



Report of an inspection of a Designated Centre for Older People

Issued by the Chief Inspector

Name of designated centre:	St Joseph's Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Patrick Street, Trim, Meath
Type of inspection:	Unannounced
Date of inspection:	02 October 2019
Centre ID:	OSV-0000542
Fieldwork ID:	MON-0027618

About the designated centre

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

The designated centre is registered to accommodate up to 50 residents. It provides 24 hour nursing care to male and female residents, who require long term, short term and respite care. A day hospital adjoins the centre. Although the building is two storey residents are accommodated on the ground floor in two distinct units. Butterstream is a 14 bed dementia specific unit completed in October 2019, providing single bedrooms with shower en-suites for all residents and Camillus has 36 single bedrooms of which 34 have full shower en-suite facilities. Camillus unit is decorated and furnished to a high standard with spacious corridors, a variety of sitting/quiet rooms and seated areas, two dining and day rooms, a spacious chapel, an activity room, a library with computer facilities and a hair salon is available for residents' use. A secure and accessible courtyard is also available. Butterstream is specifically designed to meet the needs of residents with dementia providing a range of well thought out internal and external living spaces. The centre's philosophy is one of upholding the rights of residents, promoting independence, health and well-being and aimed at facilitating residents to receive a safe therapeutic environment where privacy, dignity and confidentiality are respected. Involvement of family and friends is encouraged to enrich care and contribute to a happy homely atmosphere.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	47
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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
02 October 2019	09:00hrs to 19:30hrs	Siobhan Kennedy	Lead
02 October 2019	09:00hrs to 19:30hrs	Ann Wallace	Support

What residents told us and what inspectors observed

Residents who communicated with the inspectors were positive with regard to the control they had in their daily lives and the choices that they could make. Residents told the inspectors about their daily and evening routines, activity plans and interactions with the community. Residents expressed satisfaction regarding these matters and were happy with food and mealtimes and the support and assistance provided by staff. Residents were able to identify a staff member whom they would speak with if they were unhappy with something in the centre.

Some residents invited the inspectors to see their private bedroom accommodation and they confirmed that the layout of their bedroom space provided them with sufficient personal space for the clothing and personal items. They acknowledged that the staff members kept the bedrooms neat, tidy and clean.

The inspectors saw that residents enjoyed group and one-to-one activities during the day of the inspection. The inspectors saw that there were close links between the designated centre and the local community with a local musician entertaining residents in the afternoon.

Capacity and capability

This was a short notice announced inspection to inform a registration decision in relation to an increase in the footprint of the centre following the building of a new 14 bed dementia unit adjacent to the current premises.

The provider had previously submitted an application to register the designated centre and this information was reviewed by the inspectors prior to the inspection. The inspectors found that the application did not reflect the current use of the building as the staff rooms and storage areas on the first floor of the building were not included in the plans submitted to the Chief Inspector. In addition the Statement of Purpose did not reflect the current premises as used by residents, staff and visitors.

There was a clear management structure in place. The person in charge was an experienced registered nurse who provided direction and leadership for staff. She was supported in her role by the Director of Nursing for the St Joseph's campus. The Administrator and the Director of Nursing were the persons who oversaw the project to build the new dementia unit. The registered provider was on site regularly and was up to date in relation to complaints and incidents that had occurred in the designated centre and how these had been managed.

The inspectors reviewed a range of management documents and found that overall the centre was well managed for the benefit of the residents and staff who lived and worked there. However management oversight of the premises including maintenance and fire safety arrangements required significant improvement in order to bring the designated centre into regulatory compliance with Regulation 28 Fire Safety and Regulation 26 Risk Management. For example, the first floor of the building which was not highlighted as part of the designated centre was used to store a variety of new and obsolete equipment and furniture as well as a staff changing area and rest room. The area was untidy with large items of furniture and equipment stored along the corridor. Staff changing rooms were not kept tidy and this part of the building was not included in the daily fire checks carried out by the nurse in charge or her deputy. Inspectors also found that a fire door into the main function room on the ground floor, which was part of the designated centre, failed to close when the fire alarm was activated. This had not been picked up on the weekly fire checks which had been carried out in the building. There were a number of residents in the function room on the morning of the inspection who would have been at risk of fire and smoke inhalation in the event of a fire in this part of the building. The fire door was repaired at the time of the inspection and was in working order before the inspectors left the building.

There was a range of audits and quality assurance checks in place including the nursing metrics for key clinical areas such as pressure sore prevention, nutrition and falls management. Audit results were communicated to the relevant staff however it was not clear that the improvement changes agreed as a result of audit findings were followed up by senior staff.

Overall inspectors found that care and services were well organised and that there were sufficient staff on duty to meet the resident's needs. Staff had access to training and were supported and supervised in their day to day work. Staff worked well together as a team and demonstrated cooperation and flexibility with each other in order to complete their allocated work and to ensure that residents' preferences for care and daily routines were met.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider had submitted an application to register the designated centre to include the new 14 bed dementia unit. This was in order to comply with Condition 8 of the centre's current registration.

Inspectors found that application did not provide full and satisfactory information in relation to the floor plans for the designated centre.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The person in charge (PIC) is a registered nurse with more than ten years experience of caring for older persons in a residential setting. She had a post registration management qualification in health care services. The PIC worked full time in the centre and was well known to residents and staff.

She was available on the day of the inspection and co-operated fully with the process. Inspectors were satisfied that the PIC was engaged in the governance, operational management and administration of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of staff was appropriate to meet the needs of the residents and taking into account the size and layout of the building.

There was a registered nurse on duty at all times.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was available for inspection and was found to be maintained in accordance with the information contained in Schedule 3.

Judgment: Compliant

Regulation 21: Records

The provider had ensured that the records set out in Schedule 2 of the regulations were kept securely in the designated centre and were made available to the inspectors. This was an action from the previous inspection.

Records in relation to residents and staff were stored securely and older records

were archived and kept for the required period of time.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had appropriate insurance in place which covered against injury to residents and loss or damage to a resident's property or belongings. Information in relation to the insurance was available to residents and/or their families.

Judgment: Compliant

Regulation 23: Governance and management

There were sufficient resources available to ensure that care and services were delivered in accordance with the statement of purpose.

There was a clearly defined management structure in place which identified the roles and responsibilities and lines of authority and accountability for most areas of care and provision. However the reporting structures in relation to maintenance and in particular the maintenance of fire safety equipment and storage areas required review and clarification.

There were clear management systems in place to ensure that care and services were effectively monitored. Staff were supervised in their work and were clear about their roles and responsibilities. Where staff under performance was found this was addressed through the centre's performance management processes. A review of incidents and complaints showed that where learning and improvements were required this was communicated to the relevant staff. However, inspectors found that the oversight of maintenance services and staff training required significant improvements. In addition, the inspectors identified a number of risks in relation to fire safety, moving and handling and the management of volunteers in the designated centre that had not been adequately addressed by the management team. This is discussed under Regulation 26.

There was an annual review of the quality and care of services. The review included a resident questionnaire and feedback from the resident's forum meetings.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

Prior to the inspection the written statement of purpose had been submitted to the Chief Inspector, however, inspectors found on inspection that it did not fully reflect the designated centre. This particularly related to the pharmacy services, smoking facilities and the usage of bedrooms 105 and 106.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

There was evidence that policies and procedures in accordance with the matters set out in schedule 5 were prepared in writing, adopted and implemented.

Judgment: Compliant

Quality and safety

Residents were well looked after and enjoyed a good standard of evidence based nursing care and access to a wide range of health and social care specialists to meet their on-going needs. Although there had been a number of staff changes during 2019 inspectors found that there was a well-established core staff team who knew the residents well and who were familiar with the residents' preferences for care and support. As a result care and services were person centred. This inspection found that some improvements were required in relation to the management of restraints in the designated centre and significant improvements were required in the management of risks and fire safety procedures in order to bring the centre into compliance with Regulations 26 and 28.

A review of resident's records showed that each resident had a comprehensive assessment of their needs prior to their admission to the designated centre. This helped to ensure that the centre would be able to meet the residents' needs and that they were involved in the decision about their admission. Assessment information was used to develop a care plan with the resident and/or their family.

Overall care plans were found to reflect the residents' current needs and provided sufficient information for staff caring for the resident to ensure that they were informed about the resident's needs, their self-care abilities and their preferences for care and daily routines. Residents had good access to a range of health and social care agencies and specialists such as dietitian, physiotherapy, occupational therapy

and speech and language therapy (SALT). Records showed that appropriate referrals were made to these services and that residents were seen promptly. Where a specialist practitioner recommended an intervention this was implemented by nursing and care staff and was followed up by the specialist practitioner.

Residents saw their general practitioner (GP) regularly and where a specialist medical opinion was required this was arranged. Those residents who were eligible for the national health screening programmes were supported to access these services. Health promotion programmes such as flu vaccinations and falls prevention were also available and were accessed by residents.

There were policies in place for managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Inspectors saw that assessments had been completed and possible triggers and appropriate interventions were recorded in the residents' care plans. Staff knew the residents well and were familiar with how to support the resident if they became agitated or displayed responsive behaviours. Staff were observed offering discreet encouragement and support for residents at these times. As a result there were low levels of responsive behaviours in the centre.

The records showed that where a restraint such as bed rails or alarm mats were in use that appropriate assessment and decision making processes had been discussed with the resident and where appropriate their family. However some improvements were required to ensure that where a decision to use a restraint was made the decision was reviewed regularly and that the equipment was used for the least possible time.

There was a comprehensive range of health and safety policies and procedures in place. Staff had access to training in key areas such as fire safety, infection control and moving and handling. Improvements were required to ensure that all staff were up to date with their training in these areas. In addition not all risks were included in the risk register and managed effectively.

In addition significant improvements were required to bring the centre into compliance with Regulation 28 to ensure that residents and staff were kept safe in the event of a fire emergency. Some staff who spoke with the inspectors were not clear about the procedure to follow in the event of a fire. In addition the current fire procedure was not clear for staff and required review. As discussed earlier in the report improvements were also required in the management and oversight of fire safety processes such as daily checks of the premises and weekly checks of the fire doors. One fire door in the main function room did not close when the fire alarm was activated during the inspection. This was resolved before the end of the inspection.

The premises had benefited from an extensive refurbishment programme and a new build. The current premises provided accommodation for 50 residents in spacious well-appointed bedrooms. Most bedrooms had en-suite shower facilities and the 2 bedrooms without en-suite facilities were located close to a communal shower room.

All bedrooms were furnished with a specialist profiling bed, fitted wardrobe and drawers, a lockable bedside cabinet and a comfortable chair. Bedrooms were nicely decorated and residents were encouraged to personalise their rooms with photographs and artefacts from home. Residents told the inspectors that their bedrooms were comfortable and that they were very satisfied with their personal space.

Each of the three units had a number of communal rooms which included lounges and dining rooms and some quiet seating areas along corridors. This helped to ensure that residents had a choice about where to spend their time during the day and ensured that communal areas did not become too crowded or noisy for residents.

One area of the premises had not been refurbished at the time of the inspection. There was a plan in place to refurbish this area once the new Butterstream Unit had been completed. The visitors toilets in this part of the building were not easily accessible and did not support good infection control practices. This area also included the main kitchen, storage rooms, staff canteen facilities, the chapel and the main function room for the designated centre. The main function room was well used by residents on the day of the inspection. They enjoyed arts and crafts and music sessions throughout the day. Inspectors noted that the room had access to an enclosed garden area however the door to the garden which had previously been a fire escape was now decommissioned as a fire exit and was blocked off as it needed to be replaced. As a result staff could not open the door and residents did not have access to the garden and fresh air from this room and would need to travel some distance into Camillus or Butterstream units in order to access the garden.

The newly built dementia Butterstream unit had recently been completed. It was very well designed and laid out to meet the needs of residents with dementia. The new unit was spacious and bright with good use of colour and signage to support residents to mobilise and orientate themselves to their surroundings. There were a range of therapy rooms including a sensory room, pet and doll therapy room and beauty and spa room. Therapy rooms were well equipped and provided a comfortable safe space for residents to explore new activities and therapies to support them in their day to day routines.

Outside spaces included an enclosed sensory garden and Patrick Street. Both areas were accessible for residents, visible to staff from a number of points within the building and were secure. As a result residents could enjoy independent access to a stimulating and safe outside space.

Regulation 17: Premises

Inspectors found that the premises of the designated centre which have been newly refurbished were appropriate to the number and the needs of residents. Bedroom and communal accommodation was spacious and furnished and fitted out to a high

standard.

One area of the designated centre has not been refurbished and does not conform to the matters set out in schedule 6 of the regulation. The particular corridor includes the visitors' toilets, catering facilities, chapel and an activities room with blocked access to outdoor space.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The management of medicines was satisfactory.

Inspectors found that staff had safe procedures in place to guide their practice in relation to medicines management. The nurses on duty were well informed about the procedures and their descriptions of how medicines were prescribed, stored, administered and reviewed reflected safe appropriate standards.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Adequate arrangements were in place to assess residents' needs and treatment plans were described in individual care plans which were formerly reviewed.

Judgment: Compliant

Regulation 6: Health care

Appropriate medical and health care was provided.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff had participated in training to update their knowledge and skills appropriate to their role, to respond to and manage behaviours that are responsive.

A culture of promoting a restraint free environment was in place. Thirteen residents were using bed rails and a resident was using a wandering alert. Some improvements were required to ensure that where a decision to use a restraint was made the decision was reviewed regularly, information was recorded accurately showing the alternatives trialled and ensuring that the equipment used was the least restrictive and for the shortest duration.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were consulted with and had opportunities to participate in the organisation of the centre.

The majority of residents were encouraged to participate in the social and recreational programme and were seen to be engaged in group activities or individual activities. Various local community groups visited the centre to entertain residents.

The inspectors heard that residents have the opportunity to exercise their civil and religious rights.

Judgment: Compliant

Regulation 26: Risk management

There was a comprehensive range of health and safety policies and procedures in place, however, the risk register did not fully detail the measures and actions in place to control risks identified during the inspection. For example:

- All staff were not up to date with their training in infection control and moving and handling.
- Inspectors observed one incident where moving and handling practices used to transfer a resident were not in line with safe practices.
- Gardai vetting had not been obtained for 2 volunteers.

Judgment: Not compliant

Regulation 28: Fire precautions

Adequate precautions had not been taken against the risk of fire.

- Management did not have oversight of fire safety processes in place to ensure maintenance of the building fabric/services, particularly, in respect of the first floor premises.
- The decommissioned serving hatch from the main kitchen did not provide effective fire and smoke containment in the event of a fire.
- No simulated night time fire drill had been completed.
- Some staff were not clear about the procedures to follow in the event of an emergency.
- Adequate arrangements for detecting a fire were not evident, as it was found that staff may not be able to identify the specific area where the fire alarm was activated/detected from the daily checks of the premises and weekly checks of the fire doors.

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	
Registration Regulation 4: Application for registration or renewal of registration	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Compliant
Regulation 26: Risk management	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for St Joseph's Community Nursing Unit OSV-0000542

Inspection ID: MON-0027618

Date of inspection: 02/10/2019

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
Registration Regulation 4: Application for registration or renewal of registration	Substantially Compliant
<p>Outline how you are going to come into compliance with Registration Regulation 4: Application for registration or renewal of registration:</p> <p>The registered provider acknowledges the findings. The floor plans and statement of purpose have been reviewed and revised to provide full information in relation to the designated centre as required to comply with condition 8. An electronic copy of same was emailed to HIQA on 4/10/19 & hardcopies posted on 7/10/19.</p> <p>Completed in full.</p>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>We accept the findings.</p> <p>The daily fire & safety checklist for the units have been reviewed and revised. Frequency of checks has been increased to twice daily from 8/10/19 – after morning handover and after night handover. A daily fire & safety checklist for all rooms and corridor on the first floor has also been put in place from 8/10/19. Any issues identified through these checks will be addressed immediately with the centre's maintenance team or with Masterfire. The weekly checks on the fire register are conducted by the safety rep and overseen by the person in charge – any issues of concern noted are documented and actioned immediately.</p> <p>A review of the PEEP (Personal Emergency Evacuation Procedure) for each resident was</p>	

completed and revised to ensure accuracy and clarity for staff in the event of an evacuation. This document will be reviewed daily and kept live as a working document. The centre's fire policy was reviewed and revised and disseminated to staff on 11/10/19 and is available in the Schedule 5 policy folders in the Centre.
Completed and Checks ongoing as of 11/10/19.

A risk assessment was completed in relation to the first floor and the maintenance of the storage areas therein. A full declutter and clear out has now been completed. An itinerary of items remaining in storage is in place and monitored. A weekly cleaning schedule has also been put in place. Going forward, only a small stock of surplus equipment and furniture will be stored on site – should additional items be required, they will be sourced through the HSE central store in Tullamore. The daily fire & safety checklist for the units also identifies inappropriate storage of equipment and items and if found will be addressed immediately.
Completed and ongoing as of 16/10/19.

The training records and training dates to date have been reviewed by the PIC. It was identified that the colour coded system on the training records document being used to highlight staff who had completed, were due or overdue training was incorrectly applied, when cross referenced with the actual training dates. The record has now been updated. The Person In Charge will review the records on a monthly basis and staff identified as approaching their refresher due date (12 months or 24 months) will be issued with a reminder letter, that they must attend. Staff who do not attend their refresher mandatory training within the 12/24 month timeframe, will not be allowed to work until training is completed.
Completed and ongoing as of 11/10/19.

Regulation 3: Statement of purpose	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose has been reviewed and revised to reflect the changes required, specifically relating to pharmacy services, smoking facilities and the usage of bedrooms 105 & 106. An electronic copy of same was emailed to HIQA on 4/10/19.
Completed in full.

Regulation 17: Premises	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:

The public toilets were decommissioned on the date of the inspection (2/10/19). Funding has now been secured to renovate and upgrade these toilets with the contractor commencing on 21/10/19 with expected completion by 30th November and recommissioning thereafter.
 Timescale – by 30th November 2019.

Plans are in place for the renovation and upgrade of the area from the main front door down to the chapel (Phase 5b Future Visioning Project). Management will liaise with HSE Estates to secure minor capital funding over the coming years to complete this project on a phased basis.
 Timescale By end 2022.

Funding for additional works to upgrade fire doors on the main corridor has been secured and will be completed over the coming months.
 Timescale – by 31st December 2019.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
 On the date of inspection, one resident was wearing an anti-wander system wristband. This resident’s care plan has now been reviewed and the wristband has been removed on a trial basis. Going forward, any resident at risk of wandering and wearing a wristband will be reviewed on a weekly basis to ensure this restraint is used for the shortest time possible and only as a last resort.
 Completed in full as of 9/10/19.

A restraint log is kept live and records all forms of restraint in use in the centre and is held in the Person In Charge’s office and reviewed by her on a monthly basis. Bedrail usage is kept under review by the Person in Charge on a monthly basis also and alternatives are always trialed prior to putting a bed rail in place.
 Ongoing as of 9/10/19.

Regulation 26: Risk management	Not Compliant
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Outline how you are going to come into compliance with Regulation 26: Risk management:
 The training records and training dates to date have been reviewed by the Person In

Charge. It was identified that the colour coded system on the training records document being used to highlight staff who had completed, were due or overdue training was incorrectly applied, when cross referenced with the actual training dates. The record has now been updated. The Person In Charge will review the records on a monthly basis and staff indentified as approaching their refresher due date (12 months or 24 months) will be issued with a reminder letter that they must attend. Staff who do not attend their refresher mandatory training will not be allowed to work until training is completed. All staff have completed their infection control/hand hygiene training. A schedule is in place for the remainder of the year for manual handling training and any staff outstanding for refresher training will attend.

Completed and ongoing as of 11/10/19.

Moving & Handling – Since the Inspection a resident’s seating has since been reviewed by the Occupational Therapist and while the chair is suitable, the resident needs to be positioned correctly in the chair. All staff have been advised of this by the Occupational Therapist and are clear in relation to her positioning. Resident’s care plan has been updated to reflect same in line with safe practices.

Completed.

Garda Vetting – Volunteers identified on the day as not having garda disclosures in place are now going through the process and will not be in the centre until this is completed. Going forward, no volunteers will be allowed into the centre without a garda disclosure in place. The Person In Charge will ensure this is monitored.

Expected for the two outstanding to be completed by 31st December 2019. Ongoing.

Restraint - Regarding restraint and the use of an anti-wander system wristband. This resident’s care plan has now been reviewed and the wristband has been removed on a trial basis. Going forward, any resident at risk of wandering and wearing a wristband will be reviewed on a weekly basis to ensure this restraint is used for the shortest time possible and only as a last resort.

Completed in full as of 9/10/19.

Management of Risk -

The daily fire & safety checklist for the units has been reviewed and revised. Frequency of checks has been increased to twice daily from 8/10/19 – after morning handover and after night handover. A daily fire & safety checklist for all rooms and corridor on the first floor has also been put in place from 8/10/19. Any issues identified through these checks will be addressed immediately by the staff member, with the centre’s maintenance team or with Masterfire, as appropriate. The weekly checks on the fire register are conducted by the onsite safety representative and overseen by the Person in Charge – any issues of concern noted are documented and actioned immediately. The safety representative is also now conducting a monthly check of the fire safety equipment, specifically the ski sleds and this is being recorded appropriately.

A review of the PEEP (Personal Emergency Evacuation Procedure) for each resident was completed on 4/10/19 and revised to ensure accuracy and clarity for staff in the event of an evacuation. This document will be reviewed daily and kept live as a working document.

The centre's fire policy was reviewed and revised and disseminated to staff on 11/10/19 and is available in the Schedule 5 policy folders in the centre. Staff are now clear that all fire panels in the centre are the same following recent upgrades to the system. Completed and Checks ongoing as of 11/10/19.

The Person in Charge and Administrator conduct quarterly safety walkabout's of the centre both internally and externally, with an action plan to managers and staff and discussion at both the management team & staff meetings. Completed and Ongoing as of 11/10/19.

The risk register for the centre is reviewed quarterly at the management team meeting or sooner if there is a serious incident. The risk assessments are live documents which are reviewed annually or sooner if required. Quality and risk is a standing agenda item at both the monthly management team and staff team meetings. A memo was issued to all staff on 14/10/19 reiterating their responsibilities in terms of safety and risk and that all issues are to be addressed immediately or referred to the appropriate manager to deal with. Specific risk assessments in relation to the lift and the fire controls in the areas around the main function room & main kitchen have been completed and additional controls put in place as of 3/10/19. Completed and Ongoing.

A keypad/fob access control pad will be put in place on the lift to ensure no unrestricted access.

Timescale – to be completed week ending 25/10/19.

Serving shutter in main kitchen has been completed sealed up and is no longer a fire risk as of 12/10/19. Declaration of compliance from Masterfire emailed to HIQA on 15/10/19.

Fire shutter protection outside the sliding door of main kitchen was tested on 2/10/19 in the presence of the HIQA inspector and was fully operational. Masterfire have confirmed in writing that it is tested as part of their service contract which was forwarded to HIQA 15/10/19.

Certification for the shutter was emailed to HIQA on 11/10/19.

Completed.

In light of completion of the above actions, the HSE fire officer is satisfied that an additional fire exit from the main function room is not required and it would not be best practice to evacuate residents into an enclosed external space. Written confirmation of same was emailed to HIQA on 17/10/19.

Residents currently have access to the enclosed central garden through four other areas, all within easy access and close proximity of residents living areas.

Completed in full as of 17/10/19

HSE Estates have engaged an external service to review and update the current evacuation plans displayed in the units with a more comprehensive easily identifiable plan with clearly marked room numbers and fire zones to ensure staff are aware of the procedure. This will be further highlighted to staff during future mock evacuations.

Timeframe – Plans to be completed and displayed by 8th November 2019.

A fire safety risk assessment for the centre was carried out in 2012 by an external fire consultant and a compliance report issued. Fire compliance reports for each phase of renovation works within the centre are in place. This documentation was provided to HIQA on the day of inspection.

Further to this, HSE Estates are currently in the process of engaging an external fire consultant to carry out an up to date fire safety assessment for the centre as a whole. This will be submitted to HIQA when completed.

Timescale – to be completed and returned to HIQA by 15th November 2019.

Funding for additional works to upgrade fire doors on the main corridor has been secured and will be completed over the coming months.

Timescale – by 31st December 2019.

Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Management of risk -

The daily fire & safety checklist for the units have been reviewed and revised. Frequency of checks has been increased to twice daily from 8/10/19 – after morning handover and after night handover. A daily fire & safety checklist for all rooms and corridor on the first floor has also been put in place from 8/10/19. Any issues identified through these checks will be addressed immediately by the staff member themselves, with the centre’s maintenance team or with Masterfire, as appropriate. The weekly checks on the fire register are conducted by the onsite safety representative and overseen by the Person in Charge – any issues of concern noted are documented and actioned immediately.

Completed and Ongoing.

A risk assessment was completed in relation to the first floor and the maintenance of the storage areas therein. A full declutter and clear out has now been completed. An itinerary of items remaining in storage is now in place and monitored. A weekly cleaning schedule has also been put in place. Going forward, only a small stock of surplus equipment and furniture will be stored on site – should additional items be required, they will be sourced through the HSE central store in Tullamore. The daily fire & safety checklist for the units also identifies inappropriate storage of equipment and items and if anything noted, it will be addressed immediately.

Completed and ongoing as of 16/10/19.

Serving shutter in main kitchen has been completed sealed up and is no longer a fire risk as of 12/10/19. Declaration of compliance from Masterfire emailed to HIQA on 15/10/19. Completed on 12/10/19.

A simulated night duty fire drill was conducted on 4/10/19 and specifically focused on the evacuation of the bariatric residents. Documentary evidence in relation to same was submitted to HIQA on 4/10/19. Going forward a simulated night duty fire drill will be

carried out on an annual basis in conjunction with the Bi-monthly scheduled mock evacuation programme carried out by the centre's safety representative who also works for the fire service.

Completed as of 4/10/19 and ongoing.

A review of the PEEP (Personal Emergency Evacuation Procedure) for each resident was completed and revised to ensure accuracy and clarity for staff in the event of an evacuation. This document will be reviewed daily and kept live as a working document.

Completed as of 4/10/19 and ongoing.

An annual fire training schedule is in place. The centre's fire policy was reviewed and revised and disseminated to staff on 11/10/19 and is available in the Schedule 5 policy folders in the centre. Staff are now clear as per the fire policy, that all fire panels in the centre are the same and perform the same function, following recent upgrades to the system. All staff are required to sign a 'read & understood' checklist for the revised fire policy.

Completed and Checks ongoing as of 11/10/19.

HSE Estates have engaged an external service to review and update the current evacuation plans displayed in the units with a more comprehensive easily identifiable plan with clearly marked room numbers and fire zones to ensure staff are aware of the procedure. This will be further highlighted to staff during future mock evacuations.

Timeframe – Plans to be completed and displayed by 8th November 2019.

A fire safety risk assessment for the centre was carried out in 2012 by an external fire consultant and a compliance report issued. Fire compliance reports for each phase of renovation works within the centre are in place. This documentation was provided to HIQA on the day of inspection.

Further to this, HSE Estates are currently in the process of engaging an external fire consultant to carry out an up to date fire safety assessment for the centre as a whole. This will be submitted to HIQA when completed.

Timescale – to be completed and returned to HIQA by 15th November 2019.

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
Registration Regulation 4 (1)	A person seeking to register or renew the registration of a designated centre for older people, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Substantially Compliant	Yellow	04/10/2019
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		31/12/2021
Regulation 23(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	16/10/2019

	place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	15/11/2019
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	15/11/2019
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	16/10/2019
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency	Not Compliant	Orange	15/11/2019

	procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
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.	Not Compliant	Orange	11/10/2019
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	16/10/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned	Substantially Compliant	Yellow	04/10/2019

	and containing the information set out in Schedule 1.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant		09/10/2019