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 Columba's Hospital
Name of provider:	Health Service Executive
Address of centre:	Cloughabrody, Thomastown, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	13 July 2021
Centre ID:	OSV-0000552
Fieldwork ID:	MON-0033354

About the designated centre

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

St. Columba's Hospital provides residential accommodation for up to 68 residents in four continuing care areas. The centre is run by the Health Service Executive (HSE) and is located in a rural setting on the outskirts of Thomastown, Co Kilkenny. The stated primary aim of the hospital is to provide support and services to older people age over 65. Admissions of younger residents may only be accepted if it is deemed appropriate by the multidisciplinary team and following a full assessment of their needs. The service caters for residents from low to maximum dependencies and for short stays and long term care. Nursing care services are provided over 24 hours for respite, convalescence, dementia care and end of life care. The centre had 15 dedicated dementia care beds. The building was originally constructed in the late 1800's and has been upgraded and adapted over time, however, the layout mostly reflects a building from that period. There is a passenger lift for access to the first floor. Bedroom accommodation is provided over two floors and consists mainly of 2 to 4 bedded "bays". There is a limited number of single rooms which are generally used for end of life care. Residents may only be admitted to the hospital following assessment of individual care needs to ensure that the centre is suitable to provide for the needs of the individual. The common summary assessment record is completed for all admissions which are managed through the multidisciplinary meeting at the Local Placement Forum. There are medical reviews by the Medical Officer who visits the hospital each day, Monday to Friday and out of hours, Care Doc is called to provide the medical service. The centre currently employs approximately 110 staff and there is 24-hour care and support provided by registered nursing and health care staff with the support of housekeeping, catering, administration, laundry and maintenance staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	50

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
Tuesday 13 July 2021	10:10hrs to 19:40hrs	Liz Foley	Lead
Tuesday 13 July 2021	10:10hrs to 19:40hrs	Niall Whelton	Support

What residents told us and what inspectors observed

The provision of activities for residents was poor with a large number of residents spending their day at their bedside with little to occupy them apart from daily care tasks and the TV or paper. The layout of the premises continued to present a challenge for staff to provide person centred care and respect resident's dignity. It also impacted on the safety of residents. Inspectors met most of the residents and spoke with seven residents at length and spent time observing residents' daily lives and care practices in the centre in order to gain insight into the experience of those living there.

In January 2021 the provider had divided resident accommodation into five units, four of these units provided accommodation to residents in large open bays. These bays were large rooms which were sub divided by partitioned walls that did not reach the ceiling and did not have doors. These large rooms were also a thorough fare for access to bathrooms, lifts, day rooms, emergency exits and office space. There was up to four residents living in one of these sub divided bay areas which did not provide ample privacy or space for personal possessions.They did not exclude noise or smells. This arrangement continued to impact on the privacy and dignity of all residents living in these areas which on the day of inspection was approximately 40 people.

The provider had reduced bed numbers in two of the centre's units on the first floor of the centre, St Anne's and St Bridget's wards; this was primarily to mitigate fire safety risks. There were 10 residents living in St Anne's ward and there were nine people living in St Bridget's ward. Residents in these areas were observed to spend much of their day by their bedside, with only four residents observed in one of the unit's day rooms in the morning time. Meals were served in or at the bedside and despite the lovely weather none of the residents on the first floor went outside. There was an apathy around activity provision in these areas, for example, inspectors were told that residents didn't choose to go outside and that it took a lot of staff to bring a resident outside. Residents however told inspectors they were bored and rarely got to go outside- some residents felt it was too much trouble and therefore didn't ask to go out. For some residents on these two units in particular, their daily experiences were limited to the bed space in which they resided and this was having a major impact on their daily experiences and quality of life. Residents had limited choice within the confines of the centre and the culture of care was institutional in some units. For example, four residents on two units said there were no activities, 'nothing going on', 'I don't do anything here'. Some residents said their sleep was occasionally disturbed by noise from other residents and staff, 'but you get used to it'. One resident stated he wasn't living in the centre but he was 'dying here'.

TV's were available in bays and shared between residents however, only residents on one side of the bay could view the TV. TV's were also available for shared viewing in day rooms but day rooms were under utilised in some units. Care in these

units in particular was task based. There was no activity staff and no allocation of ward staff to provide group or one-to-one activities for residents. There was no activity schedule visible to allow residents to choose what was available to them on any given day. There was a written list in the nurse's office but his was not being adhered to. This arrangement had a major impact on the quality of life of the residents living in these units and required urgent review.

While St Mary's and St Patrick's wards had a better approach to activities, the layout of the premises and accommodation in bay areas continued to impact or the residents' safety and their quality of life.

The layout of the premises also impacted on the privacy afforded to residents during indoor visits. In most units visits were facilitated in a bay area with only a curtain for privacy. In St Mary's ward visits were facilitated in the reception/hallway area which was a thoroughfare for entry in and out of the unit. There were still up to nine people living in large open plan bay wards in the centre and this will not comply with amended regulations SI 293 which comes into effect on 1 January 2022.

Residents spoke positively about staff and staff were observed providing kind and compassionate care throughout the inspection. Staff were observed following infection control guidelines with the correct use of PPE and hand hygiene.

Inspectors noted that since fire safety risks were identified on the previous inspection, the occupancy had reduced on first floor from 38 to 19 residents and the number of residents was evenly spread out between the two first floor units. Inspectors observed that additional evacuation equipment was available on the units.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

Management systems required review to ensure they were effectively managing ongoing risks and ensuring a safe and appropriate service for residents. The centre had undergone significant changes to the senior management team since the previous inspection in January 2021. Unsuitable premises, fire risks and lack of suitable activities were impacting negatively on the safety and the quality of life of residents.

The Health Service Executive (HSE) was the registered provider for St Columba's Hospital. The person in charge worked full time in the centre and reported to the director of nursing. There were changes in senior management in the centre since January with the appointment of a director of nursing who was new to the centre. The provider representative was also new to the role since January and was located

off site but available to the centre on a daily basis and attended the centre for management meetings. In addition there were two assistant directors of nursing and each of the five separate resident units all had a clinical nurse manager. An experienced team of nurses, carers, housekeepers, caterers, administration and laundry staff support the needs of the residents.

This was an unannounced inspection to follow up on risks identified in the previous inspection in January 2021 The centre had a history of poor compliance and the previous inspection had highlighted risks associated with fire and an urgent action plan was issued to the provider. A specialist fire and estates inspector attended on this inspection as there was a particular focus on fire safety management. While the provider had put in place many measures to manage these risks, some risks remained and these are discussed under regulation 28. The premises remains unsuitable for its intended purpose and was impacting on the quality of life of residents. Further areas for improvement were also identified and included activity provision and care planning.

There were systems in place to monitor the quality and safety of care however, these were inconsistent and sometimes ineffective. A regular schedule of audits was in place and where risks and failings were found appropriate actions were developed and completed for example, restrictive practices. Following the last inspection, there had been a successful reduction in the use of restrictive practices. Other key quality of life indicators like activities and social engagement were not being effectively monitored which resulted in poor activity provision in some areas of the centre. This had a big impact on the daily experience of those residents most affected, with little opportunity to attend an enjoyable activity or even to go outdoors for fresh air.

Staffing was found to be sufficient to meet the needs of residents. There was an ongoing schedule of training in the centre and management had good oversight of mandatory training needs. Gaps in mandatory training had been identified and were being addressed by the management team. The centre was also undertaking to review training to support staff to provide suitable activities for residents.

The centre had focused on fire training and evacuation drill practice in an effort to improve fire safety in the centre. Staff had completed recent fire training on the use of recently purchased evacuation aids and key staff were practicing increased frequency evacuation drills including vertical evacuation from first floor units.

In January 2021 the centre had reduced its occupancy in response to fire risks and the layout of the building. The centre were undertaking to further reduce bed numbers to ensure the ongoing safety of all residents in response to fire risks and also to comply with regulatory requirements for premises by 31 December 2021.

Regulation 15: Staffing

Staffing levels had been reviewed following an inspection in the centre in January to ensure there were sufficient arrangements in place to care for separate cohorts of residents in line with the centre's contingency plan for COVID-19. Night time staffing levels had also been reviewed to ensure that there were sufficient staff on duty to safely evacuate residents in the event of a fire.

Staffing was found to be sufficient to meet the needs of the residents on the day of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in infection prevention and control and specific training regarding the prevention and management of COVID-19, correct use of PPE and hand hygiene. There was an ongoing schedule of training in place to ensure all staff had relevant and up to date training to enable them to perform their respective roles.

Staff were appropriately supervised and supported to perform their respective roles.

Judgment: Compliant

Regulation 23: Governance and management

Management systems required review to ensure all key areas of care were monitored and informed quality and safety improvements in the centre. Poor oversight of activity provision was impacting on the quality of life of residents and actions taken following an inspection in January 2020 were not effective and had not identified or addressed the impact of poor activity provision on many residents in the centre.

In addition, environmental walkabouts were not undertaken which would assist the service to identify obvious risks and improvements required in a building of its era. Additional risks associated with evacuation procedures identified during the inspection had not been assessed by the provider and were not being effectively managed.

Judgment: Not compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector within the required time frames. The inspector followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure in the centre which was displayed at the reception. There was a nominated person who dealt with complaints and a nominated person to oversee the management of complaints. Inspectors viewed a sample of complaints all of which had been managed in accordance with the centre's policy.

Judgment: Compliant

Quality and safety

There was ongoing non-compliance with fire safety, premises and residents rights. The design and layout of the premises continued to impact on the privacy of residents and also posed an infection control risk. Activity provision was poor in some units and was impacting on the quality of life of residents. Improvements were also required to the standards of care planning.

In relation to fire precautions, the previous inspection on 19 January 2021 raised concerns. In particular, the arrangements in place to evacuate residents from the upper floor of the centre and the fire containment measures in place.

Since that inspection, the registered provider had engaged with the Chief Inspector and had made significant progress to address those risks:

- The occupancy had reduced at first floor from 38 to 19 residents.
- The number of residents was evenly spread out between the two first floor compartments.
- An additional staff member was scheduled at night time on the first floor.
- The provider had recently purchased new evacuation aids for the upper floor.
- A focused fire training programme was implemented to ensure all staff were equipped with the knowledge of, and how to complete vertical evacuation of residents who require assistance with the various evacuation aids in use.
- A third party fire consultant was commissioned to complete a review of the fire compartment boundaries.

- Containment measures had been significantly improved. A third party specialist contractor was employed to review all fire rated construction and ensure a barrier to fire where required by sealing up openings, gaps or imperfections of fire of the fire rated elements. Inspectors observed evidence of this.

However, fire safety risks persist. The combination of those risks has raised concerns regarding the oversight of fire safety in the designated centre. Those risks are detailed under regulation 28.

Staff were found to be knowledgeable on the evacuation procedures in the centre and explained to inspectors, the increased awareness of fire precautions since the last inspection, their participation at focused fire safety training and practiced drills.

Each unit was provided with escape routes which provided alternative directions of escape. However, as the accommodation for residents consisted of multi-bedded bays, with up to three bays open to each other, most were not provided with fire protected escape corridors. This leads to increased risk of the effects of fire to residents. If a fire starts in one bay, the smoke from a fire will have direct impact on all residents within that area, while waiting to be evacuated. For this reason swift and effective evacuation is essential to protect residents from the effects of a fire.

The centre was provided with emergency lighting, firefighting equipment and fire detection and alarm system. Records available showed that they were being serviced at the appropriate intervals. Recommendations by the service contractor for the fire alarm system and the emergency lighting system had not been implemented. Assurance was sought and received from the registered provider in the days following the inspection.

The premises was not meeting the needs of residents and was impacting on the safety, privacy and dignity of most residents. Due to the size and layout of the building risks associated with fire containment and evacuation remained. Visits were not facilitated in a private space separate to the residents' bedrooms. There was inadequate storage space for residents' belongings and bedrooms were also access corridors for bathrooms and storage spaces for large pieces of equipment. The majority of the centre's bedroom accommodation would not meet the amended requirements of the regulations (SI 293) which is due by the end of the year.

Person-centered care was difficult to provide due to the impact of the premises on residents who lived there. In addition, in some units activity provision was not seen as a daily need for residents and was not routinely provided. This had a significant impact on residents who lived on these units. Residents told inspectors they were bored with little to occupy them. Inspectors observed long periods of inactivity and saw that a significant number of residents spent their day beside their beds in an environment that was not meeting their needs. Some residents did not have daily opportunities to go outside for fresh air. Televisions in bay areas were shared and some residents could not see the TV from where they lay in bed or sat. Staff in these areas confirmed there was no group activity plan and one-to one activities only happened if there was time in the day. Activity care plans reviewed in these

units were not effectively addressing the residents' needs.

An inspection in January this year highlighted poor oversight of activity provision across the service and a compliance plan was submitted to improve activities for residents. This plan had not improved the experience or quality of life for many residents living in this centre. Bed numbers had been reduced in some units in response to fire safety risks but his had had little impact on improving privacy and dignity for residents due to the layout of the premises. An audit of activities was planned as part of the centre's compliance but had not been completed. Residents were not consulted about or participating in the organisation of the service which resulted in lost opportunities to inform quality improvements. Despite the fine weather on the day of inspection, inspectors did not see any residents being assisted to go outdoors. There had been a recent garden party with outdoor music but on a daily basis and in particular on the two first floor units, residents we not encouraged or assisted to go outdoors.

There was an inconsistent approach to care planning found in a sample of care plans reviewed from different units in the centre. Some care plans were good and described individualised and evidence based interventions to meet the assessed needs of residents. Validated risk assessments were regularly and routinely completed to assess various clinical risks including risks of malnutrition, pressure sores and falls. However not all care plans had interventions in place to address identified needs. This was discussed with staff on the unit during the inspection.

Overall health care provision was good and was based on the assessed needs of the residents and in line with best practice. The GP attended the centre daily and residents had access to appropriate allied health care professionals as required. The centre had reduced the numbers of residents using bed rails which was line with their policy and best practice. Ongoing review and improvements were required in order to reduce the use of bed rails and other restrictive practices, for example, key coded doors, in line with the national policy.

Improvements were made to the centre's contingency plan for COVID-19 since the previous inspection in January 2021. There were arrangements in place for safe isolation of suspected or positive cases which would be appropriately cared for by dedicated staff. Staff were observed to be following best practice with hand hygiene and face coverings. Risks remained around cross-contamination of infections in multi-occupancy bedrooms. Cleaning schedules were in place to ensure continuation of frequent cleaning of high touch areas. The provider had reduced bed occupancy in some of these areas which may help in reducing the risk of cross-contamination. However some areas of the centre still had beds located close to each other and residents in these areas remained at risk of cross-contamination from infections and viruses and particularly from COVID-19.

There was a risk register in the centre and the provider had many measures in place to keep residents and staff safe. For example, there were good infection prevention and control measures in place to prevent and minimise a potential COVID outbreak.

Regulation 11: Visits

Indoor visits had resumed in line with the national guidelines and there were ongoing safety procedures in place, for example, temperature checks and health questionnaires for visitors. However, due to the layout of the premises the majority of units could not facilitate private visits. While there were designated visiting spaces in each unit, these spaces were in partitioned bays in bedrooms or in a reception area and this arrangement did not facilitate privacy.

Judgment: Substantially compliant

Regulation 12: Personal possessions

The majority of residents had inadequate space to store their personal possessions and belongings. Residents had access to a small wardrobe and bedside locker in which to store all of their belongings. Residents were not able to bring in large personal items from home and the environment did not facilitate residents to hang or display family photos or pictures from home.

Judgment: Not compliant

Regulation 17: Premises

The registered provider was not providing a premises that conformed to the matters set out in schedule 6 of the regulations. The major impact of this was on the daily experience of the majority of resident who lived in multi-occupancy bedrooms. For example, lack of privacy to perform basic care, noise, smells, infection risks, lack of space to store personal belongings and fire and evacuation risks.

Multi-occupancy bedrooms would not meet the amended requirements of schedule 6 of the regulations which is due by 31 December 2021.

Judgment: Not compliant

Regulation 26: Risk management

Additional risks associated with the evacuation of residents from parts of the centre had not been identified by the provider and required review. This was not in line

with the centre's risk management policy.

Judgment: Substantially compliant

Regulation 27: Infection control

Risks of cross-contamination from community and health care acquired infections and viruses to residents in multi-occupancy bedrooms could not be eliminated due to the layout of the centre. Residents in these areas were at particular risk should an outbreak of COVID-19 occur.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Although significant progress was made, since the inspection in January 2021, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. Improvements were required to comply with the requirements of the regulations. The service was non-compliant with the regulations in the following areas:

The registered provider was not taking adequate precautions against the risk of fire:

- The inspection of the electrical installation identified risks that required attention. Information received in the days following the inspection confirmed that 60% of the high and medium risks have been completed and works are ongoing with the remaining identified risks.
- The arrangements for the storage of oxygen cylinders required review. Inspectors observed oxygen cylinders stored within the open bedroom areas, some in circulation areas placing them at risk of being hit when moving beds or equipment. In one location, hoist batteries were on charge within a short distance of the oxygen cylinders.
- Hoist batteries were left on charge in the bedroom areas, with no risk assessment available.
- Although not in the resident areas of the designated centre, inspectors observed a number of fire doors propped open with wedges or furniture.
- Inspectors noted excessive aerosol containers within storage presses in the bedroom areas.
- There was an electrical transformer within a storage press with excessive storage up against and around it. While inspectors were told that the risk was low, it was poor practice. The storage was immediately removed from around the transformer.
- The lint screen on one of the dryers required review as it appeared to be too

large for its frame. Assurance is required that the correct screen is in place to collect lint.

Inspectors were not assured that adequate means of escape was provided throughout the centre:

- Inspectors noted an exit sign directing occupants towards a lift lobby and not through the door towards the escape stairs. An exit sign from a day room was not visible and another was not lit. A review of escape signage was required and this was also recommended by the third party service contractor in January of this year.
- There was storage along the route to a final exit including hoists, wheelchairs and the water drums for water dispensers. There was a clear route through the area, but storage along escape routes is poor practice.
- Inspectors were not assured that an adequate means of escape was available for two bedrooms at ground floor. The escape routes were either through the multi-bay bedroom or through narrow exits directly to open air.

Adequate arrangements were not in place for maintaining all fire equipment and means of escape:

- The annual service report for the fire detection and alarm system, recommended that a review of zone and devices descriptions be carried out as rooms appeared to have been assigned door number/stickers which were not on the device text.
- The annual report for the emergency lighting system included recommendations which were not completed.

From a review of evacuation drill records, inspectors were not assured that staff working in the centre were adequately prepared for the procedure to be followed in the case of fire and for the safe and timely evacuation of residents.

- The record of a simulated drill included moving residents from the open multi-bedded bays into two bedrooms with exits direct to open air. Considering the risk associated with beds not easily fitting through these exits, a review is required of the evacuation procedures.
- The times taken to evacuate some of the larger compartments with open bays were excessive.
- A drill record showed staff moved residents to a dayroom within the same fire compartment, and not through the fire compartment boundary. The day room was documented as a place of safety in the drill record.

Inspectors were not assured that adequate arrangements were in place for containing fires:

- The glazing over the doors to the escape stairway and a sluice room was not fire rated.
- In the main, fire doors were noted to be in good condition, however some were noted to have screws missing to their hinges and another was missing a portion of the heat and smoke seals.

- A corridor adjacent to the open plan bedroom in St. Mary's unit was not fire protected from the bedroom and had openable windows directly to the corridor. The alternative escape from this bedroom meant that residents and staff would be required to escape through a portion of this corridor.
- An electrical cupboard required sealing up of small openings in the fire rated construction. The door to this cupboard had a sign indicating it was to be kept locked; the door was not locked shut.
- The door to a storage press was not a fire door.

Improvements were required with the arrangements in place to evacuate where necessary in the event of a fire, of all persons in the designated centre:

- Further review of the evacuation procedure is required from first floor areas to ensure adequate evacuation aids are available to assist residents down the stairs, once they have moved horizontally to the other fire compartment.
- There was no signage over the evacuation chairs to alert staff to their location.
- Residents evacuation needs were assessed through the use of personal emergency evacuation plans (PEEPs). Inspectors reviewed a sample of these assessments. There was no date to show when the assessment had taken place. A small number had review dates, some of which were not reviewed for 14 months.
- Inspectors explored, at the upper level, the scenario where horizontal evacuation was not available and the alternative route down the stairs would be required. With the reduced occupancy and the recently implemented evacuation pads, inspectors were satisfied that during the initial phase of evacuation, evacuation pads with residents on them would fit in the lobby/corridor leading to the escape stairs and be protected from the effects of the fire. That said, this was not relayed to inspectors, and inspectors found that commode chairs, cleaning trolley and waste bin were stored in this area, reducing the space to a point where the evacuation pads would not fit.
- In one unit, inspectors were told that bed evacuation would be feasible, but when asked, staff were unsure if bed or ski sheet evacuation was the procedure for that unit.
- The recently purchased evacuation aids for the first floor included an evacuation pad for each resident and two evacuation chairs provided for each designated escape stairs. One evacuation chair was obstructed by a locker, numerous evacuation pads had wardrobes obstructing access to them. This may lead to delay during evacuation.
- From a review of simulated drill records, the mode of evacuation from the two bedrooms with exits directly to open air varied; mattress on ski sheet or bed evacuation. The provider undertook to arrange for a bed to be moved through the exits to ensure they would fit. Inspectors were told that manoeuvrability through the door was tight but feasible. This exercise was completed a second time with a different bed type in the presence of the inspectors. On this occasion a fitting of the bed got stuck on the threshold of the door and the bed was unable to be moved in or out. The two exit doors opened across a sloped change in floor level, resulting in the bed getting stuck. One drill record for this area indicated it took eight minutes to move

two residents through the side exits from this room, which would be considered excessive.

The person in charge did not ensure that procedures to be followed in the event of a fire were adequately displayed:

- Considering the known risks particularly at first floor and the variations in the required evacuation procedure for different parts of the centre, the procedures displayed were not specific to the area they were located.
- Drawings on display did not fully reflect the current layout and were dated 2007. Fire compartment boundaries were not identified on the floor plans.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Improvements were required to ensure that all residents had a care plan consistent with their assessed needs. In a sample viewed not all residents had care plans in place to guide staff to meet their assessed needs. For example, there were no corresponding care plans in a number of resident's files to guide staff to care for basic needs identified like personal care, sleep routine and choice of activities.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of evidence based health care provided in this centre. GP's and consultant psychiatry of older age attended the centre to support the residents' needs. Allied health professionals also supported the residents on site where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professionals as appropriate.

Judgment: Compliant

Regulation 9: Residents' rights

Residents did not have opportunities for meaningful occupation in accordance with their assessed needs and preferences. Two units in the centre did not provide scheduled group activities and one-to-one activities were only provided if time

allowed. Residents spent most of the day by their bedside.

Choice was impacted on by the institutional culture in some units and the confines of the service. For example, residents could not freely access the outdoors due to environmental restrictions and individual needs. Going outside was not a usual part of everyday life for a large number of residents due to the organisation of care and therefore residents' expectations were low. Residents felt they were putting staff out by the effort required for them to go outside.

The majority of residents could not undertake personal activities in private, due to the layout of multi-occupancy bedrooms.

Not all residents had access to television in accordance with their preferences. Residents were not routinely consulted about the organisation of the service which had resulted in a task based approach to care and poor standards of activity provision.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Substantially 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	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Columba's Hospital OSV-0000552

Inspection ID: MON-0033354

Date of inspection: 13/07/2021

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Director Of Nursing has delegated an ADON to provide governance to St Anne's/St Bridget's and another ADON to provide governance to St Patrick's/St Michael's & St Mary's with immediate effect. • This governance by ADONs involves daily multiple walk- about engaging with CNMs/staff and the monitoring and over sight of Resident's activities, meal times, outings and social interaction in communal areas such as living areas. • Resident's Satisfaction Survey completed and action plan in place since end of July 2021, highlighting the prefer choices of resident's meaningful activities. • Introduction on each ward an update visual timetable on a weekly basis outlining activities. This is the responsibility of the CNM with oversight from each ADON. • DON has allocated 1WTE HCA hours to the 1st floor (St Anne's & St Bridget's) and 1WTE to ground floor (St Patrick's & St Michael's). St Mary's Ward continues with PCC approach to Resident's activities with identified 0.5 WTE HCA for activities from immediate effect. • Quality & Safety Committee Meeting commenced on the 03/08/202 with agreed terms of reference. This is multi-disciplinary outlining Quality Improvement Initiatives which includes Service User Experience which can be measured utilising Plan, Do , Study , Act cycle for QI. This has commenced and outcome of QI to be completed by December 30th 2021. • Environmental walk-about to commence quarterly from September 2021 to include: DON, OP Hospital Manager (Provider), H&S Advisor, QPS Advisor, IPC Advisor and Fire Officer when available, utilising a quality safety tool. • Further Fire Training for all staff in September 2021. • All PEEPS reviewed and documentation of PEEPS also updated, responsibility of CNMs with oversight of ADONs. Weekly Fire drills continue in house with addition of ADON attending to enhance the oversight.	

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
St Anne's & St Bridget's:
Single room to be utilised as Visiting room with scheduled appointments.

St Patrick's & St Michael's
St Michael's Ward has a single room that can be utilized for visiting.
Both have outdoor courtyard area option for visiting.
St Patricks are in the process of enclosing area for visiting
St Mary's
Single room is available for scheduled visiting appointments
Option 2
Indoor seating area now in place outside Resident's room's as you enter corridor to main living area.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
CNMs have with Resident's and families regarding personal possessions in regards to hanging & displaying family pictures from home to be evident by December 31st 2021. This is incorporated into the social care programme.

With reconfiguration of the bay areas it will allow for further storage with wardrobes and lockers to facilitate Resident's personal possessions to be evident by December 31st 2021.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Reduction in bed numbers
• Increased evacuation equipment, training and staff provided.
• Plan to see if possible to require sub compartments secured for private areas.

• Plans in place for extra storage as a result of decrease in bed numbers.
• Strategic Plan for a new build under Public Private Partnership.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
This compliance plan response from the registered provider did not adequately assure the Chief Inspector that the actions will result in compliance with the regulations.

• Fire risk assessments been completed
• Ramps from St Patrick's ward to outside commencing 31st of August 2021.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
This compliance plan response from the registered provider did not adequately assure the Chief Inspector that the actions will result in compliance with the regulations.

• Cleaning Schedule has been reviewed and to be audited by December 31st.

• IPC walk about on the 23/08/2021 to review bed spaces.
• New cleaning manual to be launched by 31st September by SECH IPC Group

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
This compliance plan response from the registered provider did not adequately assure the Chief Inspector that the actions will result in compliance with the regulations.

• Friday 3rd of September Vertical Fire Training • Sat 4th of September Vertical Fire Training • Friday 10th of September Fire Training • Friday 17th of September Fire Drill in St Anne's/St Bridget's with ACE Fire Trainer • Environmental walk-about to commence quarterly from September 2021 • All PEEPS reviewed and documentation of PEEPS also updated ,completed on the 26th of August 2021, responsibility of CNMs with oversight of ADONs. Weekly Fire drills continue in house with addition of ADON attending to enhance the oversight.

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: • 17 RGNs including 2 ADONs have now received Documentation training which focused on Person Centre Approach. All Resident's Care Plans presently being reviewed with residents and document specific supports required for each resident based on their own preference and choice. • Resident's Recreation & Social Interaction Pathway has been developed by DON to support a Person Centre Approach to Resident's quality of life. • St Patrick's and St Michaels Wards utilizing Recreation and Social Interaction Assessments (Cork/Kerry), this approach is being launched throughout other wards. • All Resident's will have individual Activity Care Plans identifying their choices which will also include access to outdoors, oversight from Ward CNMs with support from ADONs. • All Care plans to be audited utilizing DML Audit Tool for Care Plans. Completion date 31/12/2021. Governance ADON of each ward. Full Care Plan Audits will be audited 6 monthly thereafter and evidence of actions required. • Training for all staff on: 2 day Enhancing & Enabling Well Being for the Person Living with Dementia with a focus on quality of life of resident's. Dates are : 13th & 28th Sept, 18th Oct & 1st of Nov, 15th & 30th of Nov 2021. 2022 dates to be decided. Facilitated by Advanced Nurse Practitioner In Dementia Carlow/Kilkenny and CNM2. This will require approximately 14 days of training. Aim 6 days of training will be completed by December 2021 and the other 8 days training to be completed by April 30th 2022.

Regulation 9: Residents' rights	Not Compliant

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

• DON has identified governance by ADON providing governance over St Anne's/St Bridget's and the other A/ADON having governance over St Patrick's/St Michael's and St Mary's Wards.
• Presently identifying training needs and Training program will be put into place ADONs and CNMS. External trainer will facilitate all staff training for all staff in person centre care. This is supported by enabling training as previously identified.
• Resident's Satisfaction Survey completed on the 19th & 26th of July 2021, data collected and action plan in place.
• Resident's forum re-introduced on each ward due to current Covid-19 IPC Guidelines. These forums are a monthly meeting inclusive of a member of the catering staff from the catering department.
• Each ward has now a visual, picture and written schedule of Group Activities which is displayed in main living areas but is also available weekly at Resident's bedside. This will be updated on a weekly basis by CNMs.
• Training for all staff on: 2 day Enhancing & Enabling Well Being for the Person Living with Dementia with a focus on quality of life of resident's. Dates are :
13th & 28th Sept, 18th Oct & 1st of Nov, 15th & 30th of Nov 2021. 2022 dates to be decided. Facilitated by Advanced Nurse Practitioner In Dementia Carlow/Kilkenny and CNM2. This will require approximately 14 days of training. Aim 6 days of training to be completed by December 2021 and the other 8 days training to be completed by April 30th 2022.
• Staffing reviewed and St Patrick's & St Michael's Ward's allocated 39hrs weekly HCA Activity support. St Anne's / St Bridget's Ward allocated 39hrs HCA Activity Support and St Mary's Ward 19.5hrs of Activity Support.
• Garden Party planned for 1st of September 2021.
• DON has received correspondence from Irish Therapy Dogs who hope to resume their visiting in September, DON awaiting confirmation.
• 2 HCAs attending training on the 7th of September named as: Activity Therapy Training for Alzheimer and Dementia Clients including The Enchanted Forest with Music Therapy with utilizing aromatherapy oils and aura soma room spray.
• Social Outings have recommenced on since the 11th August 2021.
• Promotion of meal times away from Resident's bedroom space has been discussed with each resident and plan now in place which is reflected Resident's Care plans. This will be measured via observation and auditing of Care Plans and discussion in Resident's forums.
• All individual televisions to be purchased and to be installed.
• Submission to Community Enterprise Scheme for additional support with Resident's Activities, new applications not available until the 29th of October 2021.
• DON will attend site visit Dungarvan Community Hospital on the 25/08/2021 and WRCC on the 9/09/2021 in liaising with DONs and their activity teams.

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 11(2)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	31/12/2021
Regulation 12(c)	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	Not Compliant	Yellow	31/12/2021

	particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.			
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	31/12/2021
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2021
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	31/12/2021
Regulation 26(1)(a)	The registered provider shall ensure that the risk management	Substantially Compliant	Yellow	31/12/2021

	policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.			
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	31/12/2021
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	31/12/2021
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/12/2021
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment,	Not Compliant	Orange	31/12/2021

	means of escape, building fabric and building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/12/2021
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/12/2021
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/12/2021
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Orange	31/12/2021
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	Not Compliant	Orange	31/12/2021

	and safe placement of residents.			
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 centre.	Substantially Compliant	Yellow	25/08/2021
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	31/12/2021
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	31/12/2021
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	31/10/2021
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise	Substantially Compliant	Yellow	31/10/2021

	choice in so far as such exercise does not interfere with the rights of other residents.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	31/12/2021
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident radio, television, newspapers and other media.	Substantially Compliant	Yellow	31/12/2021
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	31/10/2021