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:	New Ross Community Hospital
Name of provider:	New Ross Community Hospital Limited by Guarantee
Address of centre:	Hospital Road, New Ross, Wexford
Type of inspection:	Unannounced
Date of inspection:	02 June 2022
Centre ID:	OSV-0000602
Fieldwork ID:	MON-0033440

About the designated centre

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

The centre occupies the ground floor of a two-storey facility built in the 1930s with residential capacity of 35 persons (both male and female) on the ground floor. It is located on the same grounds as the Health Centre, Day Care Centre and New Houghton Hospital. It provides 24 hour 7 day qualified nursing care for persons with the following care needs: long term/ residential care, short term, non-acute medical, respite, convalescence, palliative care, family emergencies and young chronically ill over eighteen years of age. There are 13 single rooms, eight of which are en suite and 11 twin rooms. Other rooms available included a day room, an activity room, quiet room, prayer room, kitchen, dining room, sluice rooms, a laundry, treatment room and offices. There was a secure garden area for residents use in addition to a secure courtyard. Some parking was available at the front of the building. There is also access to a shared car park on the grounds. According to their statement of purpose, the centre aims to provide an environment that residents can regard as a home from home. Committed and professional staff are focused on ensuring all residents are cared for in a safe, warm, secure and caring environment, based on the principles of home. Their objective is to provide a high quality of resident-centred care to all in accordance with evidence based best practice; to ensure residents live in a comfortable, clean and safe environment that promotes the health, rights and independence of the residents of the hospital.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	34

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 2 June 2022	09:40hrs to 17:45hrs	Bairbre Moynihan	Lead
Thursday 2 June 2022	09:40hrs to 17:45hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

Overall, on the day of inspection, inspectors observed residents being supported to enjoy a good quality of life by staff who were kind and caring. Residents expressed that they were happy in the centre and were very complimentary about the care they received.

Inspectors arrived to the centre in the morning for an unannounced inspection to monitor ongoing regulatory compliance with the regulations and standards. Prior to commencing the inspection a brief check for signs and symptoms of COVID-19 was carried out. Inspectors completed a walk around of the centre with the person in charge.

The centre is on ground level, built in the 1930's with an extension added in 2016 with the addition of eight single en-suite rooms. The new wing had an inviting garden containing an awning, decked with garden furniture and a barbeque. The centre was registered for 35 residents with 34 residents present on the day of inspection. All rooms in the centre contained resident's personal items and photographs. Twin occupancy rooms in the old wing while meeting the requirements under the regulations, required review to ensure the dignity and privacy of residents occupying those rooms. This will be further discussed under Regulation 17; Premises. The single en-suite rooms in the new wing were modern in design, spacious and contained a fireplace, adding a homely feel to the rooms. There were a number of brightly lit seating areas in the new wing where residents were observed to be sitting and relaxing.

The centre had two part-time staff members allocated to activities. Activities were taking place throughout the day in the communal room, for example; the majority of residents were observed to be watching the local mass in the morning, taking part in a sing-along in the early afternoon and rosary before lunch. Inspectors were informed that bingo takes place daily. However, inspectors were informed that activities can get repetitive. Signage on the day of inspection outlined that 'bingo, radio and chat' were the activities planned for that day. Inspectors were informed that residents had attended the local church prior to the pandemic and this had not recommenced. The centre had received funding to develop a garden in the courtyard. Pictures of landmarks were purchased and displayed in the courtyard, along with a water feature and numerous bedding plants which were being planted by a small number of residents on the day of inspection. Print newspapers were observed to be readily available. Inspectors were informed that the priest visited monthly.

Inspectors spoke and interacted with a number of residents during the inspection. Residents' feedback provided an insight into their lived experience at the centre. All residents were very positive in their feedback for example; "everyone is so good", "love it here" and the "food is wonderful". One resident stated that the "place is clean, they clean everything including the wardrobe and the bedside locker".

Residents meetings were held regularly. Minutes of meetings reviewed showed that issues raised were actioned.

An inspector observed the lunchtime experience. Immediately prior to lunch hand gel was provided to each resident. Lunch was observed to be a social occasion with everyone chatting. Residents who required assistance received it in an unhurried and relaxed manner. Residents were very complimentary of the food stating that the "food is wonderful" and 'food is very good and the plate is not piled too high and love the brown bread'. The majority of residents attended the dining room, however a small number ate their lunch in their room at the residents' choosing. Nutritious snacks and drinks were observed to be offered to residents between meals.

The centre had open visiting with a number of visitors observed during the inspection. Checks for signs and symptoms of COVID-19 were observed to be taking place at the entrance to the centre. Residents had visitors in their rooms, in the brightly lit area in the new wing or some chose to meet their visitors outside in the garden.

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

Capacity and capability

This was a well-managed centre with effective leadership and management in place which ensured the residents received high quality, person-centred care and support to meet their assessed needs. The management team were proactive in response to issues as they arose and a number of improvements required from the previous inspection had been addressed and rectified.

The registered provider is New Ross Community Hospital Limited by Guarantee which consists of a board of directors of nine members. The chairperson of the board of directors is the registered provider representative. The chairperson of the board attended the feedback meeting held at the conclusion of this inspection. There was was a clearly defined management structure in place, which provided effective governance, accountable for the delivery of the service. The centre was managed on a daily basis by an appropriately qualified person in charge, responsible for the overall delivery of care. She was supported in her role by an assistant director of nursing, a nursing and healthcare team, as well as a team of catering, domestic and maintenance personnel.

Staff were knowledgeable regarding residents needs and provided care in a dignified and respectful manner. Staff meetings and shift handovers ensured information on residents' changing needs was communicated effectively. There was evidence that

newly recruited staff had received an induction, with evidence of sign off on key aspects of care and procedures in the centre. There was evidence of a good system of staff performance appraisal. Staff training records were made available to the inspector and indicated that staff had attended a range of training modules related to infection control processes, hand hygiene procedures, COVID-19 information and the wearing of personal protective equipment (PPE). Staff had undertaken mandatory and appropriate training such as, safeguarding training and manual handling. Staff confirmed their attendance at this training. Observations of the inspectors were that training was effective, for example, staff had good knowledge of how to respond in the event of a fire.

There was a very low turnover of staff. On the day of inspection, there were sufficient numbers of suitably qualified staff on duty to meet residents' assessed needs. However, further oversight of the staffing resources and requirements of the centre was required to ensure staffing resources were sufficient to deliver person-centred, effective and safe care to all residents at all times. This is detailed under Regulation 15 Staffing.

All records as requested during the inspection were made readily available to the inspectors. Records were maintained in a neat and orderly manner and stored securely. The person in charge assured the inspectors that all staff had appropriate Garda vetting and this documentation was reviewed by the inspectors. On review of staff files there were gaps in records for two members of staff which is discussed further in regulation 21: Records.

Overall inspectors found that there was a clearly defined management structure that identified lines of authority and accountability, specific roles and details and responsibilities for all areas of care provision in line with the statement of purpose and function (SOP). However, the management systems for clinical oversight, and the management of risk required improvement to ensure that the service provided was safe, appropriate, consistent and effectively monitored. This is discussed further under regulation 23.

There was a comprehensive record of all accidents and incidents that took place in the centre and appropriate action taken in the review of the resident following a fall. Incidents had been notified to the Chief Inspector as required by the regulations.

Residents were consulted about the care and services that they received. Resident meetings were held and where suggestions were made these were followed up and used to inform continuous quality improvements. Residents said that they knew how to make a complaint and that if they had a concern they could talk to a member of staff. While staffing, infection prevention and control and premises (as further detailed in the report) did not meet the regulatory requirements, overall, this was a good service, with effective systems in place to ensure that residents received safe and appropriate care. There was a clear focus on person centred care and quality improvement.

Regulation 14: Persons in charge

The person in charge was a registered nurse with the required managerial and nursing experience in keeping with statutory requirements. She was actively engaged in the governance, operational management and administration of the service. The person in charge demonstrated a strong commitment to the development of initiatives and quality management systems to ensure the provision of a safe and effective service.

Judgment: Compliant

Regulation 15: Staffing

Further oversight of the staffing resources and requirements of the centre was required to ensure staffing resources were sufficient to deliver person-centred, effective and safe care to all residents. On the day of inspection, inspectors found that the care hours were not sufficient to meet the clinical and social care needs of the residents at all times. This was evidence by:

- Rosters reviewed for the period from 14 days from 23 May to 5 June evidenced 10 days where planned staffing levels were not achieved.
- There was no administration staff at weekends to answer phone calls or attend to the front door. The impact of the absence of administrative staff was that nursing and care staff had to attend to these duties.
- No activities were provided for residents at weekends.
- Inspectors were not assured that one nurse from 5pm to 8am, 5 days per week and 2pm to 8am, 2 days per week the following day was sufficient to meet the needs of 17 maximum dependency, 3 high dependency, 8 medium dependency and 6 low dependency residents.

Insufficient staff to meet the needs of residents was identified on inspection in November 2020 and is a repeated non-compliance on this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

There was an induction system in place for all newly appointed staff which covered all aspects of the service requirements. There were improvements in the provision of staff training since the previous inspection, and mandatory training was in place for all staff with a particular focus on infection prevention and control, in response to

the COVID-19 pandemic.

Judgment: Compliant

Regulation 21: Records

Records as requested during the inspection were made readily available to the inspectors. Records were stored securely. A sample of four staff files viewed by the inspectors were assessed against the requirements of Schedule 2 of the regulations. An Garda Siochana vetting was in place for all staff and the person in charge assured the inspectors that nobody was recruited without satisfactory Garda vetting. Two of the staff files reviewed were missing two written references, including a reference from a person's most recent employer as required by Schedule 2.

Judgment: Substantially compliant

Regulation 23: Governance and management

While this centre was well managed, the provider needs to embed assurance and monitoring systems to strengthen oversight of governance and management arrangements in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c). This was evidenced by:

- There was no schedule of audits in place to ensure regular oversight of various areas of practice.
- Where audits had been completed and areas for improvement identified, a time-bound action plan was not developed. For example a hygiene and infection control audit in February 2022 identified that bathrooms were being used for equipment storage. No action plan was available. Furthermore, this was also a finding by inspectors on the day of inspection.
- Completed audit of care plans did not identify that a resident who smoked did not have an individual assessment. This was contrary to the risk management policy which stated that all residents who smoked would be re-assessed on a four monthly basis and more frequently if required.
- Further oversight of clinical key performance indicators was required to ensure accurate information was captured to effectively inform the management team about the quality and safety of a service provided.

Inspectors reviewed the incident and accident records and observed that a low level of falls were recorded, however inspectors reviewed some of the recorded incidents and found that:

- There was no root cause analysis completed.
- There was no evidence of learning from the incidents as evidenced by repeated falls involving the same residents.
- There was no risk analysis or trend analysis of these incidents.

Systems of communication were not sufficiently robust and staff meeting records were not available.

The registered provider had not prepared an annual review of the quality and safety of care for 2021 delivered to the residents, as required by the regulation.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A sample of contracts of care were reviewed. Each contract included details of the services to be provided and the fees to be charged, including fees for additional services.

Judgment: Compliant

Regulation 31: Notification of incidents

While the centre had a low use of restraint, the most recent quarterly notification which were required under regulation 31 had not been notified to the Chief Inspector.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints management system in place with evidence of complaints recorded, investigation into the complaint, actions taken and the satisfaction of the complainant with the outcome.

Judgment: Compliant

Regulation 4: Written policies and procedures

All written policies and procedures were in place as required by Schedule 5 of the regulations. However, all required updating on the day of inspection as they had not been reviewed per the centre's own time lines.

Judgment: Substantially compliant

Quality and safety

Inspectors found that the healthcare needs of the residents were met through good access to a high level of nursing, medical and other healthcare services if required. Residents were found to have a good quality of life in New Ross Community Hospital. However, improvements were required around premises, infection control, fire precautions and individual assessment and care planning.

Residents were observed to be taking part in activities during the day of inspection, however, as discussed earlier in this report the activities were described as being repetitive. Consequently, inspectors found that activities were not sufficiently tailored, varied and person centred to meet each residents' needs. Furthermore, there was no dedicated activity staff at the weekend to allow continuous engagement for the residents.

The centre was clean on the day of inspection. However, a number of areas for improvement were identified in relation to infection control to ensure the centre was compliant with procedures consistent with the National Standards for infection prevention and control in community services. These will be be further discussed under Regulation 27; Infection Control. The centre had recently come out of a COVID-19 outbreak. 17 residents tested positive during the outbreak which was declared over by public health on 23 May 2022. A COVID-19 outbreak report was completed. The review outlined what went well, the difficulties experienced and what could be improved. However, it was not clear from the review how the improvements required would be actioned and there was no evidence to show how the learning was shared with staff. Nevertheless, inspectors found that the needs of residents had been prioritised by a dedicated team of staff who worked hard to maintain safe levels of care to residents throughout the outbreak.

The centre was originally built in the 1930s and an extension added in 2016. The centre had good access to outdoor space. The new wing was modern in design, brightly lit and well maintained, however, the old wing had general wear and tear and was in need of review and maintenance. This will be further discussed under Regulation 17; Premises.

Visitors were seen to come and go throughout the day and there was a high but safe level of visitor activity. It was clearly evident that visitors were welcome in the centre.

Documentation identified that resident's end-of-life wishes were documented with reviews from the general practitioner (GP) and consultation with residents and families. Validated assessment tools were used to assess residents clinical, social and psychological needs. Inspectors found that care plans and assessments were regularly reviewed and updated with any changes to a resident's condition. However, improvements were required around care planning to ensure that all care plans were comprehensive and person-centred. Management and staff informed inspectors that there was a plan in place to align the date for reviewing and updating care plans and assessments and following this, audits of the new system would be commencing.

Systems were in place for monitoring fire safety. Fire extinguishers, the fire alarm and emergency lighting had preventive maintenance conducted at recommended intervals. There were daily checks of means of escape and weekly sounding of the fire alarm. Staff spoken with were clear on what action to take in the event of the fire alarm being activated. Each resident had a completed personal emergency evacuation plan in place to guide staff. Appropriate documentation was maintained for daily, weekly, monthly and yearly checks and servicing of fire equipment. The fire alarm system met the L1 standard which is in line with current guidance for existing designated centres. Annual fire training had taken place in 2021 and was attended by all staff. All newly recruited staff had been inducted in fire safety procedures. However, while fire drills were completed on a monthly basis and well attended by staff, improvements were required as detailed under Regulation 28 below.

Regulation 11: Visits

The centre had unrestricted visiting and visitors were noted to be coming and going throughout the day. Symptom checks for COVID-19 were completed on entry to the centre in line with guidance.

Judgment: Compliant

Regulation 13: End of life

Documentation reviewed of residents who were approaching end of life showed that resident's wishes, including wishes around transfer to hospital, religious wishes, burial and the funeral service wishes were documented. In addition, reviews had taken place by the general practitioner and documentation showed that families were updated throughout and involved.

Judgment: Compliant

Regulation 17: Premises

Improvements were required to bring premises into compliance with Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, and Standard 2.7 of the National Standards for Residential Care Settings for Older People in Ireland, 2016 as follows:

- Twin occupancy bedrooms in the centre were found to comply with the minimum floor space requirements of 7.4 metres squared per person, as set out in the amended regulations SI 293 (2016). However the configuration of a number of twin occupancy rooms did not afford residents the necessary privacy to conduct personal activities in private in that the floor space, area did not include the space occupied by a bed, a chair and personal storage space, for each resident of that bedroom.
- There was general wear and tear throughout including exposed piping, chipped wood on doors and skirting and marked walls.
- The flooring in a toilet/shower in the old wing was in a state of disrepair.
- Hand hygiene sinks were not compliant with the required specifications. In addition, only a small number of dedicated hand hygiene sinks were identified on the day of inspection.
- Inappropriate storage of wheelchairs and hoists in bathrooms and the cleaner's store room. This was identified on the last inspection in November 2020 and on an infection control audit carried out in February 2022. No action plan was devised following the audit and as such the issue remained.

Judgment: Not compliant

Regulation 26: Risk management

The risk policy contained all of the requirements set out under Regulation 26(1). The local risk register was kept under review by the person in charge. The risk register identified risks and included the additional control measures in place to minimise the risk.

Judgment: Compliant

Regulation 27: Infection control

While the centre was clean on the day of inspection, a number of areas for improvement were identified to ensure compliance with *National Standards for*

infection prevention and control in community services (2018) including:

- The centre had outsourced the laundry but some items were still washed onsite including towels, mop heads and cloths. There was no dirty to clean journey for these items. In addition, inspectors observed clean linen being stored beside laundry that was waiting to go out to be cleaned. Furthermore, the laundry room was unclean with staining noted on the stainless steel sink and washing powder spilled in the area.
- Mop heads and cloths were not dried following washing.
- While environmental audits were completed, they were not comprehensive enough to identify issues.
- The treatment room which contained medical supplies and resident monitoring equipment was also the hairdressing salon. The use of this room for a dual purpose poses a risk of cross contamination to residents.
- A small number of staff were observed using hand gel on their gloves between residents. This was brought to management's and staff attention on the day.
- While detergent wipes were available throughout the centre, packets of 70% alcohol wipes were inappropriately used for cleaning frequently touched areas for example door handles. Alcohol wipes are only effective when used to disinfect already "clean" non-porous hard surfaces.
- A chlorine based bleach was used on floors. Disinfectants are only required where residents are being cared for with transmission based precautions. Neutral detergent is recommended for routine environmental cleaning.
- The cleaner's room did not contain a janitorial sink. Waste water was disposed of in the dirty utility. This practice increased the risk of cross contamination. In addition, the cleaner's trolley was unclean and staff were unable to say when it was last cleaned.
- A COVID-19 contingency plan was in place and was up-to-date, however, Health Protection Surveillance Centre's (HPSC) Guidelines referenced were from 2020.
- An outbreak report, while completed, did not contain a timebound action plan for the improvements identified in the report.

Judgment: Not compliant

Regulation 28: Fire precautions

Notwithstanding the good practices in place, improvements were required to provide assurance that staff were able to safely evacuate all residents, as required by regulations. For example;

- Fire drills needed to include timed actions, analysis and remedial actions taken ensure safe and timely evacuation.
- Fire drills were not carried out at different times of the day and simulated at night when staffing levels are substantially reduced so as to assure the

registered provider that there were sufficient resources and equipment to safely evacuate residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of care plans. Inspectors identified that there was varied standards in care planning. Of the sample reviewed, the majority were good and described individualised and evidence-based interventions to meet the assessed needs of the residents however some further improvements were required. For example; it was identified that a small number of residents had only two care plans completed and or had incomplete care plans. In addition a smoking risk assessment and or care plan had not been completed on a resident who was a regular smoker.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a variety of medical, nursing and health and social care providers. The general practitioner attended onsite one afternoon per week and a consultant geriatrician once monthly. In addition, a community psychiatric nurse attended onsite once monthly. Access to health and social care providers was through the HSE. Residents had access to for example; physiotherapy, speech and language therapy and occupational therapy, however, inspectors were informed that residents could be waiting a number of weeks for review. At the time of inspection, inspectors were informed that no resident was awaiting review by a health and social care provider.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff were knowledgeable regarding residents' behaviours and were able to describe triggers. To support this, care plans were in place which described the behaviours, triggers and the interventions to engage or redirect residents. Bed rail assessments were in place with regular bed rail checks.

While the centre had a low use of restraint, the most recent quarterly notification which were required under regulation 31 had not been notified to the Chief

Inspector. This will be discussed under Regulation 31; Notification of incidents.

Judgment: Compliant

Regulation 9: Residents' rights

While activities were observed to be taking place at the centre including watching the local mass via the internet, singing and gardening, inspectors were informed that the activities can get repetitive. The provider needs to be assured that residents are provided with the opportunities to participate in activities in accordance with their interests and capabilities.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for New Ross Community Hospital OSV-0000602

Inspection ID: MON-0033440

Date of inspection: 02/06/2022

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The report states we only have 0.75 admin post, this is factually inaccurate(please see factual inaccuracy form). We have 1.59 admin staff and on the day of inspection and on the roster, a staff member was working from home due to covid infection. • There is a factual inaccuracy regarding household staff also in the report. It states we only have 2.5 WTE according to the roster and statement of purpose stated 5.0 WTE. This number in the statement of purpose represents all ancillary staff (household, wash up staff and kitchen staff) The Statement of Purpose is being reviewed at present and will be completed by the end of August 2022 • We have increased our nursing hours seven days per week to provide assurance that all our residents needs are met sufficiently (July2022) • A review of the activities programme and activities coordinators shifts is underway to ensure residents are provided with the opportunities to participate in activities according to their interests and capabilities 7 days per week(End of July 2022)	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • Staff files have been checked to ensure 2 references including one from most recent employers has been rectified in June 2022 post HIQA inspection. A cover sheet is now attached to each employee file to ensure each employee has all the required elements pre-employment including a reference from the most recent employer. (June 2022)	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Audit programme has been introduced by PIC from July 2022 onwards. This will be a monthly programme with a number of audits each month to ensure all areas of practice are audited and time bound action plan produced
• All care plans and assessments reviews will be completed on a 4 monthly basis(End of Jan, May and Sept) for each resident. These will be conducted by the named nurse and overseen by PIC/Deputy(June 2022 onwards). Also care plans are included in the monthly audit programme.
• Falls reviewed on a monthly basis to ensure there is learning from same and any trends related to falls
• Quality and Safety Review for 2021 will be completed by end of Sept 2022

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
PIC will ensure that quarterly notifications are sent in a timely manner (Q1 notifications sent July 2022 along with Q2 notifications)

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
A schedule of policies due for renewal will be drawn up according to review date and PIC will evidence that all policies are reviewed and up to date. (Aug 2022)

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: • A review of twin occupancy rooms is ongoing to ensure residents can conduct personal activities in private (August 2022) • A general maintenance programme to include preventative maintenance is being drawn up between PIC and Maintenance to ensure general wear and tear is dealt with regularly and in a timely fashion (August 2022) • The toilets and showers in the old wing need upgrading and this will be discussed with board members in July 2022 meeting to organize a programme of upgrades • Additional hand hygiene sinks which conform to required specifications will also be part of the improvement and upgrades needed to bring us into compliance with the standards. It is envisaged that this work will be completed in 1st quarter of 2023. • PIC contact Infection Control Nurses for CHO5 region for on site professional and expert advice following inspection regarding the issues raised. They were unable to provide any on-site professional advice expect during a Covid Outbreak. (June2022) • Audit schedule will ensure that inappropriate storage of items is actioned appropriately as well as spot checks by PIC/Maintenance	
Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: • The laundry room has been divided into clean and dirty area (June 2022) • Laundry room is undergoing full deep clean and renewal of rusted platform and storage under sink, this will be part of discussions with July Board of Directors meeting to agree works and improvements required • Cleaners made aware that mop heads should be dry and this is now happening (June 2022) • One staff member was observed by inspectors using hand gel on gloves. All staff reminded that this practice is not acceptable. PIC carries out observational spot checks on same and will also be audited during Infection Control Audit • Alcohol wipes have been removed from general circulation and chlorine based bleach only used in outbreak situations. • Cleaning products Supplier coming in to re familiarize staff with products and cleaning including cleaning of cleaner trolley (date pending. PIC has devised daily tick list for cleaners to attach to trolley to evidence trolley has been cleaned each day. • Janitorial sink will be included in list of environmental improvement and upgrade work • Covid Contingency Plan update with the most up to date HSPC Guidelines from 2022 • Outbreak report has been updated with timebound action plan for improvements identified in the report. (june2022) • Room detailed in report has been made into a hairdressing room only	

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Fire compartments identified by PIC and drills now performed to ensure staff are familiar with what is required for each compartment
• Simulated day and night time drills are in progress and evidenced to assure the registered provider that there are sufficient resources and equipment to evacuate residents safely.
• Full review of drills will be undertake in audit schedule as built into audit schedule drawn up by PIC.

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:
• All care plans and assessments reviews will be completed on a 4 monthly basis(End of Jan, May and Sept) for each resident. These will be conducted by the named nurse and overseen by PIC/Deputy(June 2022 onwards). Also care plans are included in the monthly audit programme. (As per Reg 23)

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• PIC holding meeting with activities coordinators' to look at current programme of activities, making improvements to same based on residents' wishes and also to look at weekend activities. (July 2022)
• Summer excursions to local park and hotel and resident BBQ's have taken place in July 2022 with further trips planned in the months ahead
• Live music has also returned to the house.
• Religious Services also taking place on site.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/07/2022
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/03/2023
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	Substantially Compliant	Yellow	30/06/2022

	and are available for inspection by the Chief Inspector.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/03/2023
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.	Substantially Compliant	Yellow	30/09/2022
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Orange	30/09/2022
Regulation 27	The registered	Not Compliant	Orange	31/03/2023

	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.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/09/2022
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	31/07/2022
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in	Substantially Compliant	Yellow	31/12/2022

	paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/09/2022
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	30/09/2022
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and	Substantially Compliant	Yellow	31/07/2022

	capacities.			