Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	St Patrick's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Summerhill, Carrick on Shannon, Leitrim
Type of inspection:	Unannounced
Date of inspection:	05 April 2022
Centre ID:	OSV-0000661
Fieldwork ID:	MON-0035100

About the designated centre

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

The designated centre provides 24- hour care to 46 residents, male and female primarily requiring nursing and/or palliative care. Some have a diagnosis of dementia and others are young chronic sick persons under 65 years of age. The centre is made up of three units located on the ground floor of a two storey building which was formerly a hospital. Two of the units accommodating 14 residents in each are mainly for long term care and a specialist dementia unit (SDU) accommodates 18 residents. Three beds in the SDU are for residents requiring respite or assessment on a short-term basis and one designated bedroom is for residents receiving end of life care The aim of the centre is to provide a residential setting where residents are cared for, supported and valued within a care environment that promotes their health and well-being.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	32

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
Tuesday 5 April 2022	09:30hrs to 16:30hrs	Catherine Rose Connolly Gargan	Lead

What residents told us and what inspectors observed

Overall, the inspector found that residents needs were met to a good standard but residents' rights and quality of life in two of the three units were not optimised due to the layout and organisation of the centre's environment.

Residents' accommodation was arranged into three units on the ground floor level. The first floor in the premises was being utilised by the acute hospital services as a step-down unit and both services shared a common entrance and foyer area.

Feedback from residents who spoke with the inspector was positive regarding their accommodation, the opportunities provided for them to participate in social activities, the staff that cared for them and the standards of care that they received. Residents were also complimentary about the quality of the food they were provided with. Some of the residents comments included 'my bed is very comfortable', 'I am happy here', 'the staff are very kind to me' and the food is 'delicious'. One resident said that they would prefer to be living in their own house in the community but accepted that they now needed the care and support provided in the designated centre and they were 'grateful' that their needs were being met.

On arrival to the centre, the inspector accessed the centre and was guided through the centre’s infection prevention and control procedures. These procedures included hand hygiene and temperature checking before proceeding further into the centre and resident's accommodation.

The residents' accommodation was divided into three separate units; the Monsignor Young Unit, the Dr McGarry Unit, and the Sheemore Unit. Each unit linked into the main circulating corridors. The Monsignor Young unit was a dementia specific unit built in the 1990s and had been specifically designed to support people with dementia. Dr McGarry and Sheemore Units were located in the older part of the building. The T Dr McGarry and Monsignor Young units were located close together.he Sheemore unit with easy access to the outdoor garden was located on the other side of the building. The inspector observed that due to the significant distance between the garden and the other two units residents in the Dr McGarry unit had a significant distance to travel to access an outdoor garden. Although one resident in Sheemore unit told the inspector that they were out in the garden earlier in the day, no other residents were observed availing of amenities in another unit or accessing the outdoor gardens on the day of this inspection. The inspector also observed that while residents could go outside as they wished from the Monsignor Young unit, access to the other outdoor garden for residents in Dr McGarry and Sheemore units was controlled by a key code lock. The inspector observed that the garden area adjacent to Sheemore unit was partially covered and was beautifully landscaped with raised flower/shrub beds, seating and pathways. However residents could not easily access this garden due to the number of key pad locked doors they were required to travel through to get to it.

There was also a large church on site which was accessible through the staff dining room. Although the inspector was told that residents liked to go to the church and that residents could avail of refreshments in the staff dining room, no residents were observed visiting the church or having refreshments in the staff dining room on the day of this inspection.

The inspector observed that painting and decoration had been used to support residents in identifying key areas. Colour coding and vinyl prints were used to identify toilet doors and bedroom doors to support residents with orientation and way finding. Memorabilia familiar to residents such as dressers, crockery, tea-sets, ornaments, flower pots and other items created a homely and comfortable environment for residents.

The Monsignor Young Unit offered residents a circuit for those who were walking with purpose and had several points of interests along the way for residents to engage in. Many of the residents had a background in farming and the environment was designed to capture their interests. For example, there was an area providing information about local marts and pictures of cattle and sheep were displayed along with a full size replica of a cow and calf outside grazing in the residents' outdoor garden. Another resident with interest in engineering was engaged in working with a wooden mechanical puzzle. Raised flower beds with hand trowels were available for any of the residents with an interest in gardening.

As found on the last inspection, the inspector observed that the physical infrastructure in both the Dr McGarry and Sheemore Units was much older than the that in the Monsignor Young unit. It was evident that the provider had made some improvements to the environment in these units but these units still did not offer residents an appropriate and safe living environment. Instead of bedrooms residents were accommodated in bays developed from sectioning areas off with partitions in what were traditional open plan nightingale wards. Access to the bays was from a common corridor that ran the length of the units. The bays were defined from the corridors by screen curtains. This living environment did not provide residents with privacy as their bed space could be viewed by staff and other residents walking through the unit and passers by could observe the residents eating their meals, sleeping in bed or engaging in other activities. The resident's only way to achieve privacy was to pull their privacy curtains around their bed. In addition access to the activity room at the end of Sheemore unit was through the bed space of a resident accommodated in the last bay at the end of the unit.

There was adequate dining and sitting accommodation provided in Monsignor Young Unit. Following the last inspection occupancy was reduced in the Sheemore unit, which allowed for the additional space to be made available for residents to utilise the additional space to socialise and to eat their meals away from their bedside. In the Dr McGarry unit, there was only one communal room that was seen to be used for multiple purposes, including sitting quietly, watching television, organised activities, and dining. It was the only available space for 11 residents other than their bedrooms or bed spaces in this unit. As a consequence many of the residents in this unit were observed to be spending long periods in bed or sitting beside their beds including eating their meals beside their beds. This environment did not

provide sufficient opportunities for residents to socialise together.The inspector observed some residents moving around the units independently and some other residents were mobilising with support from the staff. Residents and staff were observed to be engaging positively together and it was evident that the staff knew the residents well.

The provider had reduced the occupancy in a number of bedrooms following the last inspection. This had improved the space available to residents in these bedrooms. The inspector observed that some residents in a multiple occupancy bedroom in Dr McGarry unit were provided with additional storage for their clothes. Each resident had a chair by their bed to rest in if they wished and this was an improvement from the previous inspection. While, some residents had personalised their bed areas with photographs and other personal items displayed on the walls behind their beds, these residents did not have shelving and surface space to display their personal photographs, drawings and greeting cards where they could easily see them.

The next two sections of the report describe the provider's levels of compliance with the Health Act 2007 and the Care and Welfare Regulations 2013. The findings in relation to compliance with the regulations are set out under each section.

Capacity and capability

Overall, the provider was delivering an organised service with a number of areas of good practice observed. However and notwithstanding the improvements that had been made since the last inspection in November 2021, the layout of the premises continued to negatively impact on the privacy and dignity of residents. In addition significant focus and resources were now required to ensure that residents were protected in the event of a fire emergency.

Following the last inspection, the provider took action by reducing the number of residents including closing two single bedrooms on Sheemore unit and reducing occupancy on Dr McGarry and Sheemore units to mitigate identified fire safety risks to residents. A number of other fire safety actions had not been completed within the required time frames and regulation 28 remained not compliant on this inspection.

A condition attached to the registration of the centre following the last inspection required the provider to take action to come in to compliance with Regulation 17, Premises by 01 January 2022. This had not been achieved within the required timeframe and the premises continued to be not compliant with the regulations. Therefore the provider is required to apply to the Chief Inspector for a variation of the timeframe to complete all of the necessary works to bring the centre into regulatory compliance.

The registered provider of this designated centre is the Health Service Executive (HSE), and a service manager was assigned to represent the provider. As a national

provider involved in operating residential services for older people, St Patrick's Community Hospital benefits from access to and support from centralised departments such as human resources, information technology, staff training and finance. The person in charge has been in the role for several years and worked full-time in the designated centre. The person in charge had senior clinical support from an assistant director of nursing and clinical nurse managers who assisted her with auditing, staff supervision and staff training. The assistant director of nursing deputises during leave by the person in charge.

There was an established governance and management structure in place and whilst the existing governance and management systems resulted in a good quality of life for residents in the Monsignor Young Unit this was not consistent across the other two units. This inspection found that the provider had failed to recognise and address the impact that the poor physical infrastructure in the Sheemore and Dr McGarry units was having on residents' rights to privacy and dignity, and quality of life including access to outside space. Therefore, improved oversight and management of the service was necessary to ensure that the required actions and improvement works were completed to bring the lived environment in these units into compliance with the Care and Welfare regulations.

There was effective systems in place to monitor key clinical parameters such as resident falls , medication usage and infections.

The organisation of staffing in the centre with a separate staff team assigned in each of the three units provided sufficient numbers of staff with appropriate competencies to meet the needs of residents in accordance with their care plans. However, improvements in supervision of staff was identified as necessary to ensure residents' were appropriately supervised to ensure they had care plans developed to inform their personal care and social activity needs and that laundry procedures were in line with the centre's laundry management policy.

Staff were facilitated to attend mandatory training in safeguarding residents from abuse, fire safety and safe moving and handling procedures. Staff were also facilitated to attend professional development training to ensure they had the necessary skills and competencies to meet the needs of residents living in the centre and their attendance was facilitated and closely monitored by the person in charge.

Records were held securely and residents care records were stored electronically and were password protected. All required records with the exception of an annual certificate for emergency lighting were available in the centre

Arrangements for recording accidents and incidents involving residents in the centre were in place and were notified to the Health Information and Quality Authority as required by the regulations. Staff working in the centre had completed satisfactory Garda Vetting procedures.

Regulation 15: Staffing

The numbers of staff and the staffing skill mix provided were appropriate to ensure the needs of residents were met. Each of the three units in the centre were staffed separately and had a local clinical management structure in place who reported directly to the person in charge. Staff with assigned responsibility for coordinating residents' social activities were available and were supported by an occupational therapist and occupational therapy assistant.

Three staff nurses were rostered on duty each night in the centre and this arrangement ensured that there was sufficient nursing staff available to care for the residents accommodated in the three units in the centre and to mitigate risk of transmission of infection if cohorting of residents who developed symptoms of or confirmed COVID-19 infection was necessary.

Judgment: Compliant

Regulation 16: Training and staff development

The following findings indicated that supervision of staff in some areas did not ensure that staff were carrying out their work to the required standards. This was evidenced by;

- care plans were not consistently developed to inform residents' personal care needs or to inform the social activities that some residents needed support with participating in, to meet their interests and capabilities. This had not been identified by senior nursing staff.
- storage of used laundry awaiting collection in the communal toilet/shower used by residents in one unit was not in line with the centre's laundry management procedures. This had not been identified by supervisory staff.

Judgment: Substantially compliant

Regulation 21: Records

A record of the annual emergency lighting certificate was not available in the designated centre on the day of inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had failed to progress their own plans to replace this centre by 31 December 2021 and there is still no date whereby the new centre will be delivered. In addition in the interim of a new build the provider had failed to ensure the premises met its stated purpose to a standard that met residents' needs and was in compliance with the regulations.

The governance and management systems in place locally in the centre, including oversight of arrangements, detailed audit schedules and a skilled and knowledgeable management team ensured that residents living on one unit experienced a good quality of life in a nice homely environment with plentiful access to communal space and meaningful activities. However the same systems did not identity or address residents' fire safety, lack of privacy, choice, lack of communal space, access throughout the centre including to a safe outdoor area at will.

The provider had failed to adequately address the non-compliances in relation to Regulations 9, Residents' Rights and 17, Premises in the Sheemore and Dr McGarry units as identified on previous inspections before the required date of 01.01.2022 and are therefore in breach of their conditions of registration.

The management and oversight systems in place to ensure compliance with the Health Act 2007 (Care and Welfare of resident in Designated centers for Older People) Regulations 2013 were not effective. This is evidenced by the repeated non-compliances and risk to residents' safety and quality of life found on this inspection in relation to Regulations, 9, Residents' Rights, 17, Premises and 28, Fire precautions.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of accidents and incidents involving residents, that occurred in the centre was maintained. Notifications and quarterly reports were submitted within the specified timeframes and as required by the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The centre's policies and procedures as outlined in Schedule 5 of the regulations were available and accessible to staff. These policies were reviewed and updated within the previous three years. Policies and procedures regarding COVID-19 infection prevention and control were updated to reflect evolving public health guidance.

Judgment: Compliant

Quality and safety

Overall, residents were provided with very good standards of nursing and health care in line with their assessed needs. However, more focus and resources were now required to ensure residents' rights to privacy and dignity were respected and that the quality of their lives was optimised in two of the three units in the centre. In addition the provider had failed to take adequate precautions to ensure that the residents were kept safe in the event of a fire emergency.

The inspector acknowledged that the centre was recently recovered from a COVID-19 outbreak to one unit prior to this inspection and their commitment to strict infection prevention and control practices and procedures prevented spread to the other two units. Infection prevention and control policies in place covered aspects of standard precautions, transmission-based precautions and guidance in relation to COVID-19. Efforts to integrate infection prevention and control guidelines into practice were underpinned by mandatory infection prevention and control training for all staff. The provider had improved infection prevention and control processes and procedures in the centre since the last inspection but a small number of further improvements to ensure residents' safety from risk of COVID-19 infection were found to be necessary and are discussed under Regulations 27 in this report.

Residents were provided with good standards of nursing care and timely health care to meet their needs. These standards optimised their continued good health and clinical well being. Each resident had a care plan in place and overall, these were of a good standard, however this was not consistent and a number of care plans did not include sufficient up to date information to inform staff about the residents' social activity and personal care needs. Overall care plans were found to be person centred and were reflective of the resident's individual preferences and wishes regarding their clinical care and support needs.

Residents' records and feedback from those residents who spoke with the inspector gave assurances that residents had timely access to their general practitioners (GPs), specialist medical and nursing services including psychiatry of older age, community palliative care and allied health professionals as necessary. Effective arrangements were put in place to ensure treatment and care recommendations made by members of the multidisciplinary team were implemented and monitored.

The person in charge and staff team were committed to ensuring residents were facilitated to meet their visitors including on compassionate grounds in line with public health guidance. However, residents on Dr McGarry unit did not have a designated area to meet their visitors outside of their bed spaces and therefore had to travel outside of the unit to meet their visitors.

While, there was some evidence of a small number of residents developing pressure

related skin wounds in the centre over the past 12 months, no residents had pressure related skin wounds at the time of this inspection. The inspector found that residents' wounds were managed in line with evidence based wound care procedures and with the guidance of a tissue viability specialist, a dietician and residents' general practitioners (GPs). A variety of pressure relieving mattresses and other interventions were available and in use.

Although, the provider had made improvements in the lived environments of residents in the three units, the layout and design of a number of areas on both Dr McGarry unit and Sheemore units continued to have a negative impact on the privacy and dignity of the residents living in those units These finding are discussed further under Regulations 9, Residents' Rights and 17, Premises.

Some measures were implemented since the last inspection to protect residents from risk of fire but not all the risks identified in the provider's Fire safety risk assessment (FSRA) had been completed in a timely manner.

Measures were in place to safeguard residents from abuse and a positive and supportive approach to care was evident for residents who were predisposed to experiencing episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). These residents had a person-centred behaviour support care plan in place that directed staff with managing any behaviours they experienced. Records of behaviours was maintained for each resident and was analysed to assist with identifying triggers to their behaviours and effective person-centred de-escalation strategies. These records were also used to inform residents' treatment plans. Staff spoken with had a very good knowledge of residents' individual needs and were trained in managing responsive behaviours.

While, the person in charge and staff team demonstrated commitment to a minimal restraint use, restrictions posed by key coded doors on the doors into each unit and the door to the outdoor garden for residents in two units was overly restrictive and was not in line with national restraint policy guidelines. Five residents had full-length bed rails in place. Their needs were assessed, and procedures were in place to ensure their safety needs were met. Records showed that alternatives to full-length restrictive bed rails had been trialled, and the multi-disciplinary team were involved in the decision-making process. Care procedures were in place to minimise the amount of time restrictive equipment was in place for each resident. Use of psychotropic medicines on a PRN (as necessary) basis were closely monitored.

While, residents had access to religious services remotely and were supported to practice their religious faiths in the centre, residents were not able to access the on site church without the support of staff to travel through a number of locked doors on the way to the church.

Improvements were also required to ensure residents had choice of television viewing and listening in their bedrooms. Residents had access to local and national newspapers

Residents' meetings were regularly convened and issues raised by residents as

needing improvement were addressed.

Regulation 11: Visits

Visiting was facilitated for residents to meet with their families and friends in line with public health guidance. Staff guided visitors through appropriate COVID-19 infection prevention and control procedures and some residents were observed enjoying meeting their families and friends on the day of inspection. A comfortable area was designated for residents to meet with their visitors outside of their bedrooms on the Sheemore unit since the last inspection. There was also a visitor's room off the entrance foyer where residents from the units could meet with their visitors.

Judgment: Compliant

Regulation 12: Personal possessions

The layout of some bedrooms/bays did not facilitate residents to maintain control of their personal clothing as storage facilities were outside their personal bed spaces.

Although residents able to make their wishes known were surveyed and expressed that they did not require surface space/shelving for displaying their photographs and other mementos, the option of personal shelf space was not available if any resident changed their mind and was not available as standard for all residents living in the centre.

Judgment: Substantially compliant

Regulation 17: Premises

The design and layout of the designated centre did not meet the needs of the residents and a number of areas did not conform to Schedule 6 of the regulations. this was evidenced by;

- A room used as a cleaner's room for Sheemore unit did not have appropriate facilities or a water supply and was not fit for purpose.
- The layout and design of the Sheemore and Dr McGarry units were not laid out to meet the needs of residents. For example, several residents' bedrooms were designed as bays off a circulating corridor and the bedroom boundaries were defined by a screen curtain.
- Decor (paint and woodwork) was damaged in areas through the centre, such

as corridors, bedroom doors and doorframes and in the utility rooms. Although a painting programme was in progress, unaddressed surfaces did not support completion of effective cleaning.
- Although both residents in one of the bays on the Sheemore unit with two beds had a chair for each resident, the space was limited and the chair hindered access to residents' clothing and lockers.
- Storage for equipment was not adequate and the inspector observed storage of a linen trolley and bags of used linen awaiting collection in a communal shower/toilet used by residents. Equipment was also stored in the centre's oratory. This posed a risk of cross infection and limited access to these areas for residents.

Judgment: Not compliant

Regulation 27: Infection control

Although a number of infection prevention and control measures were in place, improvements were required in relation to the following findings to ensure consistency with the national infection prevention and control standards and to protect residents from risk of infection;

- There were not sufficient clinical hand wash sinks outside of the residents' bedrooms and communal bathrooms. Therefore, sinks in residents' bedrooms and communal toilets/showers in some areas were serving a dual purpose for both residents and hand wash sinks for staff.
- Equipment used by residents and examined by the inspector appeared visibly clean, however, a system was not in place to provide assurance that items of equipment were cleaned after each use.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Although, simulated emergency evacuation drills were completed in a number of areas in the centre, a simulated night time emergency evacuation drill had not been completed since November 2021 from the largest compartment accommodating 11 residents. A satisfactory fire drill was submitted following the inspection.

A fire safety risk assessment was required following the findings of the inspection in November 2021 assurances were not available that risks identified were addressed. Therefore residents safety in the event of a fire in the centre was not assured.

The floor plan displayed by the fire alarm panel in the foyer area of the centre did

not clearly identify fire compartment boundaries to inform the evacuation procedures to be followed in the event of a fire in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Although the information in residents' care plans was person-centred and reflective of residents' individual preferred routines and wishes, some residents' personal care and social activity needs were not described in their care plan information. This posed a risk of inconsistencies in the standard of care and support these residents received.

Although the inspector was given assurances that residents' care plans were reviewed in consultation with them or their family on their behalf, there was limited information available regarding this consultation process.

Judgment: Substantially compliant

Regulation 6: Health care

Nursing care provided was evidence based and in accordance with good professional standards

Residents had access to a general practitioner (GP) who attended the centre five days each week and an out of hours GP service was available if needed. A full range of other health care-related services were available for the residents in the centre. These included speech and language therapy, physiotherapy, occupational therapy, dietetic services, tissue viability and community mental health services. Chiropody, dental and optical services were also provided.

Treatment recommendations were clearly documented in residents' care plans and were implemented by staff.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The person in charge and staff were committed to minimising care procedures that potentially restricted residents. However, residents needed staff assistance to unlock key code and fob operated electronic locks on the main doors to each unit if they

wished to go to any other part of the centre including to the centre's church and outdoor garden. Residents in Dr McGarry and Sheemore units could not access the outdoor garden provided for them without the assistance of staff to unlock the keycodes on the doors for them. A risk assessment was not in place for each resident to inform these restrictions to their access around the centre and into the oratory and garden.

Judgment: Substantially compliant

Regulation 8: Protection

Measures were in place to ensure all incidents, allegations or suspicions of abuse were addressed and managed appropriately to ensure residents were safeguarded at all times. All staff were facilitated to attend training on safeguarding residents from abuse. Staff who spoke with the inspector were aware of their responsibility to report any allegations, disclosures or suspicions of abuse and were familiar with the reporting structures in place.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights to privacy and dignity were significantly compromised in two bays providing bedroom accommodation for residents in Dr McGarry unit and in five bays providing accommodation for residents in Sheemore unit. Residents' privacy could also not be assured in the cubicle style communal toilets provided in some areas of the centre.

Residents did not have choice of television viewing and listening as residents in bedrooms with two and three beds shared one television set. Some residents' access to a television was hindered due due to the location of the television sets on the wall on the other side of the walkway down along the bays in the Sheemore unit.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Patrick's Community Hospital OSV-0000661

Inspection ID: MON-0035100

Date of inspection: 05/04/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure Compliance with Regulation 16 (1)(b) Staff supervision , The Registered Provider shall ensure that staff are adequately supervised: Compliance will be met by : 1. The Person in charge has completed a review of care plans in the designated centre. Care plans have been updated to inform resident's personal care needs and social activities preferences. This has been completed on the 30th April 2022 and will be reviewed on an ongoing basis 2. The Person in charge has reviewed laundry practices in the centre. Laundry is now stored in its appropriate holding area on all units. This was completed on 11th April 2022 and will be monitored on an ongoing basis. 3. All staff have up to date training in the "AMRIC Standards and Transmission Based Precautions".	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: To ensure compliance with Regulation 21 (1). The Registered provider shall ensure that the records set out in Schedules 2,3 and 4 are kept in the designated center and are available for inspection by the Chief inspector	

Compliance will be met by :

1. A record of the annual emergency lighting certificate is now on site and is available for inspection by the Chief inspector. This was actioned and completed on the 5th April 2022.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.
To ensure Compliance with Regulation 23(a) Governance and Management 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:

To ensure Compliance with Regulation 23(c) Governance and Management the Registered Provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Compliance will be met by :

1. The Registered provider has a planned schedule in place in relation to the new 90 bedded Carrick on Shannon Community Nursing unit. The schedule is as follows,
Stage 2C underway at present.
Stage 2C Report to be completed 26th July 2022
Approval to proceed to Tender to be completed 6th September 2022
Tender to be returned to HSE by 31st October 2022.
Construction stage to commence 10th February 2023.
Handover Q1 2025

2 The Person in charge has discussed the accommodation and privacy and dignity with residents at the "Just Friends" meeting on the 13/04/2022. The residents expressed that they are happy with their current living accommodation. The residents were informed of the planned upcoming build and welcomed same.
3 The registered Provider commissioned a Fire safety consultant to carry out a full review of the fire safety management systems within the designated center. On the 01/06/2022 the Fire Officer for the HSE met with the fire consultant in the designated center to review Fire compliance within the center.
A Fire Risk Assessment Report was completed dated the 08/06/2022.
Red risks identified within the Fire Risk Assessment will be completed by the 30/11/2022.

Amber risks identified within the report will be completed by 06/06/2023. Green risks identified within the report will be reviewed in three years dated June 2025.
4 Works have commenced on the fire doors from the 07/06/2022 and will remain ongoing until completion.
5. Fire risks identified outside of the designated center will be completed in line with the required time frames as outlined in the risk assessment. These works will be procured via a separate tender.
6. Works have commenced on the Fire Risk Assessments. To date thirteen red risks have been completed. Ten amber risks have been completed and three green risks have been completed. A process is in place for the further competition of the remaining risks. Works are in progress on the remaining risks.
7. As of the 14/07/2022 the following risks identified on the fire safety risk assessment have been completed :

Red Risks:
• Risk Item Number 3- Completed
• Risk item Number 7 Completed
• Risk Item Number 9 – Completed
• Risk Item Number 14- Completed
• Risk Item Number 15 –Completed
• Risk Item Number 16 Completed
• Risk Item Number 19- Completed
• Risk Item Number 29- Completed
• Risk Item Number 31- Completed
• Risk Item Number 35 Completed
• Risk item Number 36 Completed
• Risk item Number 37 Completed
• Risk Item Number 38- Completed

Amber Risk
• Risk Item Number 8 - Completed
• Risk item Number 9 Completed
• Risk item Number 12 Completed
• Risk Item Number 21- Completed
• Risk item Number 22—Completed
• Risk Item Number 24- Completed
• Risk item Number 26- Completed
• Risk Item Number 30- Completed
• Risk item Number 34 Completed
• Risk Item Number 40- Completed

Green Risk
• Risk Item Number 11- Completed
• Risk Item Number 13- Completed
• Risk Item Number 20- Completed

8. Extensive upgrade works are to commence within the designated centre. These upgrades are as follows:
• Existing bedroom bays in the Sheemore and Dr Mc Garry unit are to be refurbished

with the construction of new partition walls and fire doors.
• Reconfiguration of the bedrooms in the Sheemore and Dr Mc Garry unit to become 2 bedded bedrooms. These bedrooms will have infection control hand- washing basins constructed.
• An upgrade in Monsignor Young Unit will include upgrade to the toilet area as identified in the attached drawings.
• The refurbishment will result in combined dining/sitting area in the Dr McGarry and in the Sheemore Unit with the latter having a separate activity room.
• Re-commissioning of 1 single bedroom in the Sheemore Unit and the refurbishment of a two multi bed bay to that of a single room.
• The newly formed corridor in the Sheemore Unit will enable separate access to the activity room.
• The timelines set out for the above works are as follows
1. Preparation of Tender Documents- Completion Date 22/07/2022
2. Receipt of Tenders- Completion Date 12/08/2022
3. Tender evaluation and report- Completion Date 31/08/2022
4. Specialist sub- contractor completion of works on remedial actions to Fire Risk items- Colour coded Red – Completion Date- 30/11/2022
5. Contractor Mobilisation and Lead in time on Materials for Privacy and Dignity items – Completion Date 14/10/2022
6. Works to commence in the Sheemore Unit – 17/10/2022 and completion date 18/01/2023
7. Works to commence in the Dr Mc Garry Unit and Monsignor Young Unit – 01/02/2023 and completion date 06/04/2023
8. Contractor mobilisation on site to commence works on remedial actions to Fire Risk items – Colour Coded Amber – 11/04/2023
9. Contractor completion of works on remedial actions to Fire Risk items- Colour Coded Amber – 06/06/2023

9. Phase 1: Specialist sub- contractor mobilisation on site to commence works on remedial actions to Fire Risk items- Colour coded Red
Phase 2: Construction of refurbished Sheemore Alternative – 12 beds
Phase 3: Construction of refurbished Dr Mc Garry and refurbishment in Monsignor Young Unit
Phase 4: Contractor completion of works on remedial actions to Fire Risk items – Colour coded Amber.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
To ensure Compliance with Regulation 12(a)(c): Personal Possessions: The Person In Charge shall, in so far as is reasonably practical, ensures that a resident has access to and retains control over his or her personal property, possessions and finances and, in

particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions

Compliance will be met by the following :

1. The person in charge has completed a review of all resident's bedroom layouts to ensure that residents as is reasonably practical are able to access their personnel clothing and storage. This was completed 11/04/2022.
Consultation has occurred with residents regarding their own personal space.
Shelves have been purchased and have been fitted at each resident's bedside. This will support residents to display their photographs and other mementos if this is their wish. This was completed on 14/07/2022

2. Bed occupancy has been reduced in both the Dr Mc Garry and Sheemore unit. This has afforded residents additional bedroom space and storage space at their bedside. This was completed on 26/11/2021

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.
To ensure compliance with Regulation 17(1): Premises: 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 purpose prepared under Regulation 3

To ensure compliance with Regulation 17(2): Premises: 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

Compliance will be met by the following :

1. A review of all residents seating has been completed and all residents have a chair at their bedside either an arm chair or their own therapeutic chair. This was completed 06/04/2022
2. A review of linen storage and the storage of equipment within the designated centre has been completed. All linen and equipment is now appropriately and safely stored to ensure compliance with infection prevention and control. This was completed 25/04/2022.
3. The person in charge in conjunction with the resident has reviewed the personal bed space of residents. Beds and chairs have been repositioned where requested by residents to ensure easier access to clothing and personal possessions .This was completed

26/04/2022 and will be kept under review.
4. The Registered provider has a planned schedule in place in relation to the new 90 bedded Carrick on Shannon Community Nursing unit. The schedule is as follows,
• Stage 2C underway at present.
• Stage 2C Report to be completed 26th July 2022
• Approval to proceed to Tender to be completed 6th September 2022.
• Tender to be returned to HSE by 31st October 2022.
• Construction stage to commence 10th February 2023.
• Handover Q1 2025

5. Extensive upgrade works are to commence within the designated centre. These upgrades are as follows:
• Existing bedroom bays in the Sheemore and Dr Mc Garry unit are to be refurbished with the construction of new partition walls and fire doors.
• Reconfiguration of the bedrooms in the Sheemore and Dr Mc Garry unit to become 2 bedded bedrooms. These bedrooms will have infection control hand- washing basins constructed.
• An upgrade in Monsignor Young Unit will include upgrade to the toilet area as identified in the attached drawings.
• The refurbishment will result in combined dining/sitting area in the Dr McGarry and in the Sheemore Unit with the latter having a separate activity room.
• Re-commissioning of 1 single bedroom in the Sheemore Unit and the refurbishment of a two multi bed bay to that of a single room.
• The newly formed corridor in the Sheemore Unit will enable seperate access to the activity room.
• The timelines set out for the above works are as follows
1. Preparation of Tender Documents- Completion Date 22/07/2022
2. Receipt of Tenders- Completion Date 12/08/2022
3. Tender evaluation and report- Completion Date 31/08/2022
4. Specialist sub- contractor completion of works on remedial actions to Fire Risk items- Colour coded Red – Completion Date- 30/11/2022
5. Contractor Mobilisation and Lead in time on Materials for Privacy and Dignity items – Completion Date 14/10/2022
6. Works to commence in the Sheemore Unit – 17/10/2022 and completion date 18/01/2023
7. Works to commence in the Dr Mc Garry Unit and Monsignor Young Unit – 01/02/2023 and completion date 06/04/2023
8. Contractor mobilisation on site to commence works on remedial actions to Fire Risk items – Colour Coded Red – 30/11/2022
9. Contractor completion of works on remedial actions to Fire Risk items- Colour Coded Amber – 06/06/2023
6. Phase 1: Specialist sub- contractor mobilisation on site to commence works on remedial actions to Fire Risk items- Colour coded Red
Phase 2: Construction of refurbished Sheemore Alternative – 12 beds
Phase 3: Construction of refurbished Dr Mc Garry and refurbishment in Monsignor Young Unit
Phase 4: Contractor completion of works on remedial actions to Fire Risk items – Colour coded Amber.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The inspector has reviewed the provider's compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the chief inspector that these actions will result in compliance with the regulations.
To ensure compliance with Regulation 27: The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the authority are implemented by staff.

Compliance will be met by the following :

1. The PIC and the Assistant Director of Infection Prevention and Control completed a review of all clinical sinks within the designated centre on the 16/05/2022. A further audit of all sinks within the designated took place by the assistant director of infection prevention and control and the assistant director of nursing dated the 01/07/2022.
Findings are as follows:
• Sheemore unit –In each 2 bedded bay there is a HBN 00-10 compliant hand wash basin labelled for staff use only, these are intended solely for staff use. During the audit the ADON IPC observed no signs of dual use by residents or staff. If staff observe residents using sinks not for its intended purpose, residents are discouraged from using these sinks.
Within every toilet /shower areas there are dedicated resident sinks, these are not staff CHWB and in these instances staff rely on alcohol based hand rub. All staff are aware that a CHWB is within walking distance of the bathroom /toilet if needed. This is in line with National AMRIC building Guidelines May 2022.
For residents with restricted mobility who cannot access toilets or bathroom facilities the ADON IPC has recommended resident wipes to be made available for ease of access to accommodate hand hygiene needs. This has been implemented.
• McGarry unit- All bays have Clinical Hand wash basins which are HBN 00-10 Compliant. The two single rooms on the unit have resident dedicated sinks only. These sinks are not staff sinks but there is a CHWB within easy walking distance of these 2 rooms and alcohol gel is also available.
All toilets and shower /bathrooms areas contain resident dedicated sinks for hand washing. For staff working within this area alcohol gel is recommended.
• Monsignor Young unit (MYU) - The sinks within the MYU are within the resident's rooms and these are dedicated to resident use only.
Within the multi bedded rooms the hand wash basins in the en-suite are resident dedicated and not for use by staff .Staff within this unit are relying on alcohol gel for hand hygiene purposes. During the audit two areas have been identified for the placement of CHWB. A portable CHWB has been procured and is now in use on the Monsignor young unit. This is compliant with Infection prevention and control protocols in the short term as it provides a means for clinical hand washing. This was completed

on the 13/07/2022.Consultation has commenced with the estates department regarding the fitting of the two CHWB sinks. This is to be completed by 30/09/2022.

2. The person in charge has reviewed practices and processes in relation to identifying when equipment is cleaned. A cleaning schedule is in place for cleaning of all equipment. A process has been put in place to ensure that when equipment has been cleaned that a label is placed on it indicating when it was cleaned and by whom. This was completed 11/04/2022. In terms of cleaning of resident dedicated equipment a process is in place whereby equipment is labelled with a clean sticker which is dated and timed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the actions will result in compliance with the regulations.
To ensure compliance with Regulation 28(1) (a) (2) (iv) (3): Fire Precautions The Rregistered 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.

Compliance will be met by the following :
1. Simulated night/ day time fire evacuation drills are carried out in the designated center on an ongoing basis. There is a schedule of evacuation drills and fire training in place within the designated centre for 2022.
2. Fire safety notices are displayed prominently throughout the center both in the units and in communal areas to support staff / residents and visitors of the evacuation route to follow in the event of a fire.
10. An Updated Fire Evacuation plan has been requested and this will be displayed at the Fire panel in the Main Reception.
11. The registered Provider commissioned a Fire safety consultant to carry out a full review of the fire safety management systems within the designated center. On the 01/06/2022 the Fire Officer for the HSE met with the fire consultant in the designated centre to review Fire compliance within the center.
A Fire Risk Assessment Report was completed dated the 08/06/2022.
Red risks identified within the Fire Risk Assessment will be completed by the 30/11/2022. Amber risks identified within the report will be completed by 06/06/2023. Green risks identified within the report will be reviewed in three years dated June 2025.
12. The fire risk assessment has been shared with the local fire department dated the 05/07/2022. The local fire department completed a visit to the center dated 06/10/2021.
13. The Fire safety management policy has been updated as off 13/07/2022
14. Fire safety packs are available to staff on all units as well as at Main Reception.
15. Works have commenced on the fire doors from the 07/06/2022 and will remain ongoing until all works are completed.

16. Fire risks identified outside of the designated centre will be completed in line with the required time frames as outlined in the risk assessment. These works will be procured via a separate tender.
17. Works have commenced on the Fire Risk Assessments. To date thirteen red risks have been completed. Ten amber risks have been completed and three green risks have been completed.
18. As of the 14/07/2022. The following risks identified on the fire risk have been completed

Red Risks:
• Risk Item Number 3- Completed
• Risk item Number 7 Completed
• Risk Item Number 9 – Completed
• Risk Item Number 14- Completed
• Risk Item Number 15 –Completed
• Risk Item Number 16 Completed
• Risk Item Number 19- Completed
• Risk Item Number 29- Completed
• Risk Item Number 31- Completed
• Risk Item Number 35 Completed
• Risk item Number 36 Completed
• Risk item Number 37 Completed
• Risk Item Number 38- Completed

Amber Risk
• Risk Item Number 8 - Completed
• Risk item Number 9 Completed
• Risk item Number 12 Completed
• Risk Item Number 21- Completed
• Risk item Number 22 -Completed
• Risk Item Number 24- Completed
• Risk item Number 26- Completed
• Risk Item Number 30- Completed
• Risk item Number 34 Completed
• Risk Item Number 40- Completed
Green Risk
• Risk Item Number 11- Completed
• Risk Item Number 13- Completed
• Risk Item Number 20- Completed

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:
To ensure compliance with Regulation 5(3)The person in charge shall prepare a care plan , based on the assessment referred to in paragraph 2 for a resident no later than 48 hours after that residents admission to eth designated center
To ensure compliance with Regulation 5 (4) The person in charge shall 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 residents family

Compliance will be met by the following :

1. The Person in charge has completed a review of care planning processes within the designated centre. Care plans have been updated to ensure compliance and to inform resident's personal care needs and social activities preferences. Care plans are updated at least every 4 months or more frequently as required. This has been completed on the 30th April 2022 and will be reviewed on an ongoing basis
2. Residents and their families are involved in care planning and residents and or their representative sign the care plan following discussion. This is reviewed on an on-going basis.
3. An audit schedule is in place within the designated centre. This schedule includes care planning audits. This process ensures that the regulations are met as well as ensuring that care plans are person centred in their approach. Following the audit process quality improvement plans are developed. This was completed on the 23/05/2022.

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:
To ensure compliance with Regulation 7 (3) .The registered provider shall ensure that, where restraint is used in a designated center, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Compliance will be met by :
1. The person in charge has completed a review of restrictive practices in the designated center in particular the use of key pad locks on doors on the entrance to both the Dr Mc Garry unit and Sheemore unit.

An overall risk assessment was completed per unit and it has been risk assessed that at present the key pad system on both the Sheemore and Dr Mc Garry units are required to ensure the safety of residents. This will be kept under continuous review with an emphasis on balancing resident safety whilst maintaining the resident's independence. All restrictive measures are in line with National Restraint policy

Additional to this, individual risk assessment s have been completed for residents in relation to their access in and out of their units. For those residents whom have no safety issues these residents have been provided with the access to the door code.

For those residents who do not have access to the key code for safety reasons (based on individual risk assessment) these residents are actively supported by staff to leave the unit and spend time in the gardens/ church / sitting areas as they require. All residents have individual activities plans and social plans in place to support their physical and social well-being .This was completed on the 23/06/2022 and will be reviewed on an ongoing basis

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To ensure compliance with Regulation 9(3)(a) : Residents rights The Rregistered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents

To ensure compliance with Regulation 9(3)(b): Residents Rights The registered Provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private

Compliance will be met by :

1. A review of the televisions available to residents within the center has taken place. This review has resulted in additional televisions being ordered to afford each resident access to their own individual television. Electrical cabling works will commence week beginning 18/07/2022.Televisions have been ordered and management within the center are awaiting the delivery of the televisions from the supplier. This is to be completed by the 31/08/2022.
2. Extensive upgrade works are to commence within the designated centre. These upgrades are as follows:
• Existing bedroom bays in the Sheemore and Dr Mc Garry unit are to be refurbished with the construction of new partition walls and fire doors
• Reconfiguration of the bedrooms in the Sheemore and Dr Mc Garry unit to become 2 bedded bedrooms. These bedrooms will have infection control hand- washing basins constructed
• An upgrade in Monsignor Young Unit will include upgrade to the toilet area as identified in the attached drawings
• The refurbishment will result in combined dining/sitting area in the Dr McGarry and in the Sheemore Unit with the latter having a separate activity room
• Re-commissioning of 1 single bedroom in the Sheemore Unit and the refurbishment of a two multi bed bay to that of a single room
• The newly formed corridor in the Sheemore Unit will enable Seperate access to the

activity room
• The timelines set out for the above works are as follows
1. Preparation of Tender Documents- Completion Date 22/07/2022
2. Receipt of Tenders- Completion Date 12/08/2022
3. Tender evaluation and report- Completion Date 31/08/2022
4. Specialist sub- contractor completion of works on remedial actions to Fire Risk items- Colour coded Red – Completion Date- 30/11/2022
5. Contractor Mobilisation and Lead in time on Materials for Privacy and Dignity items – Completion Date 14/10/2022
6. Works to commence in the Sheemore Unit – 17/10/2022 and completion date 18/01/2023
7. Works to commence in the Dr Mc Garry Unit and Monsignor Young Unit – 01/02/2023 and completion date 06/04/2023
8. Contractor mobilisation on site to commence works on remedial actions to Fire Risk items – Colour Coded Amber – 11/04/2023
9. Contractor completion of works on remedial actions to Fire Risk items- Colour Coded Amber – 06/06/2023

• Phase 1: Specialist sub- contractor mobilisation on site to commence works on remedial actions to Fire Risk items- Colour coded Red
• Phase 2: Construction of refurbished Sheemore Alternative – 12 beds
• Phase 3: Construction of refurbished Dr Mc Garry and refurbishment in Monsignor Young Unit
• Phase 4: Contractor completion of works on remedial actions to Fire Risk items – Colour coded Amber.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	22/07/2022
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes	Substantially Compliant	Yellow	14/07/2022

	and other personal possessions.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/04/2022
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 purpose prepared under Regulation 3.	Not Compliant	Orange	06/06/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	06/06/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	04/04/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient	Not Compliant	Orange	06/06/2023

	resources to ensure the effective delivery of care in accordance with the statement of purpose.			
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	16/05/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/09/2022
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	Orange	30/11/2022
Regulation 28(2)(iv)	The registered provider shall	Not Compliant	Orange	06/06/2023

	make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	08/06/2022
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/04/2022
Regulation 5(4)	The person in charge shall 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	Substantially Compliant	Yellow	23/05/2022

	family.			
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	23/06/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	06/06/2023
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	06/06/2023