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:	Ramelton Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Ramelton, Letterkenny, Donegal
Type of inspection:	Unannounced
Date of inspection:	29 July 2021
Centre ID:	OSV-0000615
Fieldwork ID:	MON-0033727

About the designated centre

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

Ramelton Community Hospital is a designated centre registered to provide health and social care to 30 male and female residents primarily over the age of 65. It is a single storey building a short drive from the shops and business premises in the town. Accommodation for residents is provided in single and double rooms and there are several communal areas where residents can spend time during the day.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	22

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 29 July 2021	10:00hrs to 18:20hrs	Ann Wallace	Lead
Thursday 29 July 2021	10:00hrs to 18:20hrs	Nikhil Sureshkumar	Support

What residents told us and what inspectors observed

The designated centre provided a valued care service for the local community. Residents and families told the inspectors how much they valued the short term care and respite facilities that were provided by staff working in the centre. Residents reported that they were well looked after and that they felt safe. The inspectors observed that staff worked flexibly to ensure that resident's needs were being met however there was very little in the way of activities happening for the residents and some residents said that there was not enough to do and that they would like to get out into the local community more often.

Inspectors spoke with a number of residents and families during the inspection. Feedback was positive and residents were happy with the care and attention they received in the centre. Residents were complimentary about the food served in the centre, and they spoke highly about the staff and the care and services provided for them in the designated centre.

Since the last inspection in April 2019 the provider had made a number of structural improvements to the designated centre to provide additional shower facilities and communal spaces for the residents. The provider had also improved the two internal courtyard gardens which were nicely set out for the residents on the day of the inspection. However the inspectors found that the centre required significant repairs and refurbishment in a number of areas and as a result the provider remained non compliant in relation to premises on this inspection. The community hospital had until recently provided day care services for the local community. Following the last inspection the provider had been required to make changes to the entrance and exit doors to the designated centre in order to ensure that those people who were attending day care did not use the communal facilities in the designated centre. This work had been completed and inspectors found that there was now a clear separation between the two services.

The designated centre is accessed through the main door of the hospital complex. All resident areas are on the ground floor and there are staff changing rooms and storage facilities on the first floor. The day hospital services are also located on the ground floor but there is a secure door separating them from the designated centre. there were no day care services being provided at the time of the inspection. There were 22 residents accommodated in the centre on the day of the inspection of which 12 residents were accommodated for long stay. Residents were accommodated in a mixture of single and twin bedrooms. The single rooms were small and the layout of these rooms was not suitable for high dependent residents who would need access to a hoist or large items of equipment. Five bedrooms had en-suite shower facilities. The provider had recently installed four additional communal shower rooms which were well laid out and accessible for those residents who did not have access to en-suite facilities. Residents and staff told the inspectors how much they appreciated the installation of the new shower facilities and the

clean and comfortable environment they could now enjoy when taking a shower.

There were a range of communal areas including a dining room, a lounge, two seating areas and a small conservatory area in the newly built link corridor. The seating in this area overlooked the newly created courtyard garden areas and was very popular with the residents who were seen sitting and chatting together during the afternoon. Residents said that they enjoyed the light open aspect overlooking the garden. Access to the garden was unrestricted and there was comfortable seating for the residents if they wished to sit outside. Residents told the inspectors they had recently enjoyed an afternoon tea in the garden. The dining room was small and although nicely laid out would only accommodate ten residents at one sitting. The room is open to the kitchen and this created a lot of noise which made it difficult to chat over lunch.

The inspectors spoke with a number of residents at lunch time who said that they were quite happy to have their lunch in one of the sitting rooms. Staff laid trays and tables for these residents who seemed to be quite content. Staff offered discreet encouragement and support those residents who were not able to eat independently. Residents said that they enjoyed their meals and that the food was good. Residents were offered a choice of two options at lunch time. Those residents who had special dietary needs were also catered for.

On the day of the inspection the inspectors met with a number of visitors. Visitors were made welcome in the centre and staff ensured that visiting was done safely and in line with the current guidance. During the day inspectors observed visitors using the visitor's room and visiting in the residents' bedrooms. Staff were careful to ensure that residents could meet with their visitors in private and that visiting was not overly restricted. Residents were also facilitated to use face time and mobile phones to keep in touch with their families and friends who were not able to visit in person. Throughout the day inspectors observed staff sharing local news and items of interest with the residents in order to help them stay in touch with their community. Families were also being encouraged to take the residents out into the community and to places of interest. Residents told the inspectors how relieved they were that their families and friends could now start coming to take them out. One resident described how lonely they had felt during the long months of restrictions when they could not see their family who they were dependent on for trips out of the centre.

Residents were observed mobilising around the centre throughout the day of the inspection. Those residents who spent most of their day in their rooms told the inspectors that was their choice and that they had a comfortable room and every thing they needed around them. The inspectors observed that some of the more dependent residents spent their day in bed. However from talking with staff and reviewing the daily records it was evident that these residents spent most days up and about in their specialist chairs either in their bedrooms or in one of the communal lounges. Staff were familiar with these residents and whenever possible staff were seen to take the opportunity to spend short periods of time with these residents who were often non verbal and unable to communicate their needs and wants. These staff demonstrated good skills in their interactions with the residents

using non verbal communication techniques to let the resident know that they were present with them. However these interludes were often brief and the residents spent long periods without any form of social interaction or stimulation.

Residents who spoke with the inspectors reported high levels of satisfaction with the staff who cared for them. The staff are " magnificent " one resident said. Another resident told the inspectors how well they had progressed following a recent surgical procedure and was very grateful to the staff who had helped them to mobilise and regain their confidence after the surgery. This resident was looking forward to going home the following week. The inspectors observed that staff and resident interactions were respectful and kind and it was evident that residents felt able to talk to staff if they had any concerns. Although staff were busy they took the time to talk with the residents and made sure to answer call bells promptly. This was verified by what the residents told the inspectors that they did not have to wait if they needed help and that staff answered their call bells without delay.

Capacity and capability

Although the provider had made a number of improvements since the last inspection in April 2019 the inspectors found that significant focus and resources were now required to bring the designated centre into compliance with the regulations and to ensure that residents received a safe and appropriate service in line with their assessed needs. Significant non compliances were found on this inspection including repeated non-compliance in Regulation 17 premises.

The provider is the Health Service Executive and the provider representative is part of the senior management team in Community Health Organisation 1(CHO1). The centre has a restrictive condition in place which required the provider to reconfigure the physical environment in the designated centre as outlined in the plans submitted to the Chief Inspector on 24th December 2019 in relation to segregation of the day hospital from the designated centre and the provision of additional toilets and shower facilities. The reconfiguration was to be completed by 31 March 2021. The inspectors found that the provider was compliant with the condition and that the required works had been completed.

There was a clearly defined management structure in place with lines of authority and accountability. The person in charge had responsibility for the day to day running of the centre. The person in charge also had responsibility for the day hospital that shared the same campus however there were no day services running at the time of the inspection.The person in charge met regularly with the registered provider and compiled weekly and monthly management reports which were submitted to the provider. These included risks and incidents, complaints and occupancy levels. Workforce planning was also discussed at these meetings. However inspectors found that although key issues such as staffing vacancies and the very urgent repair and refurbishment of some of the original premises had been

highlighted by staff working in the centre these issues had not been progressed by the provider.

There was a quality assurance system in place in the centre. This included nursing metrics for monitoring of key clinical areas. Inspectors reviewed the quality assurance processes that were in place including a number of audits completed in 2020 and 2021. The oversight in a number of areas was not robust including the oversight of medication practices, fire safety precautions and housekeeping in the centre.

Staff had access to mandatory training and all staff in the centre had attended training in moving and handling, fire safety, safeguarding and infection prevention and control practices. Overall staff were knowledgeable and demonstrated appropriate skills in their day to day work although improvements were required in the administration of medicines and fire evacuation procedures. There was no training matrix in place which meant that the person in charge did not have an overview of staff who required update training and there was no clear plan in place to reschedule training that had been interrupted by COVID-19 and the recent cyber security alert.

On the day of the inspection there were seven staff not available on the roster, including three vacancies and four long term absences. Only one of these posts had been filled and there was no start date available for the new member of staff. The inspectors found that staff worked hard to ensure that resident's physical needs were met however staff had little time to spend with the residents and to ensure that they had access to meaningful activities or were able to go out into the community if they wished to do so.

Regulation 14: Persons in charge

The person in charge was an experienced nurse and had the required experience in the care of older persons.

Judgment: Compliant

Regulation 15: Staffing

There were a number of staff vacancies that had not been filled at the time of the inspection and as a result the inspectors found that there were not always sufficient staff on duty to ensure that care and services were provided in line with the centre's statement of purpose and the assessed needs of the residents.

The deployment of staff across a variety of roles including care, laundry and housekeeping further impacted on the ability of the staff to provide care and support in line with the assessed need of the residents.

In addition the night time staffing levels of two persons on duty between 20.00hours and 08.00hours did not assure the inspectors that all of the residents could be safely evacuated in the event of a fire emergency. This is addressed under Regulation 28

Judgment: Not compliant

Regulation 16: Training and staff development

Training had been interrupted by the COVID-19 restrictions and the recent cyber security alert. As a result staff were not up to date with their training requirements. However inspectors found that there was no clear plan in place to schedule training or to source alternative training where training was not available. For example:

1. Nursing staff had not completed their HSE land annual medication training updates. There was no record of supervised drug rounds or systems to evaluate and support individual nurse's medication training needs. This was a particular concern as this inspection identified a number of non-compliances in medication practices.

Judgment: Substantially compliant

Regulation 22: Insurance

The insurance certificate maintained in the centre was not current. An up to date certificate was submitted to the inspectors following the inspection.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that management reports were not always acted on. For example the person in charge had highlighted two significant risks associated with the poor state of some areas of the premises. No resources had been released to carry out

the repair and refurbishment works highlighted to senior managers.

The monitoring and oversight systems did not ensure that the service was effectively monitored. For example;

- staff who spoke with the inspectors could not identify the system for documentation and management of medication errors. Moreover, the staff were unable to identify any medication audit systems to ensure that medication practices were in line with national standards for medication practices.
- there were two environmental audits carried out in 2021 however these did not ensure that the centre was well maintained and a safe environment for the residents and staff living and working in the centre.
- there was no oversight of cleaning practices in the designated centre.
- staff training was not recorded effectively and as a result managers were not able to assure inspectors that staff were up to date with their training requirements.

Risks were not managed effectively and a number of the risks the inspectors identified on the day of the inspection were not identified by the management team and were not recorded in the centre's risk register. As a result there no effective action plans or controls to manage the risks. For example:

- seven oxygen cylinders were stored on the ground in the treatment room on the inspection day. These were not all required at the time of the inspection and posed a risk as they were not stored securely.
- fire stopping along ceilings and walls had not been appropriately resealed following the recent refurbishment works and there were numerous holes on walls and in the suspended ceilings throughout the building which could lead to smoke or fire spreading from one compartment to another. This is addressed under Regulation 28.
- water leakage from a damaged roof had caused damage to plaster along the walls in a number of areas some of which were close to electrical sockets and switches.

A copy of the annual report for 2020 was not made available to residents in the designated centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

There was an up to date statement of purpose which met the requirements of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure directed the resident or family member to refer to the 'your service your say' posters and leaflets available in the centre to read about the complaint procedure in detail. However, inspectors found that this information was not displayed or made available to the residents and their families on the day of the inspection. The person in charge reported that they were misplaced possibly when arranging the COVID-19 signage.

Verbal complaints were not recorded in the centre. Staff informed the inspectors that these complaints were dealt with at the time and were not recorded or used to identify areas for improvement

Judgment: Substantially compliant

Quality and safety

Care was provided by a well established staff team who worked well together to create a calm and welcoming atmosphere for the residents in spite of the challenges posed by the poor environment in which they worked. Although the provider had completed the works to install additional shower facilities and the new link corridor significant resources were now required to improve the rest of the building and to ensure that the building was compliant with the fire safety regulations.

The residents reported high levels of satisfaction with the newly refurbished areas of the centre and the courtyard gardens. However the original premises was in a very poor state of repair and was not a comfortable and safe environment for the residents and staff who lived and worked in the centre. In addition a number of the single bedrooms were small and the layout of these rooms did not allow for the use of large items of equipment or enable the resident to bring in their own items of furniture to personalise their space.

The general lack of storage in the building meant that items were stored inappropriately in a number of rooms including the oratory and residents' bathrooms. This created a general sense of clutter and untidiness and made some areas difficult to keep clean and dust free.

Staff and resident interactions were respectful and empathetic. Staff addressed the residents by their preferred name or title and were courteous when they approached residents to offer care and support. Residents who were non verbal appeared relaxed with the staff who were caring for them and did not show any signs of

anxiety of distress. Staff who spoke with the inspectors were clear about their responsibility to keep residents safe and to report any concerns that they may have in relation to abuse of the residents.

Staff knew the residents well and were familiar with their routines and preferences for care however inspectors found that care practices were largely task orientated and staff did not spend time with the residents except when care was being given. Residents spent their days in a variety of areas and made good use of he communal dining and seating areas. Residents were sat chatting with each other or quietly reading or listening to the radio but there was little in the way of organised activities going on during the day.

There was a calm atmosphere and residents did not exhibit high levels of responsive behaviours. Staff responded promptly when one resident became agitated. A member of staff sat with the resident to offer them a cup of tea in order to calm and distract them from their anxiety. There were seven residents using bed rails and one resident using a lap belt when mobilising in their wheel chair. The inspectors reviewed the records for those residents who had bed rails in place and found that not enough information was provided in relation to alternatives discussed and offered to the resident before the bed rails were installed as set out in the national guidance towards a restraint free environment.

Residents had a pre-admission assessment prior to their admission to ensure that the centre was able to meet their needs. However improvements were required to ensure that ongoing assessments and care plans were kept up to date and reflected the residents' .current needs. Overall the inspectors found that the resident's health care needs were being met and that residents had access to their general practitioner and to specialist services such as physiotherapy and dietitian.

Regulation 11: Visits

Visiting arrangements in the designated centre were in line with the national guidance at the time (Health Protection and Surveillance Centre COVID-19 Guidance on visits to Long Term Residential Care Facilities) and local public health restrictions.

Residents were able to meet with their visitors in private.

Judgment: Compliant

Regulation 17: Premises

The premises was not appropriate to the number and needs of the residents. For

example:

- the single bedrooms were small and there was not enough room in some bedrooms for the safe manoeuvring of large items of equipment such as hoists and electric wheelchairs. In a number of single rooms there was not enough space for a comfortable chair beside the bed without blocking access either to a wardrobe or the washhand basin.
- room 28 was in urgent need or refurbishment and redecoration. The walls and skirting were marked and damaged. The shelving was broken and one shelf could not be used. The room was small and did not provide sufficient space for the resident who occupied this room to move about with ease using their mobility aids.
- the dining room was open to the kitchen when the serving hatch was raised. As a result there was a lot of kitchen noise at meal times so that residents found it difficult to communicate and chat with each other.

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

- the premises was in a poor state of repair. Damage to walls and ceilings was visible in a number of areas.
- the premises was not clean in a number of areas including the staff changing facilities on the first floor, the store room on the first floor, and the two staff shower rooms.
- the premises was in a poor state of decor except for the newly installed bathrooms and the link corridor.
- the grab rails along one corridor were blocked by clinical equipment which was being stored in the corridor.
- a number of single bedrooms were not of a suitable size and layout for the needs of the residents.
- the dining room did not provide enough seating to accommodate all of the residents who may wish to eat their meals in the dining room.
- there was a lack of storage in the centre and equipment was stored inappropriately in the oratory, in resident bathrooms and along the corridors.

Judgment: Not compliant

Regulation 26: Risk management

There was a comprehensive risk management policy in place. The Risk Management Policy included those areas required under Schedule 5.

Incidents and serious events were reported using the nursing metrics system which included the investigation and learning following an incident.

There was a major incident plan in place including an alternative place of safety for the residents if such an incident occurred.

Judgment: Compliant

Regulation 27: Infection control

The inspectors were not assured that procedures consistent with the standards for infection prevention and control in community services were implemented in a number of areas;

The processes in place for the cleaning and disinfection of the designated centre did not include

- a documented cleaning schedule which identified the frequency of cleaning especially of frequently touched surfaces.
- dedicated time for cleaning requirements
- appropriate arrangements for maintaining and refurbishing the physical environment including surfaces, fixtures and fittings so that these can be easily cleaned and are removed from use when damaged.
- clear system to ensure that single-patient-use equipment such as hoist slings were not re-used by other residents.
- clear system to ensure that communal equipment such as commodes and shower chairs were cleaned and disinfected and labelled clearly when ready for reuse by another resident.

The staff changing facilities on the first floor were visibly dirty and not fit for purpose. This area had not been cleaned and inspectors were informed that there were insufficient housekeeping resources available to clean the two rooms. The shower was broken and out of order. In the female staff changing room belongings were stored on the floor or on hooks on the wall and items were hanging close to each other creating a risk of cross contamination.

The staff changing facilities on the ground floor did not have enough lockers available. The shower was decommissioned some time ago and no alternative shower had been provided in this changing room.

The storage of items of personal protective equipment (PPE) in a room on the first floor was cluttered and disorganised with several boxes opened and items spilling onto the floor. The room was overly full with large boxes of PPE and could not be easily cleaned especially the floor surface. Boxes were not clearly labelled and there was no system of rotation to ensure that the stock did not go out of date.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspectors found that the provider had not taken adequate precautions against the risk of fire in the designated centre:

- The provider had not completed a fire safety risk assessment of the premises following the recent structural changes to install the additional shower rooms and the new link corridor.
- The fire stopping in walls and ceilings had been interrupted following the recent works and previous works that had been carried out. There were gaps and some visible holes in the walls and in the suspended ceilings in several areas of the designated centre that might allow the smoke to travel between compartments in the event of a fire.
- There was visible water damage in close proximity to light switches and electrical sockets along one corridor.
- The fire drills carried out in 2020 and 2021 did not assure the inspectors that staff would be able to evacuate the residents safely in the event of fire emergency. For example fire practice evacuation records showed that four staff required an average of six minutes to evacuate one compartment. In addition the fire drill records did not provide assurance that a simulated night time fire evacuation practice with two staff on duty had been completed in 2020 or 2021.
- There were two staff on between 20.45hrs and 08.15hrs to evacuate all of the residents in the designated centre a number of whom were of high dependency and would require the assistance of two persons to safely evacuate them leaving no staff available to supervise and evacuate the remaining residents.
- Some of the staff who spoke with the inspector were not able to articulate clearly what to do in the event of a fire emergency in the designated centre.
- The fire extinguishers had not been serviced in June 2021 when they were due. This had not been identified on the centre's fire equipment checks.
- The fire door leading into the kitchen from the main corridor was not closing correctly. This had not been identified on the centre's weekly fire door checks.
- There were no fire door between the laundry area and bedrooms 25.26.28 and 29.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medication practices in the designated centre were not in line with the national standards for the safe administration of medications and the centre's own policies and procedures. The oversight of medication practices in the centre did not ensure that medications were administered safely. For example;

- Some prescribed food supplements were stored in unsecured areas.
- A medication no longer required was found to be stored in the medication fridge and not returned to the pharmacy.
- Some laboratory samples were stored with medications and food products in the medication fridge in the treatment room.
- Crushed medications were not recorded in line the centre's own policies and procedures.
- Medications were not always administered in line with the times directed by the prescriber. For example medications for managing symptoms of Parkinson's disease.
- Some medications were administered in the dining room in full view of other residents and staff.
- Where medications were not administered as prescribed, for example where a resident refused to take a medication, this was not clearly documented in the resident's medication record.
- Staff used a pestle and mortar to crush medications. This equipment was not cleaned between residents and there was a risk not only of transmission of infection but also that residue from one medication remained on the equipment and was incorporated into the next resident's medication. This was not in line with the centre's own policy on crushed medications which required these medications to be made available in a specific crushed medications pouch.
- A medication was found left unattended in the bedroom of a resident.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Two care plans reviewed by the inspectors had not been updated to reflect the residents' current needs. For example; one resident who was on a weight reducing diet did not have a clear care plan in place for this and another resident who was at increased risk of skin breaks and developing a pressure sore did not have an appropriate plan of care for this in place.

In addition social care needs were not consistently recorded for all residents in line with their capacity and expressed preferences for social engagement and meaningful activities.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner (GP). Residents were seen by their GP for medical reviews and if their needs changed. However inspectors found an example where significant weight loss had not been reported to the resident's general Practitioner since March 2021.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Following a review of the assessment and care plans for restrictive equipment the inspectors were not assured that all reasonable alternatives were offered and trialled with the residents prior to the implementation of restrictive equipment such as bed rails.

Judgment: Substantially compliant

Regulation 8: Protection

The processes in place for the management of the resident's personal monies placed in safe keeping in the designated centre was not robust and did not ensure that receipts were obtained for all spending against the residents' individual accounts. This had been identified on a recent management audit and the administrative staff were in the process of introducing a new system to bring the process into compliance with the policy and to ensure that residents' personal monies were protected.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The following areas did not ensure that residents' rights were upheld at all times

and that residents were able to influence the service they received;

- One resident who had complex needs had not been facilitated to obtain a multi-disciplinary assessment of those needs to ensure that an appropriate plan was in put into place to enable the resident to maintain their independence and access their local community in line with their preferences.
- the facilities for occupation and meaningful engagement were limited and residents did not have sufficient opportunities to participate in activities in line with their interests and capacities.
- staffing levels did not facilitate residents to go out into their local community to access local services and facilities and events. As a result residents were dependent on their families /friends being available and able to take them out.
- resident meetings were held but the record of the meetings was the same for each meeting and did not include a meaningful account of the resident's contribution to the meeting and any suggestions they made for improvements and change.
- A resident survey had been completed in April/May 2021. Key issues identified by the residents in the survey included; lack of empowerment to influence the service, lack of choice in daily routines and activities. These issues had not been explored or progressed by the provider following the feedback from the residents.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ramelton Community Hospital OSV-0000615

Inspection ID: MON-0033727

Date of inspection: 29/07/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Three Staff now on night duty from 8.45pm-8.15am. Due to be completed by: completed and ongoing. Vacant posts are now in the process of being filled to have sufficient Staff on duty to ensure that care and services are provided in line with the centre's Statement of Purpose and the assessed needs of the Residents. Due to be completed by: 31st October 2021.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: As HSE Land is now restored all Staff which is available to the roster have submitted certificates for all Mandatory Training which was due or overdue Clinical Nurse Manager 2 overseeing this to ensure full compliance. The Activities Person completed the following training since the dementia thematic inspection in 2019; Interactive Workshop on the use of Doll Therapy-03.07.2019 and Understanding, Supporting and Responding to the person living with Dementia- 21.02.2020 to approximately 20 staff by our Advanced Nurse Practitioner in Dementia Care. A Training Matrix has been completed to reflect all Mandatory training	

Due to be completed by:12th September 2021

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Ongoing Staff Meetings are highlighting the system for documentation and management of medication errors. Medication Management is audited through the nursing metrics.

The Clinical Nurse Manager 2 is having regular information sessions with Staff Nurses to include Medication Management and Administration. All Nursing Staff available to the roster have completed the Medication Management module on Hse land. Clinical Nurse Manager 2 monitoring this to ensure compliance.
Environmental Audits are completed on a twice yearly basis by the P.I.C. available and viewed by inspectors on day of inspection.
Cleaning practices are monitored and reviewed by the Clinical Nurse Manager 2 and the P.I.C.
A Training Matrix has been drawn up to record all training for all Staff. The Administration staff will update same.
Oxygen cylinders have now been removed, with one available in the Treatment Room for emergencies. Two additional Oxygen Concentrators have also been purchased.

There is a sign on the door stating Oxygen is stored in the room, this sign has always been displayed on the door.

A copy of the Annual Report for 2020 is available in the CNMII Office on request. This will also now be discussed at the next Residents meeting and meetings thereafter which will be facilitated by the Clinical Nurse Manager 2.
A budget has been secured though the Capital Works Programme for a full refurbishment of Ramelton CH. Due to commence in 2022. The Risk Register has now been updated, a Periodic Inspection Report (PIR) will be completed mid-September 2021

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
"Your Service Your Say" posters have been reinstated to both sitting rooms and at entrances to the Residential Unit.

Verbal complaints are now being recorded at Ward level by Clinical Nurse Managers/Nurse in charge.
A copy of complaints procedure is given to all Residents on admission.
Due to be completed by: Completed and ongoing.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Rm.28 will be painted. Completed 17/09/2021

Shelving in Rm. 28 has been fixed.
The changing facilities and store room upstairs are now added to the cleaning schedule for regular cleaning.
The upstairs Staff shower is fixed – completed 31/08/2021
The grab rails are no longer blocked by clinical equipment.
If required the former Day Hospital room can be used to facilitate Residents at mealtimes.
Signs have been erected on the Oratory Door and in Resident bathrooms stating no equipment is to be stored in any of these areas.

Due to be completed by: Completed and ongoing.

A programme of works will be drawn up to address the required upgrade within the Hospital, to include reconfiguration of the single rooms and redecoration works will commence in 2022 with budget secured for same.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
One extra Staff member on night duty will assume responsibility for extra cleaning of frequently touched surfaces and document same.
All Residents have their own hoist sling which are not used for any other Residents.
Commodes and shower chairs are now being clearly labeled following cleaning and disinfecting.
Staff changing facilities on the first floor are now added to the cleaning schedule.
Lockers are on order (delivery due second week of September) for these changing rooms.

Shower has now been fixed in first floor changing facility as of 31/08/2021.
The shower in Staff changing facilities on ground floor was decommissioned several years ago as no Staff used it.
Cluttered storage of PPE in an upstairs room has been organized and the room is added to the cleaning schedule.

Due to be completed by: Completed and ongoing.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The recent works in Ramelton were carried out as part of the emergency COVID works and so were temporarily exempted from applicable statutory requirements, i.e. planning, fire safety certificate and DAC. However these areas have been assessed as part of the latest fire risk assessment and will also in due course be regularized in accordance with the building regulations.
A fire stopping company spent 3 days in the unit (12th 13th 14th August) repairing unprotected service penetrations and any other fire stopping that was required. The same company is due back to the unit in the coming weeks to review all service penetrations following the recent and ongoing works.

An electrician is always contacted to call and check electrics following any water leaks. A P.I.R. is to be completed by mid-September 2021.

Night time Staffing numbers are used when fire drills are carried out- three Staff do the evacuation and two Staff are evacuated on mattresses/wheelchairs. There have been a programme of evacuation drills completed since the inspection and ongoing every week. Three Staff are now on duty from 8.45pm-8.15am.

Admissions to Ramelton CH have been restricted to further mitigate the risk since the inspection date.

Five to six Residents accommodated in each compartment to ensure safe evacuation in the event of a fire.

All Staff have received mandatory fire training.

Fire extinguishers were serviced on 3rd August 2021. An earlier service had to be deferred due to a COVID situation

All fire doors have now been checked and are all closing properly.

The laundry room was separated from said bedrooms by means of a 30 minute fire door (which was installed as part of the 2014 works.) which would have sufficient. The

laundry service has been outsourced and will not come back to the centre until the laundry room is fitted with both a 60 minute fire door and a new 60 minute fire rated ceiling, this will be sufficient at that time.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A key pad will be installed on the door where prescribed food supplements are stored.
Checks for medications which are no longer required have been added to the checklist completed by night Staff.
Laboratory samples will not be stored in the same fridge as medications.
Crushed medications are now recorded in line with policies and procedures.
All Residents have their own tablet crusher The pestle and mortar has been removed.
CNM2 doing regular information sessions with all Nursing Staff to include Medication Management and Administration. Medications are now being administered in line with times directed by the prescriber. Medications are not administered in the Residents Dining Room. If a Resident refuses a medication this is now clearly documented by the Nurse administering the medications. No medications are left unattended in bedrooms
All Nursing Staff available to the roster have completed Medication Management on Hseland.

Due to be completed by: Completed and ongoing.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All required updates to Care Plans and assessments have been completed.
The issue of significant weight loss not recorded in a care plan-there was no concern around this Residents weight by Dietician -Resident deemed to be meeting nutritional requirements as per BMI with normal biochemistry and good skin condition-no dietetic intervention required as MUST score is 0.
Social Assessments completed for all Residents.
Performance Management will be initiated with Staff Nurses who continue to complete Care Plans which lack appropriate content. The CNM has addressed the issue of careplans being updated to reflect any potential pressure areas going forward

Due to be completed by: Completed and ongoing.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Residents have timely access to their General Practitioner and other members of the Multi Disciplinary Team as required. No issues with weight loss identified to warrant review by G.P. Resident was reviewed by G.P. post inspection and had bloods sent to lab. No issues of concern identified.
Due to be completed by: Completed and ongoing.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The use of bedrails has reduced within the Hospital in line with the National Guidelines towards a restraint free environment. . A Staff Nurse has now been assigned to ensure all reasonable alternatives are offered and trialled with Residents and same documented, prior to the implementation of restrictive equipment such as bedrails.

Due to be completed by: Completed and ongoing.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The new system to bring the process of management of Residents personal monies into compliance had been started prior to the day of inspection for some Residents and is now in operation for all Residents.

Due to be completed by: Completed and ongoing.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Clinical Nurse Manager 2 will hold Residents meetings to get a better idea of what the Residents would like to see changed around the care they receive, if they feel their needs are being met and how things could be done better. The Annual Report for 2020 will also be discussed with Residents at a meeting on 10/09/2021. Any issues identified from this meetings will be addressed and an action plan drawn up where required.

Due to be completed by: 30th September 2021.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/10/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	12/09/2021
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of	Not Compliant	Orange	10/09/2021

	purpose prepared under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2022
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	30/09/2021
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	03/08/2021
Regulation 23(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the Chief Inspector.	Not Compliant	Orange	03/08/2021
Regulation 27	The registered	Substantially	Yellow	20/08/2021

	provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Compliant		
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	27/07/2021
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	06/08/2021
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	06/08/2021
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	03/08/2021
Regulation	The registered	Not Compliant	Orange	20/08/2021

28(1)(d)	provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency 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	20/08/2021
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting,	Not Compliant	Red	06/08/2021

	containing and extinguishing fires.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	20/08/2021
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	20/08/2021
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will	Not Compliant	Yellow	20/08/2021

	not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Substantially Compliant	Yellow	10/08/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	10/08/2021
Regulation 5(4)	The person in charge shall	Substantially Compliant	Yellow	20/08/2021

	formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	25/08/2021
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	20/08/2021
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	10/08/2021
Regulation 9(2)(a)	The registered	Not Compliant	Orange	30/09/2021

	provider shall provide for residents facilities for occupation and recreation.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/09/2021
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	30/09/2021