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:	Announced
Date of inspection:	04 October 2023
Centre ID:	OSV-0000552
Fieldwork ID:	MON-0041191

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 45 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 9 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 1 to 4 bedded rooms. There is a limited number of single rooms which are generally used for end of life care. Screening in 2-4 bedded rooms is provided by means of partitions and curtains. 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:	45

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
Wednesday 4 October 2023	09:30hrs to 18:10hrs	Bairbre Moynihan	Lead
Wednesday 4 October 2023	09:30hrs to 18:10hrs	Aisling Coffey	Support

What residents told us and what inspectors observed

On the day of inspection, staff were observed being kind, caring and attentive to residents' needs. Overall, residents stated they felt happy and safe in the centre. Residents spoke positively about the "nice" staff and about the care and attention they received. The majority of residents were complimentary about the food with one resident describing the food as "gorgeous". Residents who could not communicate with inspectors appeared comfortable in their surroundings.

The inspectors arrived in the morning to conduct an announced inspection to monitor ongoing regulatory compliance with the regulations and standards. The inspectors were greeted by the person in charge and assistant director of nursing. Following an introductory meeting, inspectors were guided on a tour of the premises. During the inspection, the inspectors spoke with several residents to gain an insight into their lives in St Columba's Hospital. The inspectors also spent time observing care practices and reviewing documentation.

As part of the announced inspection, a questionnaire for residents was sent to the registered provider for residents to complete. Nine responses were submitted to HIQA. Of the nine responses; four were completed by relatives or friends of a resident, three were completed by residents and two were completed by staff on behalf of residents. The general feedback from residents was that they were happy in the centre, were complimentary about the staff and the food. Residents particularly mentioned how they enjoyed the day trips. One staff member documented on behalf of the resident how they would like to go out in the garden more. This was also a finding on the last inspection.

St Columba's Hospital was originally built in the mid-1800s. While the centre has been upgraded and renovated over time, it resembles a hospital with residents receiving care in multi-occupancy bedrooms and bay areas. The centre is registered to accommodate 45 residents and consists of four units over two floors. Since the last inspection the names in the units had changed to provide a more homely environment and to ensure they were not referred to as wards. The four units were called St Michael's Glen and St Patrick's Villa on the ground floor which operated as one unit, Mount Brandon View on the first floor and St Mary's Garden, a dementia specific unit on the ground floor that accommodates up to ten residents. While there were three en-suite bathrooms in the centre, the majority of residents access shared toilets and showering facilities located at the end of the ward areas. Communal areas included an open plan dining and sitting areas in each unit. Other than at lunch-time these areas were largely vacant with residents at their bedside or in the bed. Residents in St Patrick's Villas, St Michael's Glen and St Mary's Garden had access to an enclosed garden. The gardens in St Patrick's Villas and St Michael's Glen had minimal garden furniture available for residents and were not inviting. An inspector was informed that residents were accompanied in the grounds by activities staff for walks. A resident confirmed this with an inspector. Access doors to all three enclosed gardens were unlocked and residents could freely move from their unit into

the enclosed garden.

Efforts had been made to make the environment homely, comfortable and pleasant for the residents. Inspectors noted that areas surrounding residents' beds had been personalised with photographs, pictures, teddies, dolls and other items of personal significance. Some residents were unable to carry out personal activities in private. Privacy screening consisted of curtains and therefore conversations, noise and smells could not be excluded.

The centre had 2.5 whole-time equivalents (WTE) of activities coordinators in place covering seven days of the week with all three activities coordinators on duty on the day of inspection. Inspectors observed one-to-one activity taking place with one resident and a quiz was broadcast from the chapel. A small number of residents went on a day trip from St Mary's Garden. In addition, a resident informed an inspector about a day trip that had taken place to Tramore two weeks previously. Residents had access to the day centre which was on the grounds of St Columba's and a small number of residents accessed this facility which assisted residents in maintaining links with friends and acquaintances from the community. Mass was held onsite once weekly and residents from the local community had the option of attending. This was broadcast to all areas within the centre so residents who could not attend in person could view it. Residents were observed reading newspapers, which were provided daily. Internet services were not available for residents. This and other improvements required are detailed under the regulation.

The registered provider had introduced protected mealtimes at lunch and tea time. This ensured that during mealtimes that all non-urgent activities cease to ensure that staff are available to provide assistance to residents. The lunchtime experience was observed in all three areas. Lunch-time was a relaxed and unhurried experience. Eight of the 16 residents in Mount Brandon sat in the two sitting rooms for lunch, five were in bed, and three ate at their bedsides. Residents were observed to be enjoying their lunch. Those residents who required support received this in a respectful and dignified manner. Two residents were receiving help from a visitor. There was friendly interaction between residents and the staff supporting them. The menu was on display in the dining areas. Catering staff had a "dietery needs and preferences" sheet for each resident which detailed the residents' level of diet and fluids required and their likes and dislikes. Residents were provided with a choice and inspectors confirmed this with residents and catering staff. Those residents prescribed a modified diet were provided with the same choice.

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

Capacity and capability

This was an announced inspection carried out to monitor ongoing compliance with the regulations and standards. Inspectors followed up on the compliance plan submitted following the inspection in September 2022. The registered provider had progressed the compliance plan and improvements were identified in Regulation 18 where residents on modified diets were now provided with a choice. Improvements were also identified in the fire drills completed in the centre. However, improvements were required in Regulations 16; Training and staff development, 21: Records, 23: Governance and management and 34: Complaints.

The Health Service Executive (HSE) is the registered provider for St Columba's Hospital. The person in charge worked full-time in the centre and reported to the manager for older person services. The manager for older person services attended onsite for the feedback meeting at the end of the inspection. The person in charge was supported in the role by an assistant director of nursing who was supernumerary, clinical nurse managers on each unit, staff nurses, health care assistants, activities coordinators, catering, household and portering staff. A second assistant director of nursing was on secondment at the time of inspection and had not been replaced.

Inspectors were provided with a training matrix. Staff had access to mandatory training including fire training and safeguarding. Good compliance levels were identified in these areas. The registered provider was providing training to staff in managing behaviours that challenge. While there were significant improvements in this training since the inspection of October 2022, gaps were identified. Training in managing behaviours that challenge was ongoing at the time of inspection.

Staff personnel records were maintained on an electronic records management system. While the professional nursing registration and Garda Síochána (police) vetting were available onsite and in paper format for the inspectors to review, other staff records were not easily accessible from the electronic records management system. Inspectors were unable to locate and identify certain staff records in a timely manner and this will be discussed under Regulation 21: Records.

The annual review of quality and safety of care was completed for 2022 which was aligned to the National Standards for Residential Care Settings for Older People in Ireland. Each standard included a time bound action plan. Areas for action included the changing of ward names to reflect a more homely atmosphere and this was completed. It was identified in the annual review that the lack of hand hygiene sinks compliant with the required specifications was escalated to the appropriate people, however this remained outstanding at the time of inspection. Systems of communication were in place between the senior management in the centre and the older persons' manager from HSE Community Healthcare Organisation (CHO) Area 5. The person in charge also attended meetings within the CHO area including a directors' of nursing meetings and quality and safety executive committee meeting. Two quality and safety meetings had taken place in 2023. Incidents, audits and staff training were discussed. Clinical nurse managers meetings were held approximately two monthly and areas discussed included complaints, fire training and a new falls policy that was being rolled out. Inspectors were informed that a safety pause took place daily in the unit areas. Details of the safety pause were outlined in the nurses'

station in St Patrick's Villas. The registered provider had an up-to-date risk register in place. Risks included the lack of dietetic service in the centre and the ongoing issue with the call bells. Incidents were trended for the six months between January and June 2023. Increased reporting of incidents in medication was identified and an action plan developed. While this was good practice it required further strengthening to derive learning from the trended incidents.

The registered provider had an audit schedule in place. For example; for the month of October the registered provider planned to conduct falls and call bell audits. Audits completed in 2023 included a medication management audit and an environmental audit. Audits were identifying issues and included a time bound action plan.

The centre's complaints procedure was contained within the residents' guide, available to residents and visitors at the centre's reception. The person in charge informed inspectors that verbal engagement takes place with all new residents and relatives regarding the centres' complaints procedure upon admission. The centre had a nominated complaints officer and a review officer. Photographs and contact information for the complaints officer were displayed on multiple notice boards throughout the centre. The complaints officer informed inspectors of the training completed for the role. There were written records outlining how complaints were managed in the centre, both by the complaints officer and staff at the ward level. The staff spoken to knew how to identify and respond to a complaint.

Regulation 15: Staffing

The centre had sufficient staffing on the day of inspection taking into account the assessed needs of the residents and the size and layout of the centre. Inspectors were informed that there was a 0.5 WTE staff nurse vacancy and 2.4 WTE HCA vacancy from the actual headcount and statement of purpose. The registered provider stated that these are always backfilled with agency staff.

Judgment: Compliant

Regulation 16: Training and staff development

Gaps in training and staff development were identified:

- 22 staff had not completed training in violence and aggression.
- 37 staff were outstanding in basic life support.
- 38 staff had not completed training in positive behaviour support.

Judgment: Substantially compliant

Regulation 21: Records

The inspectors requested documentation from four staff records. Inspectors were informed that personnel records were recently scanned and uploaded to an electronic records management system. Of the sample viewed by an inspector, the scanned records were not indexed. Therefore, it was difficult to identify and retrieve Schedule 2 documents, such as photographic identification, references and curriculum vitae (CV). Some scanned documents were over 450 pages, and there was no way of promptly retrieving the required documents to assess compliance with this regulation. The information was provided in paper format at the end of the inspection, but due to the time the information was provided, inspectors were unable to assess the regulation.

Judgment: Substantially compliant

Regulation 23: Governance and management

While the registered provider had a number of assurance systems in place to be assured of the quality and safety of the service provided, areas for action were identified. For example;

- Trending of incidents was taking place but these required further analysis to elicit learning and share the learning with staff. For example; the registered provider had identified an increase in the number of medication incidents but the trending of these were not included in the report provided to inspectors.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

An action was required to ensure compliance with the regulation:

- The complaints procedure was not displayed in a prominent position in the centre as required by Regulation 34(1)(b).

Judgment: Substantially compliant

Quality and safety

Overall, residents expressed satisfaction with the care provided and the quality of life in St Columba's Hospital. Non-compliances were identified under Regulation 17: Premises. Areas for action were required under Regulations: 26: Risk management, 27: Infection Control, 28: Fire Precautions, 5: Individual assessment and care planning and 9: Residents' Rights.

At the time of inspection, the centre had a COVID-19 outbreak and residents were cohorted into two bays in St Patrick's Villas. Access to personal protective equipment and clinical waste bins were appropriately placed. Staff in St Patrick's Villas were wearing masks and personal protective equipment when staff had direct resident contact but all other residents and staff in the centre were continuing their lives in the centre as usual. Public health guidelines on visiting were being followed. Visits and outings were encouraged and practical precautions were in place to manage any associated risks.

Residents had a access to a high level of medical and nursing care. Health and social care providers were available as required with minimal waiting times. Inspectors were informed that the centre had a vacancy for a dietitan, however, staff could refer residents to the community dietitian if required. An advanced nurse practitioner for dementia was available two days a week onsite.

St Columba's Hospital was challenged with an old infrastructure and the design and layout of the building. Building of a new purpose-built centre had commenced on the grounds and was progressing at the time of inspection. Assurances were provided following inspection that documentation provided to the inspectors outlining the management of aspergillosis for the new building were reviewed by the infection prevention and control team, however, at the time of inspection a site visit of the build had not been completed. Until the new building was completed ongoing upkeep and maintenance was required of the centre. The registered provider was aware that a number of bells in the centre were not working and had explored alternatives, however, residents at a number of bedsides on the ground floor did not have access to a bell. Efforts had been made to de-clutter the centre since the last inspection and the storage areas were observed to be clean, tidy and organised. Grab rails were available in all circulating corridor areas and corridors were generally clutter free. The centre had support from an infection prevention and control nurse from CHO Area 5 who had completed an environmental walk around of the centre on the week of inspection. In addition, the registered provider had an identified infection prevention and control link practitioner and had four nursing staff who had completed training in vaccinations. Good compliances were observed in hand hygiene training and infection prevention and control. Notwithstanding the good practices, areas for improvement were identified under Regulations 17 and 27.

A risk management policy was submitted prior to the announced inspection. This was due for review at the time of inspection. The policy was not in line with the regulation and is discussed below. There was a policy in place for responding to

major incidents as outlined in Regulation 26(2).

Systems were in place for monitoring fire safety. The fire detection and alarm systems and emergency lighting had preventative maintenance completed at recommended intervals. However, issues identified on the servicing of the emergency lighting had not been actioned. A sample of fire doors were checked and were in working order. Each fire door was marked with the number of minutes that the door could contain a fire. A discrepancy was noted on one of the fire doors which is discussed later in the report. Fire drill records were detailed containing the number of residents evacuated, how long the evacuation took, the preparation during the drill for vertical evacuation and learning identified to inform future drills. There was a system for weekly checking of; means of escape, fire safety equipment and fire doors. Staff had good knowledge about fire evacuation and horizontal and vertical evacuation. Ski pads were available for residents. Since the previous inspection improvements were found in fire safety training for staff in the centre and there was evidence that fire training was discussed at clinical nurse manager meetings. The centre had ten fire wardens. Staff were knowledgeable on the compartments and the evacuation routes. On the day of the inspection there was a resident who smoked and a detailed smoking risk assessment was available for this resident. A fire blanket and fire retardant ash tray were in place in the centre's smoking area and the resident had a personal fire apron. However, no call bell was available in the smoking area. Additional improvements in fire safety were required, this is discussed further in the report under Regulation 28.

Inspectors' observed a sample of care plans. Overall the standard of care planning was good and described individualised and evidence based interventions to meet the assessed needs of the residents. Care plans were updated at four monthly intervals in line with regulations. Validated risk assessment tools were used for example; for assessing the risk of acquiring pressure ulcers and updated at regular intervals.

The registered provider had taken all reasonable measures to protect residents from abuse. The person in charge provided documentation outlining that all staff had completed online safeguarding training within the last three years. These online sessions were complemented by face-to-face sessions facilitated within the centre by the local Safeguarding and Protection Team. Staff had good knowledge and awareness of the abuse categories and how to respond to a concern appropriately. There was documentary evidence of how abuse allegations were investigated within the centre. There were two persons (designated officers) trained to complete such investigations, with further staff in the process of being trained. Inspectors were unable to access the details on residents' finances in a timely manner due to the over reliance on one member of staff to access the details. This is discussed in more detail under the regulation.

Residents were consulted about the running of the centre through residents' meetings. There were posters and leaflets for independent advocacy services on display throughout the centre. Residents had access to radio, television and newspapers. There was a chapel onsite where Roman Catholic services took place weekly. A Church of Ireland minister also visited the centre. There were chaplaincy services available to support residents of all denominations. Residents spoken to by

the inspectors expressed gratitude for opportunities to go outdoors with staff.

Regulation 17: Premises

Discrepancies were observed between the floor plans, statement of purpose and what was observed on inspection. For example; the ward pantry on Mount Brandon View was now a laundry room. No application to vary condition 1 of the registration was submitted to the Chief Inspector of Social Services for this change.

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example;

- Inspectors observed that a number of residents on St Patrick's Villas and St Michael's Glen did not have access to a call bell or their call bells were broken. Management stated that they were aware of and have escalated it. Staff informed the inspector that the issue was ongoing for a number of months.
- General wear and tear was noted throughout the centre including chipped paint on walls, doors and window sills.
- Due to the COVID-19 outbreak in the centre on the day of inspection the visitors' room in St Michael's Glen was temporarily used as an isolation room.
- A bedroom window facing a public corridor in St Michael's Glen was missing a blind and had a blanket covering this window.
- Storage in St Patrick's Villas required review as a resident's bay was being used for the storage of the foot rests of wheelchairs and a weighing scales.

Judgment: Not compliant

Regulation 26: Risk management

The risk management policy provided to inspectors was not in line with the regulation. For example; the policy did not contain the measures and actions in place to control to five specified risks.

Judgment: Substantially compliant

Regulation 27: Infection control

Inspectors observed that the centre was clean on the day of inspection, however, improvements were required in order to ensure procedures are consistent with the national standards for infection prevention control in community services. For

example;

- The centre had not been risk assessed by the appropriate HSE personnel to identify if controls were required for the management for aspergillosis as a result of the ongoing building onsite.
- An inspector was informed that sinks in resident bays were for a dual purpose; for hand hygiene and resident use. This posed a risk of cross contamination. This was identified in a environmental walkaround on the week of inspection with an action to identify the hand hygiene sinks but had not been completed.
- A sink in the ward pantry in St Mary's Garden was unclean and was detaching from the wall.
- The medication trolley in St Mary's Garden was rusted and chipped and was in a state of disrepair.
- Household stores in Mount Brandon View and St Patrick's Villas contained no janitorial sinks.
- The sluice room in Mount Brandon View contained no hand hygiene sink.
- The window sill in the visitor's room in Mount Brandon was in a state of disrepair. This does not aide effective cleaning.
- There was inappropriate placement of a clinical waste bin on a corridor in Mount Brandon.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While significant work was completed to protect residents against the risk of fire, actions were required as follows:

- The last four quarterly servicing reports for the emergency lighting were reviewed which identified a recurring action required. This had not been addressed and management were unaware of it. This was brought to the attention of the person in charge on the day and the inspector was informed that it was escalated to the relevant people in the HSE while inspectors were still onsite.
- Signage to guide staff and residents on the escape routes were on display but were not clear on the route to follow in the event of a fire.
- Ongoing actions were identified in a number of fire drills from the ground floor in relation to the availability of wheelchairs for residents in the event of a fire.
- The fire extinguishers were serviced in April 2023 and were certified as passed, however, the certificate stated that not all items were serviced as the competent person was unable to gain access to service them.
- A double fire door in St Mary's Garden was identified as a 60 minute fire door on one of the twin doors and a 30 minute fire door on another twin door. Clarification on this is required so staff are clear on the compartment

boundaries.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of care plans. Of the sample reviewed one was not prepared within 48 hours of a resident's admission to the centre as required in line with regulations.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to medical and healthcare based on their needs. A medical officer was in the centre for four hours a day, Monday to Friday. Residents who required specialist medical treatment or other healthcare services, for example; speech and language therapy and or physiotherapy, could access these services in the centre upon referral.

Judgment: Compliant

Regulation 8: Protection

Inspectors were unable to assess the processes in place for managing residents' finances as this was managed by a person on leave on the day of inspection and could not be easily accessed by any other member of staff. Inspectors were provided with resident account details at the end of the inspection day but could not assess this information as it was not provided in a timely manner.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Actions were required by the registered provider to ensure residents' rights were respected:

- The activities schedule provided to inspectors contained a number of passive

activities. For example, the morning activities from 10am-1pm six days per week were mass, a movie, a quiz or a concert broadcast on the television. While residents' spiritual needs were being respected, there was no evidence that residents had opportunities to participate in activities in accordance with their interests and capabilities.
- Residents' ability to undertake activities in private was adversely impacted by the premises, specifically multi-occupancy rooms and open-plan bay areas.
- Residents did not have access to internet services. This was a finding on the inspection in September 2022 and while inspectors were informed that internet services were requested and sanctioned they had not been installed within the year.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Columba's Hospital OSV-0000552

Inspection ID: MON-0041191

Date of inspection: 04/10/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Ongoing training in place as per training schedule for rest of 2023 & 2024 • Violence & Aggression training has increased from 78%of staff trained on day on inspection to 84% at time of writing. 4 more sessions booked Jan & Feb 24 thus aiming for 100% compliance by 01.04.2023 • Basic Life support training currently 67%. Approval given to have more BLS trainers on site. Aim for 100% compliance by 01.04.23 • Dementia training 56% on date of inspection currently 73% at time of writing. Liaison has taken place with ANP in dementia in provision of 2 day dementia training in 2024. Awaiting confirmation of training dates. Aim for 100% by 01.04.24	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • The scanned records will be supported by index of Schedule 2 documents, photographic identification, references and curriculum vitae (CV) for the purpose of Inspection	
Regulation 23: Governance and	Substantially Compliant

management	

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Meeting with QPSA advisor held 15.11.23.
• Aim to have 3 monthly formalized report of trending analysis going forward thus report to be received in January 24.
• All incidents will be discussed at QPS quarterly meetings and relevant committee meetings i.e. drugs & therapeutic, falls, restrictive practice etc. with findings communicated to identify ongoing learning and possible quality initiatives.
• All to be communicated at CMN, ward and hospital meetings. Aim for compliance 01.02.24

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Easy read your service your say policy now displayed. Action completed
• Local hospital complaint policy's detail now displayed on all wards. Action Completed.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Floor plans discrepancies will be addressed following audit. Visitor's room fully operational. Action completed.
• Meeting with Maintenance manager held on 14.11.23 with agreement to attend all environmental walkabouts with immediate effect. General wear and tear areas highlighted to Maintenance manager.
• Portable call bells had been ordered prior to inspection date. Escalated to Senior Maintenance Management now awaiting delivery. Aim for compliance by 01/01/24
• Blinds ordered prior to inspection escalated to Senior Maintenance Management and awaiting confirmation of delivery. Aim for compliance by 15.12.23.
• Review of storage areas.
• New build in process. Aim for completion and occupied by 01/04/25.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
• Meeting with Quality and Safety Risk Advisor held on 15/11/23 with aim of composing hospital specific risk management policy which adheres to Regulation 26 (1c) in particular to the risks of Abuse, unexplained absence of any resident, accidental injury to resident, staff or visitor, aggression and violence , self-harm aim for compliance by 30/01/24.
• Working group to be established to compose site specific policy.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Ongoing IPC & Waste Management training in place. All staff made aware of appropriate placements of clinical waste bins. Daily walkabout of units for monitoring of same.
• Environmental walk- about quarterly with all personnel to remain ongoing with appropriate action plans and follow up particular in relation to sinks in sluice rooms and Household storage areas. Dual sinks have the relevant signage instruction
• Repair of window sill escalated to senior maintenance management for repair. Aim for compliance by 15.12.23
• Purchase of medication trolley completed awaiting delivery. Aim to have on ward by 16/01/24.
• IPC have undertaken a site visit in relation to Aspergillios on 31/10/23 with follow up meeting on 14/11/23.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Meeting with Senior Maintenance Management on 14.11.23 with agreed communication pathway with outside contractors/ maintenance dept. updating Hospital management of reports of service requirements. Copies of service reports to be keep at hospital level as well as original in Estates dept.
• Servicing requirements for Emergency Lighting and Fire Extinguishers as per reports escalated to Senior Maintenance Manager for action. Contractors on site 28/11/23
• Meeting with HSE fire officer requested in relation to fire signage plans on the first floor

and fire doors in St Mary's Garden.
• Wheelchair requirement review undertaken 12/11/23. Wheel chair order submitted 21/11/23 and awaiting delivery.

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:
• In- house Documentation committee established 11/10/23 with aim on ongoing development of staff education in accordance documentation policy and regulation 5 Whilst ensuring care-plans reflects the individual resident's will and preference.
• Quality Metric and Audit system already in place to monitor compliance with documentation.
• All wards will nominate link nurses in this area.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Pathway to be developed for replacement of clerical staff who managed residents finances.
• Meeting with Administration Manger on 28/11/23 with agreed actions of
• Standard operating procedure to be developed by staff in charge of finance as reference guide.
• Training of other staff to undertake role in cases of absences to commence in 11th Dec 23

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Meeting with Senior Maintenance Manager 14/11/23 for escalation of the approved Wifi.
• Activities meeting held 23/11/23 in relation to expanding time table to include more activities in the morning schedule.

• New build in progress which will address the provisions of privacy for individual resident's activities.
• Meeting held with ANP Dementia on 23/11/23 re activities suitable for residents with Dementia. Will provide recommendations and education for activities 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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	01/04/2024
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	01/04/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	01/03/2024
Regulation 23(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	01/04/2024

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	01/03/2024
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Substantially Compliant	Yellow	30/01/2024
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	01/03/2024
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5	Substantially Compliant	Yellow	01/03/2024

	includes the measures and actions in place to control aggression and violence.			
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Substantially Compliant	Yellow	01/03/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	01/03/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	01/03/2024
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	01/03/2024

Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.	Substantially Compliant	Yellow	20/11/2023
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	01/12/2023
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	01/02/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	01/03/2024
Regulation 9(3)(b)	A registered provider shall, in	Substantially Compliant	Yellow	01/04/2024

	so far as is reasonably practical, ensure that a resident may undertake personal activities in private.			
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may communicate freely and in particular have access to radio, television, newspapers and other media.	Substantially Compliant	Yellow	01/03/2024