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 John's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Munster Hill, Enniscorthy, Wexford
Type of inspection:	Unannounced
Date of inspection:	13 May 2025
Centre ID:	OSV-0000604
Fieldwork ID:	MON-0044236

About the designated centre

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

St. John's Community Hospital is located on the outskirts of a busy town. It is a purpose-built single-storey centre which can accommodate up to 104 residents. It provides rehabilitation, respite and extended care to both male and female residents over the age of 18, although the majority are over 65 years of age. The centre is divided into four units. In total, there are 20 four-bedded rooms, two twin rooms and 20 single rooms. All have full en-suite facilities. Other areas include day rooms, a smoking room, kitchenettes, offices and treatment rooms. There is also a large main kitchen and laundry. There are enclosed external gardens which are spacious and well maintained. Seating is provided there for residents and their visitors. There is parking space provided for residents, staff and visitors. According to their statement of purpose, St. John's aim to provide person-centred care to the older population of County Wexford. They aim to provide quality care in a homely environment where everyone is treated with dignity and respect.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	94

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 13 May 2025	10:45hrs to 19:45hrs	John Greaney	Lead
Tuesday 13 May 2025	10:45hrs to 19:45hrs	Niall Whelton	Support

What residents told us and what inspectors observed

Residents living in St. John's Community Hospital were predominantly complimentary of the quality of care they received from staff who they described as caring, patient, and kind. Residents told the inspectors that staff were attentive to their needs and made them feel safe living in the centre.

Inspectors arrived at the centre unannounced and were met by the person in charge and an assistant director of nursing. Following an introductory meeting, the inspectors walked through the centre, reviewed the care environment and met with a large number of residents and spoke to eight in detail about their experience of living in the centre.

St. John's Community Hospital is a modern, single storey building situated on spacious grounds close to the town of Enniscorthy. In addition to the designated centre for older people, there is also a day centre for older people and a range of mental health service facilities on the same campus.

Bedroom accommodation in the centre is predominantly multi-occupancy with over 75% of residents accommodated in 4-bedded rooms. The centre is divided into four wards, Oak, Elm, Ivy and Beech. Ivy ward is the designated dementia ward and accommodates 20 residents in three 4-bedded rooms and eight single rooms. Beech ward is predominantly for short stay residents that are admitted for rehabilitation, respite or as step down from acute hospital prior to returning home or transitioning to long term care. Beech ward accommodates 32 residents in five 4-bedded rooms, two twin bedrooms and eight single bedrooms. Both Oak and Elm wards accommodate long stay residents. Oak comprises six 4-bedded rooms and two twin bedrooms. Elm also comprises six 4-bedded room and two twin bedrooms. Due to the number of residents accommodated in multi-occupancy bedrooms in both Oak and Elm wards, there is a designated palliative care room in each of these wards to accommodate residents that wish to have a single room as they approach end of life. One of these rooms was occupied for this purpose on the day of the inspection.

There was a calm and relaxed atmosphere in the centre throughout the inspection. During the morning, staff were observed to respond to residents requests for assistance promptly. Residents told inspectors that they never felt rushed by staff and they reported that they were always greeted with respect. Residents informed inspectors that they knew some of the staff very well, but also added that there were a lot of staff that they did not know as there were frequent changes in staff personnel. Residents reported that this could sometimes result in their care not being delivered according to their preferences.

The premises was generally well- maintained, appropriately decorated, clean, well-lit, and warm for residents. Corridors were wide and spacious, containing appropriately placed hand rails to support residents to walk independently around the centre. There was a large enclosed garden accessible to residents. There was

access to a number of outdoor spaces for residents with additional outdoor spaces to the sides. These were maintained to a high standard and created a pleasant external environment for residents.Residents had ready access to these areas through multiple access points from within the centre.

There was ample storage facilities for equipment, and corridors were maintained clear of items that could obstruct residents who were observed walking around the centre throughout the day. Furnishings in communal areas and bedrooms were observed to be well- maintained and comfortable for residents.

The main communal sitting rooms in in both Oak and Elm are adjacent to each other, separated by an accordion like dividing screen. There is also a kitchenette in this area that straddles both wards. The dining rooms in both Oak and Elm were previously 4-bedded rooms. As found on previous inspections, despite efforts to provide a more homely dining environment these areas remain clinical in appearance even with the addition of old style kitchen furniture.

Inspectors availed of opportunities to spend time in communal rooms, observing the interactions between the staff and residents. Staff were attentive to the needs of the residents. Inspectors observed a number of staff and resident interactions during the inspection. In general, residents were seen to be relaxed and comfortable in the company of staff. Staff were observed assisting residents with their care needs and overall, staff provided this support in a patient and respectful manner.

Residents could receive visitors within communal areas or in the privacy of their bedrooms. Multiple families and friends were observed visiting residents during the inspection day.

The following sections of this report details the findings with regard to the capacity and capability of the registered provider and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

This was an unannounced inspection carried out over one day by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

The findings of this inspection were that the provider had taken action to address issues identified on the previous inspections conducted in January 2024 and April 2024. However, this inspection found that action taken to address infrastructural design deficits, to the means of escape and fire containment had made little progress.

The Health Service Executive is the registered provider of St. John's Community Hospital. The organisational management structure for the designated centre

consists of the head of social care and the general manager of older person services who provided operational oversight and support to the person in charge. As part of the most recent registration renewal in May 2024, the Chief Inspector attached two restrictive conditions to the registration of the centre. Condition 4 required the registered provider to nominate a person who would participate in the management of centre by 31 October 2024. The purpose of the restrictive condition was to ensure that person in charge was adequately supported by a suitable management team and to ensure that there was a sufficient and clearly defined management structure in the designated centre. The condition was subsequently varied following an application by the provider to extend the date to 30 June 2025. Condition 5 of the registration required the provider to arrange for a fire safety risk assessment (FSRA) of the designated centre carried out and submit a copy of the report to the Chief Inspector by 30 September 2024. The purpose of this condition was to ensure that the provider takes adequate precautions to protect residents from the risk of fire. Findings on the day of the inspection were that some action was taken to address the findings of the previous inspection, namely;

- a new widened exit had been fitted in the Beech Ward, and the external route from this exit had been upgraded
- new sixty minute fire rated doors were fitted in the Oak and Elm to protect the bedroom corridors from a fire in the day rooms

Further action was required by the provider to review the fire safety strategy in the centre for nursing home use and the additional fire safety risks arising from that use. For example there were still;

- extended travel distances
- excessively large fire compartments to facilitate horizontal evacuation
- inadequate numbers of final exits

In line with condition 5, a fire safety assessment had been submitted to the Chief Inspector in September 2024. The assessment did not address in full the findings of the previous inspection and there has been repeated engagement with the provider to progress this. As the scope of the project had increased, the provider committed to submitting a timebound action plan, including a full scope of the works, by the end of quarter two of this year.

The person in charge of St. John's Community Hospital is a director of nursing (DON) and also has oversight of another designated centre for older persons, in which the person in charge is an ADON. The person in charge of St.John's Community Hospital is supported by an assistant director of nursing in the administration of the service and a number of clinical nurse managers.

A review of the centre’s staffing roster found that the staffing levels and skill-mix were appropriate to meet the assessed health and social care needs of the residents, given the size and layout of the building. The centre. however, was heavily reliant on agency staff particularly healthcare assistants, to meet the staffing needs of the centre. There were adequate numbers of house-keeping, catering and maintenance staff in place.

There was a training and development programme in place for all grades of staff. Records showed that most staff were facilitated to attend training in fire safety, safeguarding of vulnerable people, and manual handling. However, a significant number of staff had not completed training in supporting residents to manage their responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Regulation 15: Staffing

The inspector reviewed a sample of staff duty rotas. There is a high level of use of agency staff, however, every effort is made to ensure that there is continuity among the agency staff that work in the centre. Communication with residents and staff indicated that the number and skill-mix of staff was sufficient to meet the needs of residents, having regard to the size and layout of the centre. Staff had the required skills, competencies and experience to fulfil their roles and responsibilities.

Judgment: Compliant

Regulation 16: Training and staff development

Action was required by the provider to ensure that staff had up-to-date training to support them provide care and support in accordance with their role. For example:

- approximately 85% of staff had not attended training to support them respond to and manage behaviour that is challenging
- while there was a high level of attendance at fire safety training, approximately 20% were overdue refresher training by a number of weeks
- a small number of staff were overdue attendance at refresher training in recognising and responding to abuse.

Judgment: Substantially compliant

Regulation 23: Governance and management

A condition had been attached to the registration of the centre for the registered provider to arrange for a fire safety risk assessment (FSRA) of the designated centre by 30 September 2024. The FSRA should identify, assess and rate all fire risks throughout the centre, informed by the resident profile, with particular emphasis paid to the accommodation and fire safety requirements of all residents.

While a FSRA had been submitted by 30 September in line with the condition, it did not address in full the findings of the previous inspection. At this inspection, there was still no scope of work, nor time bound action plan available for review.

In relation to risk, a trolley for hot food was located on a circulation/escape corridor. This created two risks; an obstruction to the escape route and a surface which was hot to touch posing a risk to residents. The person in charge confirmed an alternative location would be sought and used to eliminate the risk.

Two electrical cupboards were found to be unlocked, creating a risk to residents that may open and access the electrical panels. This was actioned during the inspection and they were locked.

Judgment: Not compliant

Regulation 30: Volunteers

A number of volunteers visited the centre regularly to spend time with residents and to support them to participated in activities. The information as detailed in the regulations relating to volunteers, such as roles and responsibilities and and Garda Vetting disclosures were in place to safeguard residents.

Judgment: Compliant

Regulation 4: Written policies and procedures

Not all policies listed in Schedule 5 of the regulations were reviewed at a minimum of every three years. Policies found to have not been reviewed included, End of Life policy, Recruitment and Selection of Staff, and Temporary Absence and Discharge of Residents.

Judgment: Substantially compliant

Quality and safety

Residents living in the centre received care and support to enable them to feel safe and to enjoy a good quality of life. Residents reported feeling safe and content living in the centre. However, action was required in relation to fire safety, predominantly from an infrastructure perspective. Action was also required to ensure that the premises conformed to matter set out in Schedule 2 of the regulations. Other areas

that required attention included care documentation and there is also a need to ensure that there was a clear decision-making process prior to the use of any restrictive practices.

The centre had a paper-based resident care record system. The inspectors found that while each resident had an assessment of their physical, psychological and social care needs on admission to the centre using validated assessment tools. Care plans were developed based on these assessments, however, there was not always an adequate degree of personalisation to support staff, particularly staff that may be unfamiliar with the residents, provide person-centred care for the residents. This is discussed further under Regulation 5 of this report.

A review of residents' records found that there was regular communication with residents' general practitioners (GP) regarding their health care needs and arrangements were in place to ensure that the general practitioners were informed of residents that showed signs and symptoms of physical deterioration. Out-of-hours GP services were also available. Residents could access the expertise of allied health care professionals such as dietetic services, and speech and language therapists for further expert assessment through a system of referral.

There were no residents presenting with significant responsive behaviour living in the centre on the day of the inspection. There were ongoing efforts to minimise the use of restraint. However, further action was required to ensure that there was adequate exploration of alternatives prior to the use of restraint. This and other issues in relation to managing behaviour that is challenging is further discussed under Regulation 7 of this report.

At the previous inspection, immediate risks were identified relating to inadequate fire safety training and the poor management of the call bell system; this had been actioned. Additional pager units were procured and available for staff to carry. The provider had arranged for a programme of site specific fire safety training, which is discussed further under regulation 28: Fire Precautions.

Similarly to the previous inspection, the building did not align with best practice for nursing home occupancy, and was still designed to meet the requirements of a health care facility. Compartments to facilitate progressive horizontal evacuation comprised up to 56 residents, with sub-compartments for up to 20 residents. Travel distance (the distance to travel when escaping from a position in the building to an exit) still exceeded the guidelines for nursing home use and there were no exits available along the full length of the south side of the building, resulting in the extended travel distance to get to a final exit.

The provider was still exploring options to further subdivide the building into smaller sub-compartments, however these proposals were not yet finalised.

Floor plans on display, to support evacuation had been updated with the newly installed fire doors in Elm and Oak units.

The person in charge, had implemented an audit system for fire drills practiced, unit by unit and had a scoring system in line with the centres own guidance for

objectives and outcomes of the drill. The latest audit showed two units scored high, however improvements were required with the other two units.

The call bell had been upgraded on the Oak unit, and wiring for same was completed on Elm unit; the work to complete the upgrade in Elm was ongoing during the inspection. The inspectors observed that staff were aware of the ongoing work and had increased supervision in areas where the call bell would not be heard, however it was not documented in a risk assessment. It was reported to the inspectors that there were future plans to continue the upgrade of the call bell system in the remaining units in 2026.

Improvements were evident to the premises; inspectors saw newly decorated sitting areas on corridors creating a more homely and less institutional appearance. Activity corners had been provided in the large day rooms in the Elm and Oak, with new wallpaper and decals setting them apart from the day space. The small visitors room in the Elm was similarly decorated. However, the dining areas in the Elm and Oak, were not homely and and was apparent they had been bedrooms. Some efforts had been made by the provision of side boards, furniture and a mural in one, however further improvements could be made to create an environment more suited to a dining experience. While only just delivered that morning, an order of new bed tables were being stored in one of the dining rooms.

Residents were supported to continue to practice their religious faiths and had access to newspapers, radios and televisions. There was a programme of activities and residents were observed to participate in a variety of activities over the course of the inspection. Resident were supported to maintain links with the community through outings to places of interest and shopping trips. However, the inspectors found that a significant number of residents spent a large amount of time in their bedrooms with minimal stimulation. This is outlined further under Regulation 9 of this report.

Residents that spoke to the inspectors were positive regarding the choice of food provided to them in the centre. There were systems in place to ensure residents at risk of dehydration and malnutrition were regularly reviewed and timely interventions provided.

Visitors were openly welcomed in the centre and residents were happy with the arrangements in place.

Regulation 11: Visits

Inspectors observed visiting being facilitated in the centre throughout the inspection. Residents who spoke with inspectors confirmed that they were visited by their families and friends and adequate arrangements were in place to receive visitors in private.

Judgment: Compliant

Regulation 17: Premises

Action was required by the provider to ensure compliance with regulation 17 and schedule 6;

- The dining rooms in Elm and Oak were not designed and laid out to promote a homely dining experience. These rooms were formerly multi-occupancy bedrooms and still maintained that appearance. For example the overhead hoist tracks were still in place and the services bank with sockets and oxygen outlet were still in place
- The relatives room was not fitted with a call bell
- The hairdressing rooms were in former en-suites opening onto the dining rooms in the Elm and Oak. There was malodour in the hairdressing room in the Oak, potentially from the drain
- Some areas of flooring was damaged in the Elm unit and required repair
- Some doors were damaged from impact from equipment and required repair; one example includes the door to a toilet in The Ivy. There was a large hole in the ceiling of this bathroom also, impacting fire containment
- The closing force on the door to the internal courtyard area from the Elm dining room was seen to close with excessive force; this was not risk assessed
- Within two quiet rooms (formerly single bedrooms), there was disused cabinets with redundant electrical panels; assurance is required that these are appropriately disconnected
- The door to the clean utility and fridge within were not locked, with unrestricted access to medications.

There were a number of rooms, used for the running of the designated centre, which were not within the red line (the line on the registered floor plan which sets out the extent of the registered designated centre), which included the maintenance workshop, the boiler room, pump house, electrical room.

Judgment: Not compliant

Regulation 28: Fire precautions

Notwithstanding the action taken, as described under capacity and capability above, most of the non-compliance in relation to means of escape and fire containment was still outstanding.

While the inspectors noted improvements by the provider in taking precautions against the risk of fire and reviewing fire precautions, further improvements were required as evidenced by;

- there was a fire safety policy in place, however the named key personnel was incorrect (repeated finding)
- the small leaf of a double door to an activity room was left open and was not fitted with an automatic closing device; the door would not close to contain fire
- There were nurse stations open to bedroom corridors and included equipment such as printers. This was not risk assessed to inform appropriate controls for staff to adhere to, to manage the risk on a bedroom corridor, in particular given the known deficits to the means of escape and fire containment

Action was required to ensure adequate containment and detection of fire, for example;

- the inspectors were not assured that the centre was adequately sub-divided into effective fire compartments to support the progressive horizontal evacuation strategy. While units were subdivided with thirty minute 'sub-compartment' walls, it was not clear if these boundaries were effective compartment boundaries to support horizontal evacuation. The size of the sixty minute fire compartments were excessive, as a result of being designed as a health care building. The Elm and Oak had had new sixty minute doors fitted, but further investigation was required to determine if the wall in which they sit formed an effective fire compartment; essentially it still comprised one large sixty minute compartment, with capacity for 52 beds. The Ivy and Beech each formed a separate sixty minute compartment with 20 residents in Ivy and 32 residents in Beech
- the inspector observed gaps between the frame of a fire door and the wall in which it is fitted, to a sample of electrical cupboards reviewed. This means that fire would not be effectively contained (repeated finding)
- it could not be confirmed that glazing within some fire rated enclosures achieved the appropriate fire rating and required review (repeated finding)
- smoke detectors in some bedrooms were too close to the wall to be fully effective (repeated finding)

The provider was not ensuring an adequate means of escape was provided, including emergency lighting, for example:

- the distance to travel within wards, and to reach final exits exceeds the limits for travel distance in a nursing home (repeat finding)
  some areas of the external escape routes did not have adequate coverage of emergency lighting to ensure safe escape to the assembly points (repeat finding)
- the day space for the Elm and Oak wards were adjoined, separated by a folding partition. New fire doors were fitted to separate the dayrooms from the corridors, however it could not be assured that the walls in which the new

doors were fitted created fire compartment boundaries, this was part of a future scope of work
- designated exits from two day spaces in the Ivy ward were taken out of use as exits in the absence of appropriate risk assessment (repeat finding)
- some bedroom escape corridors were not effectively sub-divided by fire doors to restrict the spread of smoke along their length (repeat finding)

The arrangements in place for maintaining fire equipment, means of escape, building fabric and building services were not adequate, for example;

- new wires provided for the call bell system penetrated the plastered ceiling, these required sealing up to maintain the fire rating of the ceiling
- fire doors were generally in good condition, however some deficits had occurred since the previous fire door servicing. For example, the laundry door had a large gap to the bottom of the door.

The provider had made arrangements for staff to receive fire safety training, however the frequency of this training was not detailed in the centres fire policy. The inspectors were told the fire safety training arrangements included in-person site specific training annually and fire extinguisher training every three years. The inspectors were not assured that the frequency of the extinguisher training was adequate to ensure that staff competency in this training would be maintained. Attendance at fire safety training was high, however a number of staff were recently due their annual training. In terms of the fire extinguisher training, a large number had not yet completed this training.

The inspectors noted improvements in staff knowledge and the drill practices taking place. The providers own audit identified improvements were required in two units to meet the drill objectives. The inspectors reviewed drill records and noted they simulated the occupancy at the time of the drill, but hadn't simulated the evacuation of a full compartment in order to fully test the evacuation strategy. Staff spoken with confirmed they had attended fire safety training and participated in drill practices. They also were aware of the new fire doors installed.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required in the development of care plans to ensure that they provided adequate guidance to staff to provide person-centred care to staff. This is particularly relevant due to the high number of agency staff that may not know residents usual routines and preference. For example:

- there was a variation in the degree of personalisation of care plans, with some care plans detailing generic information that did not reflect individualised preferences

- there were behaviour charts in place for some residents detailing incidents of responsive behaviour, however, not all of these residents had behaviour care plans in place.

Judgment: Substantially compliant

Regulation 6: Health care

Residents living in this centre had access to a good standard of health care and support. Residents had good access to general practitioner services that visited the centre daily. Out-of-hours GP services were also available. Residents had access to allied health professionals such as speech and language therapist, dietitian, and specialist medical services such as community palliative care and psychiatry of old age, as required. There was also access to advice from a tissue viability nurse specialist regarding wound care management.The services of a physiotherapist had been sourced to commence in the weeks following this inspection.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

While there was a focus on the reduction of the use of restraint and there was evidence of a reduction in bed rail usage, further action was required to ensure that the least restrictive measure was used at all times. For example:

- not all assessments conducted prior to the use of bed rails documented alternatives trialled prior to the use of bed rails
- there was a high use of alarms that alerted staff when residents got out of bed but there was no clearly documented process to support the decision making process, for example, multidisciplinary team input.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The programme of activities is overseen by designated activity staff with the support of community employment scheme workers. While improvements were noted in the provision of activities since the last inspection, the inspector observed a significant number of residents either in their bedroom or in communal sitting rooms with minimal stimulation.

Bedrooms had glazed panels on both the doors and the adjacent walls, impacting residents' privacy and rights. The multi-occupancy rooms had privacy curtains for each bed but this was an unnecessary means to have privacy from the corridor if relaxing in their room. The single rooms in a number of instances, did not have obscured glazing and had no means of protecting the resident's privacy in the bedroom.
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 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 30: Volunteers	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not 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 9: Residents' rights	Substantially compliant

Compliance Plan for St John's Community Hospital OSV-0000604

Inspection ID: MON-0044236

Date of inspection: 13/05/2025

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: • The centre has funded a member of staff to upskill as an onsite trainer for positive behavior support including managing responsive behavior. This person is now certified and roll out of the training programme is underway with a programme of training to ensure all staff are captured by year end. This additional support will also allow for targeted support should any residents present with new responsive behavior. • Staff at the centre complete online fire safety eLearning as well as site specific fire evacuation training with an external fire safety training specialist. This site specific training is booked in for further upcoming dates to ensure all staff receive refresher training each year. • Monthly fire drills continue on each ward with a record maintained of staff attendance and includes agency staff participation to ensure familiarization of fire evacuation procedures. • The small number of staff overdue refresher training in recognizing and responding to abuse will complete same prior to July 31st. Expected completion date: 31/12/2025	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

• A scope of works and a phased plan of works has been submitted to the regulator. This scope of works is now for tendering considering the significant investment and the provider will endeavor to update the regulator as the project progresses. Action Complete.

• The hot food trolley has been relocated within the ward pantry and is no longer maintained on the corridor. Complete.
• All electrical presses are kept locked at all times with signage indicating this. The ward managers will include monitoring of same in their daily safety checks.
Action complete.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• The identified policies due for renewal – the center's End of Life policy, Recruitment and Selection of Staff policy, and Temporary Absence and Discharge of Residents policy will be reviewed and updated by July 31st.

Expected Completion Date:31/07/2025

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The dining rooms in Oak and Elm Ward have be reviewed with a plan developed to refurbish both areas to enhance the dining experience.
• This project will initially encompass the Oak dining room through a PDSA cycle (Plan-Do-Study-Act) with resident feedback informing the evaluation and success of the refurbishment. From these learnings, we will then upgrade the Elm Ward dining area in early 2026.
• Within the Oak dining room, the hairdressing side-room will be relocated, and this area will be redesigned as a serving area with serving hatch. This will serve multiple purposes of allowing the serving trollies to be safely accommodated, create more floor space in the dining room itself and create a restaurant style environment.
• The tracking hoist, the service socket bank and drain in the hairdressing room will be removed. The room will be refurbished on the advice of the HSE fire officer and risk assessed for suitable materials to minimize any fire risks to create an enhanced dining room experience. Projected completion date of 30th November 2025.

• When the Oak project completed, this will be replicated in Elm dining area with additional improvements if required further to resident and staff feedback. This will have an expected end date of 31st March 2026. An alternative space will be provided for the hairdressing salon.

• Calls bells have been ordered to be installed in both relative's rooms and projected date for works to be complete is August 31st 2025.

• The damaged flooring in Elm unit will be repaired with a projected end date of August 31st 2025.

• The hole in the ceiling of the bathroom in Ivy ward has been repaired. Action complete.
• Painting and decorating is ongoing in the centre and all damaged doors will be repaired and painted during this process commencing with the doors in Ivy unit with a projected end date of 30 September 2025.

• A slow closure release device is being fitted to the door from the Elm dining room to the courtyard. Expected completion 31st July 2025. All doors will be inspected to ensure slow release in place and functioning. Expected completion 30/09/2025. Doors are regularly serviced on a continuous basis.

• The disused cabinets with redundant electrical panels have been removed from both quiet rooms. Action complete.

• All doors to medication areas and medication fridges are kept locked at all times and environmental checklist updated to reflect this. Action complete.

• Floor plans will be updated to incorporate rooms used for the running of the designated centre including the boiler room, pump house and electrical room. Expected date of submission 30/09/2025. The maintenance workshop is not under the remit of St Johns Community Hospital and is not specifically used for the running of the designated centre.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Fire safety policy has been updated with correct named personnel. Action complete.

• The double door to the Activity Room is to be fitted with an automatic closing by July 31st 2025. . All doors will be inspected to ensure slow release in place and functioning. Expected completion 30/09/2025. Doors are regularly serviced on a continuous basis.

• Nurses stations will be enclosed as part of the upgrade of fire works within the building. A risk assessment re the current arrangements will be completed by July 31st

2025.

• A scope of works to ensure adequate containment and detection of fire was submitted on 15th July 2025 and minor works are ongoing including the maintenance of fire doors, review of glazing of fire doors and location of smoke detectors. Evidence of same has been submitted as of 15th July 2025.

• Works to install the upgraded call bell system on two wards have now been completed and all areas affected "made good" to ensure fire protection.

• Staff at the centre complete online fire safety eLearning as well as annual site specific fire evacuation training with an external fire safety training specialist. This site specific training is booked in for further upcoming dates to ensure all staff receive refresher training each year. The centre has also booked additional fire extinguisher training and has sought guidance on evidenced based recommendations as to the frequency of fire extinguisher training.
• Full compartment evacuation drills will be incorporated into the drill schedule to fully test the evacuation strategy.

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:
• Further in house care plan training will be provided to all staff with an emphasis on person centered care documentation, this will commence rollout to all staff in September 2025.
• CNM's on each unit will audit care plans 6 monthly to assess that the information recorded is person-centred based
• All residents who have behavior charts in place have been reviewed and a detailed care plan has been implemented
Action complete.

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:

• All bed rail usage will be reviewed with a focus on further reduction and alternatives will be trialled and documented prior to use.
• The use of bed and chair alarms will be reviewed with a clear documented decision making process chart established and incorporated into the residents care plan. Action to be completed by July 31st.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Residents that prefer to stay in their bedrooms will have the opportunity to take part in a survey to establish their preferred activity and will also have the option to partake in group activity if they so wish. Each day the activity staff will let them know what activity is taking place and we have also introduced a mobile unit for them with various activities included and they can choose between books/magazines to read, art work or crafting. There is also the opportunity to take a visit to the new garden if they so wish. Expected completion: 30/08/2025.

• All bedroom doors and adjacent windows will have glazed screening applied to provide privacy for all residents. Expected completion: 30/09/2025

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/12/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/03/2026
Regulation 23(1)(d)	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	16/07/2025
Regulation 28(1)(a)	The registered provider shall take adequate	Substantially Compliant	Yellow	30/09/2025

	precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/06/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/09/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/07/2025
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire	Not Compliant	Orange	31/12/2025

	alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/07/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/06/2026
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	31/07/2025
Regulation 04(3)	The registered provider shall	Substantially Compliant	Yellow	31/07/2025

	review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
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 family.	Substantially Compliant	Yellow	31/07/2025
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	31/07/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to	Substantially Compliant	Yellow	31/07/2025

	participate in activities in accordance with their interests and capacities.			
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	30/09/2025