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 Vincent's Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Irishtown, Mountmellick, Laois
Type of inspection:	Unannounced
Date of inspection:	23 August 2023
Centre ID:	OSV-0000533
Fieldwork ID:	MON-0041259

About the designated centre

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

St Vincent's Community Nursing Unit is a 57-bed facility located within walking distance of Mountmellick town centre. Residents' accommodation is arranged in four units/wards. The 'units are: St Paul's ward has 10 beds with one additional bed for End of Life/ isolation purposes. St Anne's ward has 13 beds. Dun Ainne located off st Anne's ward, had two bedroom areas- one palliative bed and one IPC isolation purposes. St Martha's unit has 8 beds dementia-specific unit. St Mary Theresa's ward has 25 beds and one additional bed for End of Life/ isolation purposes. The centre provides care for male and female residents over 18 years of age with continuing care, dementia, respite, palliative care and rehabilitation needs. The provider employs nurses and care staff to provide care for residents on a 24-hour basis. The provider also employs GP, allied health professionals, catering, household, administration and maintenance staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	55

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 23 August 2023	08:45hrs to 18:45hrs	Frank Barrett	Lead
Wednesday 23 August 2023	08:45hrs to 18:45hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

This was an unannounced one day risk inspection to monitor compliance with the regulations made under the Health Act 2007 (as amended). This inspection primarily focused on a review of fire precautions and an inspection of the premises. The centre was registered for 57 residents and there were two vacancies on the day of the inspection. The previous inspection of this centre in February 2023 had identified some areas that required improvement in relation to fire precautions and premises.

Inspectors arrived unannounced at the centre and were met by the clinical nurse specialist who was deputising for the person in charge. Following a brief introductory meeting, inspectors walked through the centre and spent time talking to residents and staff, observing the care provided to residents, and the care environment. The Director of Nursing arrived shortly afterwards at the centre and accompanied inspectors on the inspection.

The centre was located in an urban area close to shopping centres, residential areas, public parks, and local transport links. The centre consisted of a large two-storey building on extensive grounds with three enclosed gardens that provided a pleasant space for residents to sit out. Access to the centre through the front door required visitors to call the nurse desk from the communication device at the door. The ground floor of the centre consisted of eleven twin rooms and twelve single rooms divided into three areas; St Anne's, St Martha's and St Paul's. The remaining areas of the ground floor consisted of staff rooms, staff canteen, offices, a large oratory, storage rooms, living/dining spaces, a kitchen, and an internal smoking room. Access to the first floor was through a passenger lift or by two stairways. The first floor consisted of twelve twin rooms and two single rooms. There were also living and dining spaces on the first floor as well as staff areas. Three of the single rooms at the centre are designated as "special purpose rooms" and were not permanently occupied.

Inspectors noted that residents' bedrooms were personalised with their belongings and photographs. The centre was clean, warm and communal rooms were nicely decorated. However, inspectors noted a number of issues relating to the upkeep of the centre. For example, a leak on a corridor wall that had been identified on a previous inspection had not been addressed. The centre's laundry was housed in a separate building next to the main building that contained the residents' bedrooms. Inspectors noted that the flooring in this room was cracked and not clean. In addition to the laundry, this building also contained a maintenance workshop and canteen for maintenance workers. The boilers for the centre were housed in a further separate building next to the laundry.

Inspectors noted that there were a number of issues in the centre that impacted on fire safety. Inspectors observed that gates had been placed at the top of both staircases in the centre. Trolleys were stored along escape routes. Both of these issues impacted on the safe evacuation of residents in the event of an emergency.

An urgent compliance plan was issued to the provider to remove these obstacles. Inspectors also noted that signage throughout the centre relating to fire safety required improvement. Some signage was out of date and some signs displayed conflicting information. Inspectors observed issues relating to the maintenance of fire doors throughout the centre and that attic hatches were not fire rated. This impacted on the ability to contain smoke and fire within a section of the building in the event of a fire. Inspectors noted that flammable and combustible materials were stored next to each other in over-filled store rooms. This increased the risk of fire. Further, inspectors noted that one fire detection head in a store room had been covered with a surgical glove, which meant that it would not detect smoke in the event of a fire. At inspectors' request this was removed on the day of inspection.

A construction project was underway on the day of inspection on the grounds of the centre. While access to the construction area was restricted, noise from site activity was evident throughout the day in the centre. Inspectors noted that the building works were impacting on the centre by reducing the access around the building. The main laundry building was also modified by removing a door to accommodate the building works. In addition, a shed that had previously been used for laundry storage had been removed. This resulted in a change to the dirty-to-clean flow that had existed in the management of laundry. The removal of the laundry storage area resulted in staff transporting dirty linen trollies through the centre and storing them in a disused office near the front entrance lobby. Changes were also noted to the boiler house facilities with the placement of a large, temporary kerosene storage tank beside the plant room, and adjacent to construction traffic. The back-up generator was now isolated inside the building site area which was inaccessible to inspectors.

Residents that spoke with inspectors reported that they were happy with the care in the centre. One resident reported that they would like to be able to shower more frequently. Staff were observed assisting residents throughout the day and spoke to residents with care and respect. However, inspectors observed that two residents who each required full assistance with their meals were assisted simultaneously by only one member of staff at lunchtime.

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

Capacity and capability

This unannounced risk inspection was carried out over one day by inspectors of social services to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).
- follow up on the actions taken by the provider to address significant issues of non-compliance found on the last inspection in 22 February 2023.

The findings of this inspection were that the provider had failed to take the required action to address significant non-compliances that had been identified on the last inspection. Given the totality of the findings of this inspection an urgent compliance letter was issued to the provider in the days following the inspection. The registered provider engaged in this process, and supplied the requested information within the specified timeline. This information provided assurance to the chief inspector that the issues raised were being addressed.

The registered provider of St Vincent's Community Nursing Unit is the Health Service Executive (HSE). The management structure, as set out in the centre's statement of purpose, consisted of a person in charge supported by an assistant director of nursing, eight clinical nurse managers, a clinical facilitator, and a clinical nurse specialist in dementia. This was not in place on the day of inspection. Three positions for nurse managers, clinical nurse facilitator, and assistant director of nursing were vacant or not back-filled. The clinical nurse specialist in dementia was redeployed to carry out nursing administration duties.

The centre was experiencing an outbreak of COVID-19 on the day of inspection. There were six positive cases over three units. Residents had completed their required period of isolation. However, a further two residents were awaiting PCR (polymerase chain reaction) test results. Appropriate infection prevention and control precautions were in place.

Staff had access to mandatory training including safeguarding, fire safety and infection control. However the findings of this inspection confirmed that further training was required on the use of equipment to safely evacuate residents and on the cleaning and decontamination process of residents' equipment.

The clinical management support for the person in charge was not maintained in line with the statement of purpose. Inspectors found that the available clinical nurse managers were required to fill vacant shifts in the nursing roster and to cover nursing administration as a consequence of inadequate levels of nursing staff. This reduced the ability of the clinical nurse managers to fulfil the management component of their role and impacted on the supervision of staff. Furthermore, due to reduced daily nursing administration cover, the senior staff nurse assumed the charge nurse role for all five units, in addition to the nurse duties for their own unit, and the duties of fire warden from 5pm. Previously this had been from 6:30pm. The impact of this change had not been risk assessed.

From a review of rosters and discussion with staff, inspectors found that there was a significant amount of absenteeism over a number of years. As a result, there was a high usage of agency staff for both nursing and non-nursing staff. From a sample of five weeks rosters viewed, the agency usage was 18-29 WTE persons (whole time equivalent) per week. While announced sick leave was covered for the most part,

planned leave for clinical nurse managers had not been covered. Inspectors acknowledged that attempts were made to assign the agency staff to the same units on a consistent basis. However due to a COVID-19 outbreak, it had not been achieved in the weeks prior to and during the inspection.

The management systems failed to ensure that the service provided was safe, consistent and effectively monitored. The provider maintained oversight of fire safety in the centre through the use of audits and fire safety checklists. These were completed in line with the timelines set out by the provider. However, inspectors noted that these checks were not adequate to detect all fire safety issues in the centre. For example, the checklists had failed to identify obstructions on escape routes such as stair gates, and trollies in stair lobbies. The provider had employed an external company to complete a fire safety risk assessment. This was completed in July 2022. The risk assessment identified a number of areas that needed to be addressed urgently and advised that these be completed within three months. On the day of inspection, it was found that these actions had not been addressed. For example, the risk assessment identified that some fire doors needed to be replaced and this had not yet commenced. Issues with containment of fire had been identified on a previous inspection and the provider could not give assurances that these issues would be addressed in line with the compliance plan submitted following that inspection.

The systems in place to manage risk were not effective. Inspectors noted that the impact of the ongoing construction works had not been adequately assessed. The provider had not assessed the impact of noise on residents and ensured that adequate measures were in place to limit the impact on residents. Further, inspectors noted that the provider had not assessed certain safety risks relating to the construction works and taken adequate precautions to reduce that risk. For example, the storage of oxygen cylinders immediately next to the contruction site had not been identified and assessed by the provider.

A sample of policies and procedures, as required by Schedule 5 of the regulations, were reviewed by the inspectors. The complaints and fire policy required review.

Regulation 23: Governance and management

The registered provider had failed to ensure that resources in the centre were planned and managed to ensure person-centred, effective and safe services. The provider had failed to ensure the service had sufficient staffing resources to;

- Ensure the management structure was maintained in line with the centre's statement of purpose. This impacted on the effective governance and oversight of the centre. For example there were vacancies in the Assistant director of nursing, clinical nurse manager and clinical facilitator role. Furthermore the clinical nurse specialist (CNS) for dementia was redeployed to nursing administration. Senior nursing management team hours had reduced daily from 6:30 pm to 5pm. At 5pm a designated senior nurse took

responsibility for clinical decisions for each unit, attending to visitors and acted as fire warden in addition to her duties as nurse on their own unit.
- Maintain adequate clinical nurse manager staff levels to ensure effective support and supervision of the nursing and health care staff. Due to vacancies and sick leave, the clinical nurse managers were undertaking direct care duties, thus reducing the time available to supervise clinical care.

The registered provider had failed to ensure there were clear lines of accountability and responsibility. For example, accountability and responsibility for key aspects of the service such as the oversight and management of risk associated with the new build and its associated impact on the current designated centre. Consequently, there were poor systems in place to escalate risk to the provider. This was evidenced by:

- A lift in the centre which is used by staff and residents accessing the second floor was not serviced on the day of inspection. An inspection of the lift by a third party in January 2023, had identified concerns with the lift viability. This lift could not be certified by the contractor. It was not clear when or who was responsible to ensure the issues identified in the service record were followed up.
- Minutes of a meeting in May 2023 identified that emergency lighting was to be checked weekly, however there was no action plan as to who was to do this.
- Meeting minutes from May 2023 identified that staff required further training on the use of ski pads, however no one was assigned responsibility and no action was taken.
- Fire drills carried out in February, June, July and August also identified staff training in the use of Ski sheets needed further attention.

Inspectors found failings in the governance arrangements and ineffective management systems to ensure a safe, monitored and consistent service was provided. This was evidenced by;

- Oversight of infection control required strengthening as inspectors observed that some equipment for use by residents was not clean. The procedure for transporting and collection of dirty linen had changed, however there was no risk assessment completed to inform this process and no procedure for staff to follow. The sluice room on St Paul's unit was not clean, as well as the kitchenette on St Martha's. Furthermore, the contents of the spill kit and first aid kit were out of date.
- Identification and oversight of fire safety risks were not adequate; for example the registered provider had failed to review potential risks to residents following a decision to relocate the laundry, oxygen cylinders and generator. Additional details are provided under Regulation 28; Fire precautions.
- The complaints procedure and policy were on display in the centre, however, they were not in line with the changes required under S.I. 628 of 2022.
- Insufficient oversight of maintenance of issues, for example a bathroom was

out of order since 26 of June. 2023

- Files were found in various rooms throughout the centre. Many of the files, and filing cabinets were in rooms being used for other purposes, and some files dated back more than 10 years. There was no evidence of indexation of the file storage, which would result in difficulty finding particular files. These paper files were also impacting on safe storage, as they were obstructing storage areas.
- There were repeated non-compliance's in premises and fire precautions, and commitments given in previous compliance plans not fully met.

An urgent compliance letter was issued following the inspection. The providers response to this letter provided assurance that the issues identified were being addressed.

Judgment: Not compliant

Quality and safety

The safety of residents in the centre was negatively impacted by significant issues in relation to the evacuation of residents in the event of a fire. These were noted on inspection and subsequently highlighted to the provider in an urgent action plan following the inspection.

This centre was previously inspected on 2 February 2023. That inspection found that improvement was required in relation to premises maintenance and the fire safety arrangements in the centre at that time. Since the time of that inspection, the provider had taken measures to address a number of these issues. Improvements had been made to the premises including the replacement of some floor coverings, however, repeated findings in relation to a crack in the wall were identified. These issues are discussed further under Regulation 17; Premises.

The provider had made some improvements to the emergency lighting in the centre since the previous inspection. This lighting system was tested and certified on a quarterly basis by a competent external fire professional. The records for this testing were reviewed on the day of inspection.

The provider was unable to provide assurances that adequate measures were in place to ensure the containment of fire. There were issues with fire doors not closing fully on release of the holder, significant gapping around the perimeter of fire doors and service penetrations through compartment walls which were not fire sealed. A fire door audit carried out at the centre, had identified a number of doors which required remedial action. The provider had set out a plan to address the issues in relation to this audit, however, the completion date identified for this works would not be met. Assurances in relation to the containment of fire in the attic area could not be provided. Inspectors found attic hatches in various rooms in the centre

which were not fire rated.- Further containment issues were found in service risers; for example extensive service penetrations were found in an electrical service riser, which were not fire sealed.

Inspectors reviewed procedures at the centre to raise the alarm in the event of a fire.The fire alarm was inspected and tested on 30 July 2023. However, inspectors observed a smoke detector head, which was covered by a blue clinical glove, rendering it dormant. This had not been identified by the centre, and inspectors were told that this was most likely put in place up to six weeks earlier, during floor replacement works in this sluice room. Immediate action was taken on the day to remove the glove and ensure that the fire detection in this room was operational.

Improvement was required in relation to the system of evacuation and fire drills in the centre. Inspectors found that staff were unsure of the correct use of ski-sheets for evacuation of the centre. While demonstrating their use, inspectors observed staff using the ski-sheets incorrectly. Fire drill records were not specific to high-risk areas, for example the first floor, nor were there simulated night-time evacuation drills. No record of a fire evacuation of the largest compartment was available on the day of inspection. Inspectors could not be assured that the use of evacuation aids in some of the evacuation routes had been trialled by staff at the centre.

There was improvement required in relation to signage relating to the evacuation of the centre. Signage displayed throughout the hallways gave conflicting information. Signage directing staff and visitors on the evacuation procedure was not displayed near the layout maps which would give a visual identification of the route to safety.These issues are discussed further under Regulation 28; Fire Precautions.

Regulation 17: Premises

The registered provider did not, having regard to the needs of the residents at the centre, provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- Some areas of the premises were not being kept in a good state repair internally. The laundry had damage to the floors, and there was no wall finishes in sections where doors were removed. These issues would make cleaning the area difficult.
- There was evidence of a leak coming through a section of wall on the ground floor. While there was evidence that an attempt had been made to repair the leak, there was still damage to the wall. This was a repeat finding.
- There were a number of areas throughout the centre where the floors sloped into ramps. These changes to the gradient in the floors were not identified by visual aids to persons walking. This could result in difficulty for persons mobilising using mobility aids.
- The carpet in the two offices adjacent to the entrance lobby was in a poor

state of repair.
- Inappropriate storage was found throughout the centre for example, laundry trollies in escape stairwells, overfilled store rooms with boxes piled on the floor. This would cause difficulty in cleaning these areas.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider did not take adequate precautions against the risk of fire, and did not provide suitable fire fighting equipment for example:

- There was inappropriate storage and excessive amounts of combustible materials in storage rooms without any fire protection, for example
    - Batteries stored along with aerosols, paper towels etc. in a domestic supplies cupboard.
      Significant amounts of materials such as cardboard boxes, bulbs, chairs and batteries were stored in a communications room. This room was a location of high fire risk, and this material increased the fire load in this room. Immediate action was taken by the provider on the day to remove these items.
    - A maintenance store room was filled with tools, building materials, spare parts etc. This material was stored alongside paint, aerosols, and other flammable items. This room was also the location of an electrical cabinet which did not have fire protected doors.
    - Large amount of activities materials, Christmas decorations etc. were piled in a space above the door in the laundry. This area was not accessible, and the area was not suitable for storage as it was open to the laundry, and there was no organisation of the material. An urgent compliance letter was issued in relation to storage.
- Inspectors found Oxygen cylinders stored in areas which were not suitable for the storage of oxygen. Some cylinders were not adequately protected from collision, and there was no signage on the door to indicate the presence of oxygen cylinders in the room. Oxygen signage was also missing from doors to bedrooms of residents that were using Oxygen.

The registered provider did not provide adequate means of escape for example:

- There were stair gates at the top of both escape stairs from the first floor. These gates were retractable, however, they were kept in the closed position, and linked across the top of the stairs. This barrier to evacuation could cause delays in evacuating residents on the first floor in the event of a fire. This was the subject of an urgent compliance letter to the provider following the inspection.
- Materials such as used medication boxes, and linen trollies were obstructing the escape route at the ground and first floor of the two escape stairs.

- Signage relating to evacuation in the centre did not reflect the situation at the centre. There was conflicting information given on different signs posted on escape routes. This could cause confusion or delays in the event of an evacuation.

The registered provider did not make adequate arrangements for detecting and containing fires. For example:

- Fire doors throughout the building had large gaps underneath and around the perimeter. Many doors were found to remain open on release of the door holding device. This was a repeat finding.
- There was a lack of fire stopping material around pipe penetration in walls and ceilings throughout the centre. Extensive penetrations which were not sealed were found in service risers, electrical cupboards and comms room.
- The attic hatches of the centre did not appear to be fire rated hatches. Inspectors could not be assured that containment measures were in place in the attic above containment lines. Containment lines are compartments within the building which contain fire and smoke for a specified period.These containment lines need to be effective above and below ceiling level to ensure containment of fire so that evacuation of residents to the relative safety of the next compartment can be competed.
- A smoke detector in a sluice room was covered by a glove. A fire in the sluice room would go undetected. An immediate action to remove the glove was taken by the provider on the day.

The registered provider did not make adequate arrangements for evacuating where necessary in the event of a fire, of all persons in the designated centre. For example:

- Inspectors could not be assured that staff knowledge on the use of "Ski-Sheet" evacuation aids was adequate. Staff demonstrated their knowledge of using a ski-sheet, however, inspectors observed that the ski-sheet was not used according to the manufacturer's instructions. Belts were not fastened in one case, and another ski-sheet was used from the wrong end. This was the subject of an urgent compliance letter following the inspection.
- Fire drills were conducted at the centre, however, there was no follow-up action evidenced on issues found during fire drills. For example, ski-sheets use was identified as requiring further training. This was not completed. The procedure for vertical evacuation of residents on the first floor, and safe placement of these residents was not practiced by staff.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for St Vincent's Community Nursing Unit OSV-0000533

Inspection ID: MON-0041259

Date of inspection: 23/08/2023

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review of the resource allocation and deployment of staff has been undertaken.

The Management structure within the unit consists of an Interim Director of Nursing who is supported in her role by two clinical nurse managers in Nursing Administration. Plans are in place for the Assistant Director of Nursing to return to her substantive post in the next 6 weeks.

Clinical Nurse managers are responsible for direct care which includes supervision of staff and clinical care. They are allocated one day per week protected time to undertake the administration duties relative to their role. Cover for sick leave and other vacancies is filled by agency nursing staff.

Nursing Administration support ward managers/ward staff from 08.00-17.00 seven days per week. A nominated person from Nursing Administration is available to support staff in charge after 17.00hrs if required.

The out of hours on call is rotated between the nursing administration management team. The out of hours on call is now identified on the daily shift handover report to ensure it is clear to all staff and they are aware of the out of hour's governance arrangements.

A CNM 2 has returned from long term leave, this has facilitated the clinical nurse specialist (CNS) for dementia to return to their substantive post.

Two additional CNM 2 positions are being filled. These posts are progressing through recruitment with candidates successful at interview being offered a position. The filling of these posts will ensure an adequate complement of nurse management staff to oversee the operational, clinical and strategic management of the service.

The position of a Foreman has being recruited and commenced in post onsite on the 18th Sept. The Foreman is responsible for the management of the onsite maintenance team. The PIC and the Foreman now meet every two weeks to ensure oversight and management of any potential risks associated with the new build and any impact on the current designated centre and the quality and safety of care for residents. A range of risk assessments with controls identifed are outlined on the risk register of the centre. Risk assements with control to mitigate any impact of noise, fire, aspergillosis and site security are in place. These risks and control are discussed with centre's Foreman, HSE Estates, PIC and the onsite contracting management team on a routine basis.

A new process is now in place since the recruitment of a Foreman for the escalation of all maintenance issues to ensure they are resolved without delay. A reporting system for any faults or matters requiring repair are now communicated to the Foreman who oversees the maintenance team. All staff are aware of the new system and this has been discussed at team meetings with each department in the centre.

The lift has been serviced by a specialist company and a service report has been issued confirming the lift is functioning correctly. All service reports on the lift in the future will be issued to the PIC and the Foreman in the centre.

Each department carries out a weekly check of the emergency lighting and the department head is responsible for ensuring the weekly checks have been completed. In addition the onsite electrician carries out a quarterly random check selecting a different area each time. Furthermore an external contractor completes quarterly inspections of the Fire Panel/Alarms/Smoke and heat detectors and emergency lighting throughout the building. The actions arising from all fire safety precautions checks are brought now to the schedule of yearly planned Quality and Safety meetings for discussion to ensure any corrective action required or learning is implemented.

Ski Mat Training refresher training has been completed by approximately 80% of staff. A final training day is scheduled for 28th November for all remaining staff. A record of staff attendance at fire safety training and evacuation is maintained by the PIC to ensure oversight and monitor all staff attendance at mandatory fire evacuation drill practices.

The minutes of the local governance meetings on Fire Safety, Health and Safety and Quality Improvement matters, in future will have a responsible person assigned for ensuring actions are followed up and completed.

Oxygen Cylinders have been relocated to the rear of the building, away from the building site in a new enclosed cage for safety and security to mitigate against the risk of fire.

An updated process is in place to reflect the changes to the laundry arrangements. The PIC has met with the Domestic Supervisor and discussed the new system for the management of laundry onsite and this has been communicated to all staff. The system ensures now there is separation of clean and dirty laundry at all times to mitigate the risk of cross infection.

The frequency of audits of the premises has been increased to ensure a high standard of

cleanliness throughout in all areas. All staff complete an ongoing program of training on Infection Control and Best Practice.

The complaints policy has been reviewed in line with under S.I. 628 of 2022. The revised complaints procedure are displayed in the entrance foyer and have also been updated in the Statement of Purpose and Residents' Guide.

The management and storage of files has been reviewed. A clerical support has been assigned for a three month period to the centre to reorganise the management of records to include removal of old files in accordance with the policy of the centre and centralise the storage of current records.

The fire policy for the centre has been reviewed. The fire emergency evacuation procedures have been updated along with fire compartment floors plans and these are displayed throughout the centre. Notices are displayed to advise of each compartment boundary line.

A fire safety risk assessment has been completed and fire safety structural upgrade works are planned to commence onsite. The contract to complete the work has been allocated to a specialist company and fire safety upgrade works and fire containment works are due to commence on site prior to the end of 2023.

All first aid and spills kits have been checked and replaced where required.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Maintenance works have been completed in the laundry to include sealing around areas where doors were removed. Air conditioning units have been provided in the laundry.
A new cleaning schedule has been developed and implemented.
The PIC has identified a new area within the centre which is larger and will meet the future needs of the service. The relocation of the laundry to the new area will be prioritised as part of the structural upgrades work ongoing in the centre presently.

The damage to the wall area due to a leak will be repaired. Funding has been approved by the management team and a contractor has been sourced to complete the works.

Flooring has now been replaced in the office located inside the front door and the internal adjacent office.

Storage rooms in all departments have been decluttered, cleaned and tidied with all storage boxes removed from floor area's to allow for cleaning.
All boxes stored on overhead shelving close to pipework removed to mitigate against the risk of fire

The maintenance canteen and office have been tidied, painted and re-floored.

In each area where the floor is ramped signage is now in place to alert residents, staff and visitors of the change in gradient. All residents who are at a risk of falls have an individualised risk assessment in place with a care plan where a risk is identified to ensure they can mobilise safely.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All Portable Fans and Oil filled storage radiators have been removed from ward area's- PAT tested on 01/09/2023. These will only be used following the completion of a risk assessment

Each clinical room contains 1 portable oxygen container which is secured to the wall. Appropriate signage is displayed on each clinical room door. Bedroom signage indicating "Oxygen therapy in use" is available for all departments. This has been communicated to all areas at our QPS meeting.

First Aid box outside the smoking room has been replaced. Fire Retardant furniture and new ash trays have been ordered.
A safety check sheet for the smoking room has been introduced where housekeeping staff/activities staff will check the room every hour between the hours of 9am and 9pm.

The units Fire Policy/Evacuation Policy is under review. Compartment Floor plans received and on display in the front hall. Signage identifying compartment lines placed throughout the unit as per the compartment floor plan.

Vertical Evacuation Drill has been carried out with all staff on St Mary's Ward and St Teresa's ward. Both day and night staff attended this drill. Housekeeping and kitchenette staff also attended.

Further vertical evacuation drills have been taking place using night time staffing levels on St Teresa's ward where the dependency level is high. The drills consist of 5 staff evacuating 12 residents reflecting the night time staff roster taking into consideration the staffing level at night, the need for the person in charge to carry out their duty and the need for a member of staff to remain in each ward area to ensure the safety of all other residents.
A record of each staff members participation in fire drills is maintained to ensure oversight and monitoring of all staff involvement in fire drills.

The fire emergency evacuation procedures have been updated along with fire compartment floors plans and these are displayed throughout the centre to ensure

consistency and standardisation in the fire evacuation information displayed. Notices are displayed to advise of each compartment boundary line.

Storage rooms in all departments have been decluttered, cleaned and tidied with all excessive materials removed.

Stainless steel lockable cupboards which are being custom made have been ordered and delivery and installation is awaited for the storage of higher risk items which have a combustible factor.

Oxygen Cylinders have been relocated to the rear of the building, away from the building site in a new enclosed cage for safety and security to mitigate against the risk of fire.

The stair gates at the top of both stairs on the first floor have been removed to ensure there is no impediment on the fire evacuation escape route.

Daily check of all fire exits and escape routes are in place to ensure fire exits are unobstructed and escape routes are clear.

Following the completion of a fire safety risk assessment, fire safety structural upgrade works are planned to commence onsite. The contract to complete the works outlined in fire risk assessment report has been awarded to a specialist company. Fire safety upgrade works and fire containment works are due to commence on site prior to the end of 2023. These works will also include the replacement of fire doors, fire stopping at wall and ceiling penetrations.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	15/12/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	01/12/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability,	Not Compliant	Orange	15/11/2023

	specifies roles, and details responsibilities for all areas of care provision.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	15/11/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	01/09/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	01/09/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	15/03/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where	Not Compliant	Red	01/09/2023

	necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			