans are audited on a quarterly basis, following audit a robust time bound quality improvement plan is put

in place to ensure any actions identified and are actioned. This is kept under review by the Person in Charge
- The Registered Provider will continue to monitor the results of care plan audits and ensure that Quality improvement plans are actioned and are kept as a live document. The purpose of the audit and Quality improvement plan is to ensure that each individual residents care plan is person centred and is reflective of their actual care needs and is appropriate to meet the health and social care needs of the residents.
- The Registered Provider will ensure that this is reviewed and monitored on an ongoing basis and that this continues to form part of the provider compliance inspection visits.
- A sample of care plans will be reviewed and audited as part of the Registered Provider governance compliance meetings on an ongoing basis

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
To ensure compliance with Regulation 6 (2) (c): Healthcare:
The Person in Charge shall in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.

Compliance will be met by:

- The Person In charge has reviewed resident's access to physiotherapy on 20/03/2024.
- Following this review ,additional private physiotherapy services have been secured to supplement the existing HSE service within the designated center This will support residents rehabilitation and promotion of independence
- This additional physiotherapy service is in place from 11/05/2024.
- The Registered Provider will continue to monitor resident's access to appropriate Physiotherapy services based on resident assessed clinical need and requirement for this on an ongoing basis.
- The Registered Provider will review this at the provider meetings and compliance visits within the center with the Person In Charge and also through Key performance indicators and resident feedback
- If at any stage additional resources are required to support healthcare these will be put in place.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

To ensure compliance with Regulation 9(3)(b) : Residents rights The RRegistered Provider shall in so far as is reasonably practical, ensure that a resident may undertake personal activities in private

Compliance will be met by:

- The Registered Provider and Person in charge had reviewed resident's privacy and dignity and had identified works to be completed prior to the inspection on the 08/03/2024.
- Transparent one-way mirror film had been ordered and has been applied to glass windows in bedrooms and on corridors to promote residents privacy and dignity. This was completed on the 12/04/2024.
- The gaps in communal toilet in Monsignor Young Unit and Dr. Mc Garry have been addressed by maintenance and completed on the day of the inspection itself (11/03/2024).

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	15/05/2024
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	20/03/2024
Regulation 16(1)(b)	The person in charge shall	Substantially Compliant	Yellow	20/03/2024

	ensure that staff are appropriately supervised.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	19/03/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	22/03/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections	Substantially Compliant	Yellow	30/08/2024

	published by the Authority are implemented by staff.			
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	18/03/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	19/03/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	11/04/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	19/03/2024
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	Substantially Compliant	Yellow	15/03/2024

	the resident concerned and where appropriate that resident's family.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	11/05/2024
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	12/04/2024