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:	Carndonagh Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Convent Road, Carndonagh, Donegal
Type of inspection:	Unannounced
Date of inspection:	20 October 2022
Centre ID:	OSV-0000616
Fieldwork ID:	MON-0035206

About the designated centre

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

Carndonagh Community Hospital is a designated centre registered to provide health and social care to 46 male and female residents primarily over the age of 65 who live in the Inishowen area.
It is a single-storey building, located a short drive from the shops and business premises in the town. There are three units Oak and Elm providing general and respite care and Ard Aoibhinn a dementia specific unit. The Oak and Elm units are part of the original building that dates from 1956. Accommodation for residents is provided in single, twin and four bedded multi-occupancy bedrooms. Ard Aoibhinn is a more recent addition that was opened in 2007 and where care is provided for people with dementia, in single and twin bedrooms. There are several communal seating and dining areas where residents can spend time during the day around a central courtyard. A day care service that is separate from the residential area is provided on-site.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	26

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 20 October 2022	10:35hrs to 18:25hrs	Nikhil Sureshkumar	Lead
Thursday 20 October 2022	10:35hrs to 18:25hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

Overall, the residents enjoyed a good quality of life in the designated centre. The residents' choices were respected in the centre, and resident-focused care was delivered in this designated centre.

Inspectors spoke to several residents during the inspection, and many commented that they were happy in their homes, happy with the staff and with the service that they received. In addition, most residents said that they liked their homes and are looking forward to going to the newly refurbished rooms. Some residents told the inspector that they got the opportunity to select their rooms and that they felt safe in the centre.

The designated centre is located in Carndonagh town and is close to local amenities accessible to residents. The centre has three units, namely Elm Ward, Oak Ward, and Ard Aoibhinn, which is a dementia-specific unit. All the units are located on the ground floor of the building.
Following a short introductory meeting, the inspectors went for a walk around the centre with the person in charge. The entrance of the centre led to the reception area of the centre, and there were seating arrangements for residents to sit and relax in the centre. The centre has a spacious communal room and a dining area adjacent to the reception. This dining and communal area is shared between oak and elm units. The inspectors found residents moving around the communal areas and accessing the internal garden adjacent to the communal room independently.

The communal areas and corridors of the Ard Aoibhinn units were clutter-free and spacious, and residents were found moving around the communal areas independently. There were two kitchenettes available for the residents' use in the unit, and a range of equipment such as a dishwasher, toaster, ovens and tea kettle were available in each kitchenette to support the needs of the residents. However, the kitchenettes were of open plan type, and there were no fire doors installed to separate the kitchenette from the rest of the unit to ensure the fire safety of the residents.

The inspectors went to the oak ward to review the recently completed reconfiguration works of the Oak unit, which is the proposed long-stay unit of the designated centre. The corridors in the Oak unit were bright and spacious, and dedicated areas were available for the storage of equipment. The walls of the corridors were decorated with photo frames, and adequate signages were available for the residents and visitors to navigate around the centre.

The oak unit has 17 beds with a mix of single and multi-occupancy bedrooms. There were an adequate number of toilets and shower facilities available to the residents in the Oak unit. There were a sufficient number of hand wash basins available in each toilet and bedroom. Suitable adaptations were made to communal toilets to support the needs of residents, and call bells were available in toilets. However,

there were insufficient call bells available in some communal toilets, especially near the toilet and shower areas, to support residents if they needed to call for staff assistance.

Appropriate sluice facilities were available in the unit, and the provider was in the process of installing a racking system to store cleaned commode basins and bedpans. A dedicated clinical hand wash basin was available to carry out hand hygiene, and hand sanitisers were provided in various locations. However, there were insufficient hand sanitisers available near the sluice room.
The inspectors reviewed the bedrooms in the designated centre, and the residents' bedrooms in the designated centre were personalised, and residents have access to a wardrobe and a bedside cabinet. Residents have access to their personal clothes and other belongings, and many residents told the inspectors that they loved their bedrooms.

The bedrooms in oak and Elm units were provided with ceiling hoists to support residents with higher dependencies. Privacy curtains were made available in all bedrooms in the designated centre, however, the inspectors noted that the privacy curtains around the bed space of a four bedded room in the newly refurbished unit did not fully extend to ensure resident's privacy, and the bed space was close to a wash hand basin that was accessible to other residents. Furthermore, several residents in twin-bedded rooms in Ard Aoibhinn unit did not have access to a window. As a result, they did not have access to natural sunlight or see out through the window of the rooms when other residents decided to use their privacy curtains.

Furthermore, the premises in the Ard Aoibhinn unit and chapel area required repainting. The floor linings and door frames of bedrooms and some communal rooms in Ard Aiobhinn unit were visibly damaged and needed to be redecorated.

An activity schedule was available to the residents in the designated centre, and staff were knowledgeable about the residents' needs. The residents in the designated centre were found to be engaged in a range of social care activities. Several residents who spoke with the inspectors said that they enjoyed the activities in the centre. Some residents were found to be engaged in playing puzzles in the dementia-specific units, and the staff were found to be encouraging residents with verbal clues to complete the puzzle, and the staff were found to be supportive of the residents' needs. The residents have full access to the indoor garden area of the centre. Some residents told the inspectors that they enjoyed gardening and that they felt like being at home and safe in the centre.

Inspectors reviewed the care practices in the centre and found that the staff assisted with the needs of the residents. Call bells were attended to in a timely manner, and the residents said that the staff attended to their needs in a kind and respectful manner. Some residents informed the inspectors that they enjoyed the staff interactions in the centre.

The centre has a chapel area adjacent to the Elm unit, and the residents and staff told the inspectors that the residents could access the chapel area, and mass was held at regular intervals in the chapel. However, the inspectors noted several fire

safety risks in the chapel area and adequate precautions were not taken to ensure residents' safety. For example, wax candles and fire lighters were used in the chapel, and combustible items were stored near a gas boiler, which is located in a room near the chapel. These fire safety risks were not appropriately managed in the centre. In addition, a safety gas valve located outside the chapel area was found to be cable tied. This arrangement did not allow to shut off the gas supply during a fire emergency. Furthermore, the chapel area was not visibly clean and was not included in the centre's cleaning schedule.

The inspectors noted that the residents were provided with meals that were wholesome and nutritious. The meals were not hurried, and mealtimes were a relaxed social occasion for the residents. Menu choices were available for residents, and the residents told the inspector that they enjoyed the food served in the centre.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Overall the care provided to the residents was of good quality, and the clinical oversight of the centre had significantly improved since the last inspection. The provider had made arrangements to renovate the Oak unit, however, the oversight required for maintaining the physical environment of the centre required significant improvements to ensure that the residents are safe in the designated centre.

The Health Service Executive (HSE) is the registered provider for the designated centre. As a national provider providing residential services for older people, the designated centre benefits from access to and support from centralised departments such as human resources, accounts and information technology. On the inspection day, the service manager was available and supported the person in charge with the inspection.

The person in charge was supported by clinical nurse managers and a team of staff in the centre. Management meetings and staff meetings were held regularly in the centre, and there were clear communication channels in the centre to ensure effective clinical governance in the centre.

Even though regular audits, such as environmental audits, were carried out in the centre, they failed to identify the issues the inspectors identified on this inspection. Furthermore, even though the centre has a risk management system, it failed to identify and manage the fire safety risks in the centre. The provider was issued with an urgent action to manage the fire safety risks in the centre. Details of fire safety deficiencies are outlined under regulation 28: fire precautions.

The centre has a safeguarding policy, and safeguarding incidents were appropriately

investigated and managed in the centre. There were safeguarding plans in place for residents who required them. However, the inspectors found that a safeguarding concern occurred in the centre was not notified to the Chief Inspector. This notification was submitted following the inspection.

Regulation 15: Staffing

The provider had kept the staffing resources of the centre under review, and the rosters reviewed on the day of inspection evidenced that there was a sufficient number of nurses on duty at all times in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Arrangements were in place to ensure staff were facilitated to attend mandatory and professional development training appropriate to their roles.

Judgment: Compliant

Regulation 21: Records

The inspectors reviewed a sample of records and noted that the records required under Schedules 2 and 3 of the regulation were available for the inspectors to review.

Judgment: Compliant

Regulation 23: Governance and management

Even though there were management systems in place, the quality assurance systems failed to ensure that the service provided in the centre was safe and effective. For example:

- The provider had failed to identify and manage several fire safety risks in the centre. For instance, even though regular fire checks and environmental audits were carried out in the centre, they failed to address the fire safety risks in the centre.

- In addition, the oversight of the physical environment was not robust, and the provider's arrangements did not ensure that the areas of the centre's premises that the residents have access to were safely maintained. For instance:
    - A plant room, which contained several combustible items, was accessible to residents and posed an injury risk to residents.
    - There were visible cracks on the walls and ceiling of the chapel area, and staff confirmed with the inspectors that the building is subsiding. The provider had not made any arrangements to ensure the safety of the residents while the residents continued to access this unsafe part of the building.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider had not notified the Chief Inspector in writing about a safeguarding incident that occurred in the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A centre-specific complaints policy was in place and available to staff. The complaints policy identified the nominated complaints officer and included an appeals process. A summary of the complaints procedure was displayed at appropriate locations. Procedures were in place to ensure that all complaints were logged and investigated and that the outcome of the investigation was communicated to complainants.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the staff provided a good standard of care for the residents. However, significant focus is now required to ensure that the physical environment of the centre is maintained to a high standard to ensure that it supports a safe and effective delivery of service to the residents.

The provider's arrangements were ineffective in reviewing the fire precautions in the

centre. As a result, the inspectors found several fire safety risks in this inspection. This is further discussed under regulation 28.

The provider had made significant efforts to carry out the renovation works of the Oak unit. However, further improvements were required to maintain the premises of the centre, and this is further discussed under Regulation 17.

The provider's arrangement to ensure effective infection prevention and control processes in the centre required some improvement. The chapel area that was used by the residents in the centre was not effectively maintained, and this posed a cross-contamination risk to the residents.

The inspectors reviewed a sample of medication administration records and noted that all medicinal products were administered in accordance with the directions of the prescriber of the resident concerned. The medicinal products and the records of medication-related interventions were found to be stored securely at the centre. However, out-of-date medicines and medicines that are no longer required for some residents were not disposed of in accordance with the regulatory requirement.

Regulation 12: Personal possessions

Residents were supported to maintain control of their clothing and personal belongings. Residents had adequate storage space in their bedrooms, including a lockable space for their valuables if they wished.

Judgment: Compliant

Regulation 17: Premises

The layout of the bed space of several bedrooms did not support the needs of the residents in line with the centre's statement of purpose. For example:

- The layout of several twin rooms in Ard Aoibhinn unit meant that when the resident in the bed space near the window pulled their privacy curtain, other resident in the bedroom could not see out of the window and access natural light.
- The layout of one four-bedded room in the Oak ward meant that the position of the hand wash basin in the room was close to a resident's bed, and insufficient privacy curtains were installed around the bed space. This arrangement did not ensure the privacy of the resident in this bed space when other residents or staff were using the hand wash facility.

The premises of the centre did not conform to the matters set out in Schedule 6 of

the regulation. For example:

- The premises of Ard Aoibhinn unit were not timely repaired and redecorated. For example, the floor linings and door frames of bedrooms and some communal rooms in Ard Aoibhinn unit were visibly damaged, and some areas in the unit required repainting.
- There were insufficient call bells installed in some bathrooms of the newly refurbished Oak unit.
- There was no shelving system available in the housekeeping room to store personal care and hand hygiene products effectively in the newly refurbished Oak unit.
- A damaged lid of a sewer hole in an external walkway leading to the fire assembly point was found to be damaged, and this posed a trip hazard for residents accessing this area, and this was not timely repaired.

Judgment: Not compliant

Regulation 26: Risk management

A centre-specific risk management policy and procedures were in place, which included hazard identification and assessment of risks throughout the designated centre and measures in place to control the risks identified.

Judgment: Compliant

Regulation 27: Infection control

The centre's infection prevention and control processes required improvement to ensure compliance with the national standards for infection prevention and control in community health services and other national guidance. For example:

- The chapel and the nearby toilet facility the residents have access to were poorly maintained and visibly not clean. As a result, the providers' arrangements posed a cross-infection risk to residents and staff accessing the area.
- There were insufficient hand sanitisers near the sluice room in the newly refurbished Oak unit to support effective hand hygiene.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The centre's day-to-day arrangements in place to review the fire safety risks and fire precautions against the risk of fire were not effective. For example:

- The inspectors observed storage of electrical equipment and flammable items stored in a switch room (used to manage electrical systems in the centre). This presented a potential fire risk- - if a fire did develop, it would be accelerated by the presence of these items.
- A plant room located in a courtyard that is used by residents had inappropriate storage of flammable items such as cardboard boxes, cushions, plastic containers, some of which were stored in front of fire extinguishers. In addition the doors to the plant room were not locked, as a result residents could potentially gain access to this area.
- A gas safety valve located outside of the building was permanently fixed using cable ties, and this arrangement prevented closing the emergency gas valve in the event of a fire emergency.
- Combustible and flammable materials were inappropriately stored in a room with a gas boiler.

The provider needs to improve the means of escape for residents and emergency lighting in the event of an emergency in the centre. There was a lack of emergency exit signage in some areas to indicate the route to access a fire exit. For example, a emergency exit sign was not required above a door in the Ard Aoibhinn Dementia Unit. In the church, an emergency exit sign was missing above a fire exit and a fire exit door magnetic lock was not connected to the fire alarm system. In the event of an emergency, this lack of signage could cause confusion and could delay an evacuation.

Externally, emergency lighting and directional signage were missing along some fire exit routes to illuminate the route of escape in the event of a fire evacuation at night-time, and this required a review by the provider. For example, emergency lighting outside a final fire exit door was not functioning on the day of the inspection and did not support the emergency evacuation of residents. Directional signage was unavailable outside a final fire exit door in order for residents and staff to be aware of the location of the fire assembly points.

The provider needs to improve the maintenance of the means of escape and the building fabric. For example, some fire exits were not readily openable and required a key to unlock them. Fire exits should be readily openable with simple fasteners such as thumb turns. The procedure of using key locks on fire exits required a reviewed by the provider. In addition to this, a gate located in an external enclosed garden area was found to be fitted with a padlock, and required a key to unlock it. This presented a risk to staff and residents as the gate was not readily openable in the event of a evacuation.

On the day of the inspection, a protected corridors in the church was cluttered with a hoist and a bed. The person in charge gave assurance that this was in the process of being removed.

Some areas in the centre were noted to have utility pipes or electrical cabling that penetrated through the fire-rated walls and ceilings (walls and ceilings built in a way to provide a certain amount of fire resistance time), and these required appropriate fire sealing measures.

Arrangements for reviewing fire precautions required improvement by the provider. For example, while weekly checks of fire doors were taking place, due to the observed deficiencies to fire doors in the centre, improvements were required to ensure the checks of the fire doors were of adequate extent, frequency and detail. Due to the potential fire risks to residents identified by the inspectors, the provider was requested to have a comprehensive fire safety risk assessment carried out by a competent fire safety consultant.

While fire evacuation drills were taking place, further fire drill practice is required, and fire drill records required improvement in order to further support staff to protect residents from the risk of fire. For example, a fire drill for the largest compartment, which accommodates eight residents in Ard Aoibhinn Dementia Unit was not available to the inspectors. Furthermore, the inspectors were informed that the largest compartment only accommodated six residents, this was not the case. This could potentially create a risk to residents in the event of an emergency and a potential delay in evacuating residents in such circumstances. A full evacuation drill of the largest compartment, based on night time staffing resources was requested by the inspectors at the end of the inspection.

In addition, fire drill records reviewed on the day of the inspection required further detail. For example, it was not clear which staff took part and which staff observed a drill. Furthermore, it was unclear where the residents' had been evacuated to.

Arrangements for containment of fire in the event of a fire emergency in the centre required improvement by the provider. For example, the inspectors were not assured of the ability of a selection of fire doors to prevent the spread of smoke and fire. The provider needs to have a full assessment of fire doors in the centre carried out by a competent fire safety expert. A number of fire doors observed by the inspector had door-closer mechanisms and fire door seals missing. Gaps were noted at the bottom and between doors. Furthermore, a number of fire doors did not meet the criteria of a fire door and did not close fully when released. These deficiencies posed a significant risk to residents in the event of a fire.

In the Ard Aoibhinn Dementia Unit, two separate kitchen/dining room areas open onto a protected corridor used as a means of escape in the event of a fire emergency. As a result, the protected corridor could potentially become compromised if a fire developed in these areas. Furthermore, the inspectors were not assured by the fire-rating of a roller metal shutter and hatch door to the main kitchen/staff dining area. The provider is required to review the containment measures in these areas with their competent fire consultant.

The procedures to be followed in the event of fire were not adequately displayed. For example, floor plans were not displayed beside a main fire detection panel in the centre. Floor plans that were displayed in other areas did not indicate the extent of

the compartment and sub-compartment boundaries suitable for horizontal phased evacuation. This could form part of the procedure to be followed by staff in the event of a fire.

Furthermore, the inspectors noted the floor plans had discrepancies and required updating. For example, a room used for storage purposes in the church area is indicated on the floor plans as an assisted shower room. A residents bedroom was indicated on the floor plan to be a twin occupancy room when it was actually a single occupancy room.

The recently completed reconfiguration works of the Oak unit was inspected on the day. Some deficiencies in relation to fire safety were identified by the inspectors and required a review by the provider. For example, some fire doors did not close fully when released and non-fire rated brass screws had been fitted to door hinges. Some fire door identification tags indicated that fire doors were FD30, when FD60s fire doors are required in this area. The inspectors noted a fire drill had yet to be completed in this area in order to test fire evacuation procedures and to familiarise staff with this new area of the centre.

The inspectors noted a lack of fire action notices to inform staff and visitors of the procedure to follow when a fire alarm is activated. Some fire action notices were also missing information. In addition, a smoking shed located in this area did not contain a fire extinguisher. However the inspectors were informed that the shed was in the process of being removed.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The providers arrangements were insufficient to ensure that the medicinal products which are out of date or has been dispensed to a resident but is no longer required by that resident is disposed of in accordance with the national legislation.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of care plans and noted that they were personalised and updated regularly and contained detailed information specific to the individual needs of the residents. Comprehensive assessments were completed that informed the care plans. Residents and their family members were involved in the care planning of residents where appropriate.

Judgment: Compliant

Regulation 6: Health care

Residents' nursing care and health care needs were met to a good standard. Residents were supported to safely attend outpatient and other appointments in line with public health guidance. Residents had timely access to general practitioners (GPs) from local practices, allied health professionals and specialist medical and nursing services.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff spoken with inspector had up-to-date knowledge appropriate to their roles to positively react to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). Records showed that where restraints were used, these were implemented following risk assessments, and alternatives were trialled prior to use.

Judgment: Compliant

Regulation 8: Protection

Measures in place included facilitating all staff to attend safeguarding training. Staff were knowledgeable regarding safeguarding residents and were aware of their responsibility to report any allegations, disclosures or suspicions of abuse. Staff were familiar with the reporting structures in place.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' meetings were held regularly and were involved in the organisation of the centre. The provider's arrangements to ensure residents have access to meaningful activities in the centre were satisfactory.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Carndonagh Community Hospital OSV-0000616

Inspection ID: MON-0035206

Date of inspection: 20/10/2022

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: A risk assessment was subsequently carried out in the centre by the HSE Fire Officer and Estates team on 03/01/2023. This is further outlined under Regulation 28. Master Fire has been contracted to carry out 6 monthly inspections in the centre . Garden furniture has been removed from outside the outside plant room and the door locked- 20/11/2022. Immediately following the Inspection, access to the chapel area was restricted to residents and staff until a further assessment is completed. This will be completed by the 30/01/2023, with action plan to follow. Residents have access to several quiet areas for reflection and Masses are celebrated in the sitting rooms. Training in the completion of the Fire Register has been scheduled for the Clinical Management Team and the newly appointed General Operative on the 30/01/2023. The local Infection control team with assist and provide guidance to the Clinical Management Team with an environmental audit. This will be completed by the 30/01/2023.	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All incidents were reviewed by the Inspectors and while fully investigated and closed by	

the relevant teams, one was not notified to the Chef Inspector. This was submitted following the Inspection and subsequently closed by the Inspector- 20/11/2022 A. ll future incidents will be notified to the Chief Inspector within the timeframes.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The issue raised regarding access to light in several twin rooms in Ard Aoibhinn is noted. The service confirms that in line with Schedule 6, Premises, Part 1, 3 (n) of the Health Act 2007, all residents have access to suitable light. If for any reason there is a need to have privacy screens closed for long periods, all efforts will be made to ensure that lighting within the room is maximised for all occupants.

The layout of the wash hand basin/curtain in one four-bedded room in the Oak ward was due to an an error by the hoist installer and the routing of the privacy curtain has since been corrected 30/11/2022

The number of call bells were increased in the the bathrooms identified following the inspection 30/10/2022

Personal care and hand hygiene products were not planned for storage in the housekeeping room. They are stored in a store room in the Elm Ward 20/11/2022

The identified damaged lid of a sewer hole and footpath will be addressed in the Chapel area works 30/01/2023

Costings for upgrade works of the Dementia Specific Unit with Infection control and Estates team has been submitted for funding to senior management. This will include the full redecoration of the unit- Completion 30/01/2024

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.

Regulation 27: Infection control	Substantially Compliant

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

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The storage of electrical equipment and flammable items were removed from the switch room – 20/10/22.
The plant room located in the courtyard which was found to have in appropriate storage of flammable items were removed on the day of inspection, in addition this door is consistently locked.
The gas safety valve located outside of the building was permanently fixed using cable ties. 20/10/22

The cable ties were removed from the gas valve at the time of inspection- 20/10/2022
Combustible and flammable materials that were stored inappropriately in a room with a gas boiler were removed on the day of inspection – 20/10/22.

In the Chapel area there was a lack of emergency signage identified and a magnetic lock was missing from a fire exit door, this risk has been eliminated due to the closure of the Chapel to residents and staff and pending a further assessment due to be completed on 30/01/23 by the Fire Officer.

All Fire exits have been reviewed for key locks. This was an integral part of the initial design of the Dementia Specific. Master Fire is currently reviewing the doors for potential Key pad access- Completion 30/01/2023.

The gate of the external garden has been completed with a keypad opener which is linked to the Fire panel. In the event of a fire this gate will automatically open to allow a safe evacuation 30/11/2022

The equipment in the chapel area was for return to the company and was collected on the 21.10.2022.

The utility pipes/cabling that penetrated fire rated walls and ceilings has been closed with fire sealant- 30/11/2022

Training in the completion of the Fire Register has been scheduled for the Clinical Management Team and the newly appointed General Operative on the 30/01/2023.
The local Infection control team with assist and provide guidance to the Clinical Management Team with an environmental audit. This will be completed by the 30/01/2023.

A comprehensive Fire risk assessment has been completed and the report issued along with this compliance plan.04/01/23. Please see attached additional report from the service clearly indicating progress made in relation to fire risks identified by the

Independent Fire Risk Assessor.

Fire Drills have been increased to fortnightly and includes further details of the evacuation and staff involved including evacuation of the largest compartment based on night time staffing levels - 30/12/2022.

Fire doors have been assessed, fire door seals have been replaced and door closer mechanisms are to be completed by 20/01/23.

All kitchen appliances were removed from the Kitchen/Dining rooms areas in the Dementia Specific Unit, thus removing the risk identified in the report- 20/11/2022.

In the main kitchen, works have commenced to close the hatch and allow further fireworks to be completed, thus closing the risk identified- Completion 30/01/2023.

Floor plans and Fire Notices have been reviewed, completed and displayed in the appropriate areas and beside the main fire detection panel - 30/11/2022

The floor plan has been reviewed and updated by HSE Estates and submitted along with this compliance plan 04/01/23

The wax candles and matches, that had been used for recent a recent Mass, have been removed in the chapel following the inspection. Battery candles are available for use in End of Life situations- 20/11/2022

Immediately following the Inspection, access to the Chapel area was restricted to residents and staff until a further assessment is completed. This will be completed by the 30/01/2023, with an action plan to follow. Residents have access to several quiet areas for reflection and Masses are celebrated in the sitting rooms. The Chapel area poses no risk at present as access has been restricted. - 20/10/22

Night time staffing will be further reviewed on the reopening of all beds within the Centre.

A comprehensive Fire risk assessment report has been completed and included with this compliance plan - 03/01/2023

Issues identified in the recently refurbished Oak Ward have been addressed in full – fire doors close fully when released, fire rated brass screws have been fitted to door hinges. A fire drill has been completed in this area to test fire evacuation procedures and to familiarize staff with this new area. – 30/11/22.

Fire notices have been reviewed, completed and placed in appropriate areas – 30/11/22.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately

assure the chief inspector that the actions will result in compliance with the regulations.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: A weekly check of medicinal stock and resident's medication is completed by the nursing staff. This check will now also include a weekly sign off by the Clinical Management Team.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/06/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/01/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	30/01/2024

	associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	27/10/2022
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/01/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	27/10/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	27/10/2022
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons	Not Compliant	Orange	30/01/2023

	working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	27/10/2022
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.	Not Compliant	Orange	30/10/2022
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or	Substantially Compliant	Yellow	30/10/2022

	risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	20/10/2022