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:	Phoenix Park Community Nursing Units
Name of provider:	Health Service Executive
Address of centre:	St Mary's Hospital, Phoenix Park, Dublin 20
Type of inspection:	Unannounced
Date of inspection:	27 January 2023
Centre ID:	OSV-0000476
Fieldwork ID:	MON-0039155

About the designated centre

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

Phoenix Park Community Nursing Units can accommodate 146 residents, both male and female over the age of 18. The registered provider is the Health Service Executive and is located on the St. Mary's Hospital Campus, Phoenix Park in Dublin. The centre consists of two purpose-built buildings,Teach Iosa (100 beds) and Teach Cara (46 beds). Both buildings have two storeys, and are divided into six units. Residents of all levels of dependency can be accommodated in the centre, and 24 hours nursing care is provided. There are a range of multidisciplinary staff who strive to promote person centred care and aim to implement evidence based quality care for all residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	131

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
Friday 27 January 2023	08:00hrs to 19:00hrs	Arlene Ryan	Lead
Friday 27 January 2023	08:00hrs to 19:00hrs	Frank Barrett	Support

What residents told us and what inspectors observed

The overall feedback from residents living in the Phoenix Park Community Nursing Unit was positive. The centre was generally clean and bright and corridors were clutter free. Inspectors had the opportunity to meet and chat with residents and their visitors throughout the day. Residents were content and pleased with their living experience and said that they felt safe living in the centre. Visitor feedback was also positive with most commenting on how easy it was to access the centre and their loved ones.

The centre is located across two buildings, Teach Iosa and Teach Cara, both within a short walking distance from each other. Each building had two floors, ground and first floors. Teach Iosa had 100 beds over four units and Teach Cara has 46 beds over two units.

The residents' bedrooms were a mix of single, double and quadruple occupancy rooms with en-suite facilities. Residents were supported to personalise their rooms with pictures photographs and personal items. Some residents' artwork was hanging in their rooms and created a very personalised space. However, inspectors saw that a large number of rooms and communal areas had damage to walls, painted surfaces and flooring, and were in need of repair and redecoration. All rooms had privacy blinds on the windows and some had additional curtains. A number of rooms did not have curtains hanging despite there being curtain poles above the windows.

Most residents had adequate storage in their rooms for their clothes and belongings, however a number of residents required additional storage and were using cardboard boxes and bags for this purpose. One resident told the inspector that they needed some more drawers to store their belongings.

The residents in shared rooms had smaller wardrobes and some were bulging open as there was not enough space for their clothing and personal items. One resident in a shared room told the inspectors that they did not have much space for their belongings. A lockable unit was available to all residents who wished to use one.

Inspectors saw that the units operated a privacy light system to indicate to others when the staff were providing personal care for a resident. This allowed others to know not to disturb the resident at such times. However the screen placement in the double rooms did not allow for the second resident to enter or exit the room when their roommate was receiving personal care.

The communal spaces were observed to be comfortable and spacious. There were additional rooms such as conservatories which provided spaces for residents to receive visitors in a space other than their bedroom. There was a large spacious central courtyard on the ground floors of the two buildings. The courtyards had unrestricted access and residents could access them when they wanted. The doors were locked at night time for safety however if a resident wanted to go outside staff

facilitated this. The door to the units did not have any restrictions or locks allowing residents to move freely throughout.

The inspectors had the opportunity to speak with residents and some of their visitors during the day. Both residents and their visitors were very complimentary of the staff and the care provided and told the inspectors that staff were respectful and kind to the residents. Inspectors observed many positive interactions and it was evident that the staff were knowledgeable about the residents individual preferences, care and needs. The residents were able to make choices about their daily living arrangements. The residents who spoke with the inspectors were happy with the view from their rooms. They enjoyed seeing the deer and other wildlife coming up to the buildings and said the location was lovely. One resident also commented that they were looking forward to the warmer weather so as they could go out into the garden more often.

The inspectors visited the dining room during the lunch time meal. Residents told the inspector that they liked the food provided and that there was always choice of meals and plenty of food available to them. Tables were set with tablecloths and had condiments available for residents to use. The majority of residents attended the dining room to have their lunch however if a resident preferred to eat in their room or was unable to come to the dining room, this was facilitated by staff. Inspectors did note that one of the dining rooms on the ground floor was in need of redecoration due to wear and tear to painted surfaces, walls and damage to the flooring.

The inspectors saw a comprehensive activities programme for each of the units including one-to-one activities for residents. The inspectors met the activities coordinator and saw that there were a good number of staff dedicated to activities. These staff updated the residents' therapeutic care plans with details of the residents individual preferences and activities. A sample of activities such as bingo, crafts, live music, nail painting, exercise classes, yoga classes, reminiscence sessions, film afternoons and interactive newspaper discussions were available on a regular basis. Residents also had access to televisions, radio, telephones and newspapers and were involved in activities and discussions on current affairs and local matters.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, the inspectors found that there was a clearly defined management structure in place, with management systems to promote the delivery of quality care to residents. However, better oversight of measures that support the quality and safety

of the service was required based on the inspection findings. The compliance plan from the previous inspection carried out in January 2022 was followed up and some items had not been completed. These are included under the individual regulations later in this report. Action was required to bring the centre into compliance with the following regulations: Contracts for the provision of care, complaints, premises and fire precautions.

The Health Services Executive is the registered provider. The centre is registered for 148 residents, and on the day of the inspection, there were 131 residents living in the centre. The person in charge was supported by a team of nurses, healthcare assistants, activities staff, housekeeping, laundry, administration and support services staff.

Some of the management systems in place to oversee the effective running of the service were not sufficiently robust to provide effective oversight of service provision including the oversight of premises and infection control practices to ensure that they effectively identified areas for improvement. Maintenance works were seen to be reactive rather than proactive. The inspectors did not see a plan for oversight of a proactive preventative maintenance strategy to ensure that the premises was in line with Schedule 6 of the regulations. The senior management team informed the inspectors that a proposal was being developed to address this issue.

Inspectors found that there was a lack of storage in the centre. Multiple store rooms and an "independent living room" were being used as staff rooms in contravention with the designated centres statement of purpose. Items of stock were found in these rooms, and other rooms such as the sluice rooms and assisted bathrooms stored excessive and inappropriate items.

Inspectors found mould on a ventilation extract in one empty ensuite, which raised concerns relating to the effectiveness of the ventilation system within the shower room.

The monitoring of outstanding maintenance jobs was not sufficient resulting in many outstanding works such as painting and decorating, damaged floor coverings and electrical safety checks not being performed. Requests had been submitted for these works however they were not followed up. For example a curtain pole was not secured correctly in one of the bedrooms posing a risk to any person closing or opening the curtain. An immediate action was requested due to the risk identified and the issue was resolved on the day.

Training records for staff were available to the inspectors. There was a clear process to identify who had completed training and when they were next due for refresher training. All records were maintained by the clinical nurse managers on each unit. An significant improvement was seen in the monitoring of staff training, however, a review of the training matrix (a record of staff training) showed that many staff were not up to date with their training for specified topics, in line with the organisations training requirements. A training schedule was in place supported by the on-site practice development team.

Regulation 16: Training and staff development

There were gaps in records of staff completion of their mandatory training including training in fire, moving and handling and safeguarding. For example on one unit seven staff had not completed their fire safety training. On another unit nine had not completed their mandatory safeguarding training. Additional training was required in relation to fire safety to ensure that staff closed all bedroom doors as part of fire evacuation procedures.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The inspectors did not have access to the directory of residents containing the information specified in Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres For Older People) Regulations 2013. The assistant director of nursing explained that this information was computerised and all details were entered electronically on the PAS system as part of the entire St Marys Hospital compus system but they did not have access in the designated centre. The centre had a folder with admission details printed from the PAS system such as names addressed and phone numbers of the resident, their next of kin and general practitioners (GP's), admission date, gender, marital status, religion, consultant, speciality, bed type, referral source and medical card number. However information relating to transfers, deaths and discharges was not clearly available. There were gaps in the information on some admission sheets for some residents such as next of kin details, GP details and admission sources.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider was not in compliance with condition 1 of of their condition of registration. Store rooms were found to be used as staff rooms. An independent living rooms was also being used as a staff room.

Some of the management systems in place to oversee the effective running of the service were not sufficiently robust to provide effective oversight of service provision. For example; the monitoring of outstanding maintenance jobs was not sufficient resulting in many pending works such as painting and decorating, repairing damaged floor coverings and electrical safety checks not being performed. Premises issues had not been identified by the provider and therefore improvements

were not actioned, to comply with Schedule 6 of the Health Act (Care and Welfare of Resident in Designated Centres for Older People) Regulations 2013 as detailed under Regulation 17: Premises.

Management and oversight of risks relating to fire precautions was reviewed by inspectors. It was noted that while staff were knowlegable on the procedure and method for evacuation of residents in the event of a fire, there was no clear procedure in place to mitigate the risk of not having door closers on bedroom doors. A lack of staff training on the fire safety risks associated with leaving doors open was evidenced by doors seen left open, and some being wedged open.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Of the sample of 14 contracts viewed by inspectors, approximately 12 did not have their full contracts available for review. Some documents were available including the residents name, room occupancy, fees and signature for all residents. However details of the services to be provided, arrangements for financial support under the nursing home support scheme, other services which residents may choose to avail of and the residents allocated room number were not recorded on all of the contracts reviewed.

Judgment: Not compliant

Regulation 34: Complaints procedure

The inspectors were presented with a log of complaints including the description of the complaint, action taken and outcome. However the results of investigations into complaints were not included on this record. Some had hyper links to other electronic file systems but were not accessable on the paper log. Outcomes were not recorded for three closed complaints. There was no record of the complainants' satisfaction for closed complaints.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Schedule 5 Policies had been updated within the specified time frame. A tracking system was in place to monitor when and who was responsible for updating

individual policies and procedures.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that residents were generally well cared for and supported to live a good quality of life in the designated centre. However, improvements were required in key areas of quality and safety such as premises, fire safety, infection prevention and control and residents' rights to ensure residents' safety was promoted and maintained at all times.

The inspector reviewed a number of residents' assessments and care plans. Each had a comprehensive assessment on admission using a variety of validated assessment tools, for example nutritional, falls risk, tissue viability and pain assessment tools. Care plans were completed within 48 hours of admission. They were found to be very detailed, comprehensive and person-centred. Specific care plans were updated whenever there was a change in the resident condition. Residents care plans were seen to be detailed and care plans for those with continence issues, infections and those on antibiotics were completed. Restrictive practices assessments (such as bed rails) were completed and documented in the residents care plan. Wound assessments, monitoring of the wound, tissue viability nurse interventions and plans of care were sufficiently detailed to guide staff in the delivery of care.

The activities staff arranged the residents' forum meetings held every three months. The persons in charge allocated the role of ensuring that residents maintain their civil rights to vote in elections to the activities team. They organise for a ballot box to be brought to the centre for those residents who wish to vote in local and national elections. Voluntary groups such as Alone, were also welcomed into the nursing home to visit and chat with residents.

A comprehensive antimicrobial stewardship programme had been developed and the practice development nurses were involved in this process. There was input from the multidisciplinary team and antibiotic usage was monitored closely. Residents at the centre also had good access to social workers and a designated safeguarding officer. Access and referrals to the safeguarding officer was a simple process, and could be arranged in person, by phone or email.

The arrangements in place to identify and rectify maintenance concerns were not adequate to ensure that the building was kept in compliance with Schedule 6 of the Regulations. In one corridor near the nurse's station, there was extensive damage to the bottom of the wall. This had not been identified by environmental checks. There were several areas of the designated centre, where the beds were causing damage to the floor coverings in the bedrooms. Damaged floor coverings were also found on corridors. This had been identified on a previous inspection, but not all areas of

concern had been addressed. Inspectors also found ceilings in poor condition in a number of areas, including, ceiling tiles damaged or missing in the Oisín unit day dayroom, the Tara ward sluice room and treatment room.

The arrangements to protect residents from the risk of fire were reviewed. Staff had acess to fire safety training. The provider had identified any staff who required refresher training and had scheduled training sessions for those staff members. Staff were knowledgeable on the evacuation procedures. These procedures were tested by way of regular drills using different scenarios. Records reviewed evidenced that there were an adaquate number of staff to evacuate residents in a safe and timely manner. On the day of inspection, fire alarm panels were in the process of being upgraded. Fire extinguishers were located throughout the centre and these were regularly serviced. Improvement was required in relation to the containment of fire. Inspectors noted that although all bedrooms were fitted with fire doors, none were fitted with door closers. This meant that bedroom doors remained in an open position and, as a result, would not be effective at containing fire. A number of fire doors were observed to be defective due to damage to smoke seals and some doors did not close completely. This meant that the doors would not function properly in the event of a fire. A review of the centre's emergency lighting was also required as inspectors noted that one corridor did not have adequate emergency lighting.

Regulation 12: Personal possessions

Although residents had access to their personal belongings and clothes in their rooms, some residents did not have adequate space to store their clothing and belongings, for example residents in the shared rooms had smaller wardrobe space and some of these wardrobes could not be closed as they were full. Three residents in single rooms were using boxes and bags to store some personal items as they did not have enough space for their belongings.

Judgment: Substantially compliant

Regulation 17: Premises

The registered provider failed to provide a premises which conform to the matters set out in Schedule 6.

- Damaged floor coverings were found in bedrooms beneath and at the ends of the beds posing a trip hazard and reducing the effectiveness of cleaning procedures.
- Inspectors observed floor coverings throughout the centre with cracks and breaks which were noted on the previous inspection.
- The floor in one en-suite was pushed downwards under foot when inspectors

entered the room.

- The tiling in one assisted bathroom was loose, and sections missing. This had been identified on the last inspection.
- Ceiling tiles were found to be in a poor state of repair in some areas. For example, in the Oisin unit day room and in one of the assisted bathrooms.
- There was a hole in the external wall in the laundry room which did not protect against the entry of vermin.
- Damage was seen on walls notably at the nurses station in the Connall unit where the structure of the wall had been compromised with large holes.
- There was an overall lack of storage in the designated centre resulting in excessive and inappropriate storage. One sluice room, a day room and assisted bathroom were being used to store equipment. Insufficient storage was identified on the last inspection.

Judgment: Substantially compliant

Regulation 27: Infection control

Although the premises was found clean overall, the deficits in the premises impacted on the effective cleaning of the centre such as damage to walls, painted surfaces and floor coverings. The following issues were identified:

- One vacant room that was cleaned still had resident moving and handling slings in the bathroom. The slings were not identified as being clean.
- Staff lockers and a staff rest area were located in a store room, which contained boxes of supplies posing a risk of cross-contamination.
- The infrastructure of the laundry did not support the functional separation of the clean and dirty phases of the laundering process. Due to the space limitation, there was no clean area to sort and fold laundry and the staff had to do this on a trolley in the corridor.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Improvements were required to protect residents from the risk of fire and provide suitable fire fighting equipment.

Exposed electrical distribution boards were found in three assisted bathrooms. The cabinet which housed these boards was not fire rated, and the units themselves were missing the fire rated doors. Maintainance staff were alerted to this and committed to take action to resolve the risk.This was addressed by staff on the day

of inspection

- There were no fire blankets in two staff break rooms where there were toasters which could be a potential source of ignition. The person in charge gave a verbal undertaking that she would provide same.

The registered provider was required to take appropriate measures to provide adequate means of escape, including emergency lighting for example:

- There was a lack of emergency lighting and directional escape signage at Ailbhe ward near room 30. This was a repeat finding.
- There were no layout plans visible at the fire alarm panel at Teach Cara. This could impact on the time taken to evacuate residents in the event of an emergency as staff would not readily be able to see the location of a fire from looking at the fire alarm panel.

The registered provider was required to make adequate arrangements for detecting, containing and extinguishing fires for example:

- The fire doors to each bedroom did not have door closers fitted to ensure they closed in the event of a fire. Several doors were seen to be wedged open. For example the staff room in the Oisin unit and the laundry room in Teach Iosa. This was also noted on the last inspection.
- There were a number of doors which were damaged, or had parts of the fittings missing e.g Teach Tara staff changing room, Comms room door, store room door and female changing room. A number of fire doors were not closing when released from the door closers. For example the staff room door and assisted bathroom door in the Ailbhe unit, Laundry room in Teach Iosa, and a 60 minute compartment door near in the Bebhin unit. Fire seal strips were damaged or missing on some doors including 60 minute stairwell door and a 60 minute compartment door on the Connall unit .

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Each resident had a comprehensive assessment completed using a variety of validated tools and care plans prepared within 48 hours of admission. Care plans were in place to support the individual needs of residents such as wound care, multi-drug resistant organisms, those at risk of falls and therapeutic activities based on the individual residents assessments. Care plans were seen to be person centred and provided good instructions and guidance for staff caring for the residents. They were updated within the required time frame.

Judgment: Compliant

Regulation 9: Residents' rights

Residents in all of the twin shared rooms visited by inspectors did not have adequate privacy to undertake personal activities in private due the the configuration of the privacy screens. The screens divided the room in half but in doing so did not allow the resident (furthest from the door) access to the bathroom or to enter or leave the room whilst the other was receiving personal care.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Phoenix Park Community Nursing Units OSV-0000476

Inspection ID: MON-0039155

Date of inspection: 27/01/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. A training needs analysis will be completed for the designated centre to identify and collate staff training gaps for manual handling, safe guarding and fire training 2. CNM's will circulate Memo to to all relevant staff regarding requirement to complete outstanding mandatory training by All staff to be encouraged to do mandatory training 3. Protected time will be given to staff to complete their training 4. PIC will ensure that staff have access to required mandatory training 5. Fire training commenced on February 16th 20223Training now includes Fire safety risks and Evacuation training including closing of bedroom doors 6. Manual handling training has been outsourced and has commenced on 24th Feb 2023 and staff are being encouraged and given time to complete same. 7. We have identified 6 staff to be trained as MAPA trainers in May 2023 who will then run in house training for all staff. 8. CNM's will update the designated centre training record monthly and forward same to ADON's and Admin support will update campus training record. 9. Monitoring system , CNM's will monitor the training records, and notify staff when they are due	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: 1. The registered provided will ensure the directory of residents shall include the information as specified in paragraph 3 of schedule 3 by 30/06/2023.	

2. It will be updated by Admin support in line with changes in residents status
3. All ADON's, Admin support and CNM's will have access to same via shared folder
4. The directory of residents will be available when requested by Chief Inspector or delegate.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The registered provider will review the designated centres floor plans and the allocated usage of each room where required applications to vary will be submitted to HIQA
2. Upkeep and oversight of the premises and fire management systems will be monitored through the designated center's management meeting
3. Quality and safety walk rounds take place bi-annually on each ward

The Designated Centre introduced the following system to provide oversight and monitoring of outstanding maintenance jobs to ensure the environment is maintained, safe, and effective:
1. Currently the system in place requires the generation of requisitions for maintenance in the form of blue dockets. Blue dockets are screened (to prioritise the requests) by facilities services. Blue dockets are sent to Administration, updated onto SAP system and managed and monitored by maintenance manager daily – anything urgent will be prioritised.
2. PICs and CNMs monitor requests for all outstanding maintenance jobs on a weekly basis.
3. PICs revert to maintenance services and escalate to Operations management and Hospital manager weekly through Senior management Team (SMT) meeting.
4. Trirega, new software maintenance management package – is planned to be introduced in Q2 – Q3 under the supervision of the hospital manager
Completion Date: 31st August 2023
Persons Responsible: Hospital Manager / PIC's / HSE Estates

Regulation 24: Contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:

1. The registered provided will ensure an audit will be completed of all current residents contracts for care by the 30th of June 2023 2. The registered provider shall ensure that a complete contract of care is given to and agreed with each resident in line with requirements by 30th of September 2023. 3. Completed Contracts of Care will be stored in a file in ADoN's office.

Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: 1. There are now 2 designated Complaints Officers, who maintain the complaints log. The Director of Nursing manages Clinical complaints and the Operations Manager manages non clinical complaints 2. The complaints log for 2023 will be reviewed to ensure all required information is recorded on the paper log by end of April 2023. 3. Going forward the Complaints Officers will ensure the outcomes, results of investigations and complainant's satisfaction are included in the complaints log.	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: 1. Additional storage e.g. chest drawers will be requested for residents in single rooms where it is required by the 30th of April 2023. 2. Additionally extra storage e.g. chest drawers will also be provided for residents in multi occupancy rooms where it is required by the 30th of April 2023	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1. Plan for major floor repairs to commence by 30/06/2023 and contractor engaged to commence other small flooring repairs 2. Maintenance department to carry out repairs to cracked tiling and ceiling tiles to be replaced as part of the major floor repairs as above.	

3. Hole in wall of laundry room to be filled in as part of the major floor repairs.

• Flooring upgrades commenced at the end of April 2023 across both units, Oisin and Conall with priority given to the rooms and en-suite identified in both units. Priority is given to floors in need of immediate repair. Room 1 in Oisin is complete and works are ongoing in en-suite bathroom for Room 20 (4 bedded), Room 17 in Conall is complete and works ongoing for en-suite bathroom for Room 20 (2 bedded).
Completion Date: 31st December 2023
Persons Responsible: HSE Estates
• The management team are committed to a continuous refurbishment program through the HSE minor capital funding, works are prioritised based on risks. This process is ongoing and submitted in November of each year for allocation of funding.
Completion Date: Ongoing
Persons Responsible: Hospital Manager
• The disintegrated plaster at the wall of nurse's station in Conall unit has been repaired.
• HSE Estates have assigned a painter to the site and is working to remove all wall paper and re-paint the wall.
Completion Date: Complete
Persons Responsible: PIC's

• A rectangular block of missing floor at this nurses station is being re-instated in the floor repair works as discussed above.
Completion Date: 31st August 2023
Persons Responsible: PIC's / HSE Estates

Management have engaged with a clinical engineer consultant to carry out the following:
• A review of all equipment whereby obsolete equipment is removed from ward level.
• Equipment requiring repair is labelled and sent to a centralised location for repair
• A development of an equipment library is underway.
• Review of TIM (Total Inventory Management) around minimum stock quantities is underway, this will assist in dealing with overstock which is carried at ward level.
Completion Date: 31st August 2023
Persons Responsible: Hospital Manager

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. Staff shall ensure that all patient equipment will be removed from vacant rooms and stored appropriately
2. All staff have been informed to use the designated staff room only and not to use the Store rooms on individual units during break times.
3. Plan for major floor repairs to commence by 30/06/2023 and contractor engaged to commence other small flooring repairs

Management have engaged with HSE Estates (March 2023) around the installation of extract ventilation, however this will require a capital submission. We are working on an interim solution to address this issue. Interim solution is to relocate the laundry to the main campus laundry.
Completion Date: Interim Solution Date: 31st May 2023
Persons Responsible: Hospital Manager
Completion Date: Permanent Solution Date: 31st December 2023
Persons Responsible: HSE Estates

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Fire Alarm and Detection System (FDAS) upgrade works are being carried out at the moment. When these works are complete, an assessment of fire door closure will be taken with the service.

2. Emergency lighting will be updated by Fire contractor as part of the upgrade works
3. Directional signage to be updated (Ailbhe near RM 30) by Fire contractor as part of upgrade works.
4. Electrical distribution boards to be secured by fire contractor as part of FDAS.
5. Fire blanket provided in staff break room
6. Fire plans are displayed beside fire panel in Teach Cara.

1. Upgrades to the fire system in Teach Cara (50-bedded Unit). This work was completed on 30th April 2023.
Completion Date: Complete
Persons Responsible: HSE Estates

2. Upgrades to the fire system of Teach Iosa (100-bedded unit) work commenced on 2nd May, project expected to run for 5 months, on completion both units will have a fire alarm system at L1 level. The expected completion date is 31st Oct 2023.
Completion Date: 31st October 2023
Persons Responsible: HSE Estates

Upgrades to the emergency lighting system is due for completion 30th September 2023
Completion Date: 30th September 2023
Persons Responsible: HSE Estates

Upgrades to the directional signage and electrical distribution boards is due to be completed by 30th September 2023
Completion Date: 30th September 2023
Persons Responsible: HSE Estates

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Provision of privacy screens will be reviewed to ensure that a) each resident's privacy is adequately facilitated at all times and b) that each resident has full continuous access to their environment. Mobile screens will be ordered by By 15/4/2023.	

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(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 and other personal possessions.	Substantially Compliant	Yellow	31/08/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/07/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises	Substantially Compliant	Yellow	31/12/2023

	which conform to the matters set out in Schedule 6.			
Regulation 19(1)	The registered provider shall establish and maintain a Directory of Residents in a designated centre.	Substantially Compliant	Yellow	31/08/2023
Regulation 19(2)	The directory established under paragraph (1) shall be available, when requested, to the Chief Inspector.	Substantially Compliant	Yellow	31/08/2023
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	31/08/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/08/2023
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other	Not Compliant	Orange	31/08/2023

	occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
Regulation 24(2)(a)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.	Not Compliant	Orange	30/09/2023
Regulation 24(2)(c)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of where appropriate, the arrangements for the application for or receipt of financial support under the Nursing Homes Support Scheme, including the arrangements for the payment or refund of monies.	Not Compliant	Orange	30/09/2023
Regulation 24(2)(d)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the	Not Compliant	Orange	30/09/2023

	designated centre concerned and include details of any other service of which the resident may choose to avail but which is not included in the Nursing Homes Support Scheme or to which the resident is not entitled under any other health entitlement.			
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	31/12/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	30/09/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including	Substantially Compliant	Yellow	31/08/2023

	emergency lighting.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/06/2023
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Substantially Compliant	Yellow	30/04/2023
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	30/04/2023
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any	Substantially Compliant	Yellow	30/04/2023

	investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			
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.	Substantially Compliant	Yellow	30/04/2023