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

Issued by the Chief Inspector

Name of designated centre:	Raheen Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Tuamgraney, Scariff, Clare
Type of inspection:	Unannounced
Date of inspection:	16 May 2023
Centre ID:	OSV-0000611
Fieldwork ID:	MON-0039926

About the designated centre

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

Raheen Community Hospital iIs situated in an idyllic rural setting in Raheen Woods, three miles from Scariff. It is registered to accommodate 25 residents. It is a two-storey building and the bedroom accommodation comprises of eight single rooms, one twin room, two palliative rooms, three three-bedded units and one four-bedded unit, all with en-suite facilities. Communal areas comprise of sun room/ conservatory, relaxation garden room, sitting room, church, dining room, family room, kitchen and St Teresa's Garden. Raheen Community Hospital provides 24-hour nursing care to both male and female residents aged 18 or over requiring long-term, short-term, respite and palliative care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

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 16 May 2023	10:00hrs to 19:00hrs	Sean Ryan	Lead
Tuesday 16 May 2023	10:00hrs to 19:00hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

Residents living in Raheen Community Hospital told inspectors that the care and support they received from staff was of good quality. Residents enjoyed living the centre, and they felt that they were supported to be part of their community. Residents complimented the staff, and described the care they received as kind, patient, and respectful.

Inspectors arrived to the centre unannounced, and were met by a senior nurse in charge. Following a brief introductory meeting, inspectors walked through the premises and met with a number of residents and staff. There was a calm and relaxed atmosphere in the centre. Residents were observed to be relaxed and comfortable in a variety of areas such as the communal dayrooms, the dining room, and, in the comfort of their own bedroom. Staff were observed attending to residents requests for assistance without delay, and spent quality time with residents to discuss the plans for the day ahead.

Raheen Community Hospital is a two-storey building located in a rural area near the village of Scarrif, County Clare. The designated centre provided accommodation to 25 residents. Bedroom accommodation was provided on the ground floor and comprised of ten single rooms, one twin room, three three-bedded rooms, and one four-bedded room. All bedrooms had en-suite facilities. The first floor of the premises consisted of office space and staff rest areas. This area was accessible through stairs and a passenger lift.

The inspectors walked through the designated centre. The centre provided a homely and relaxed environment for residents. There were appropriately placed grab rails along corridors to support residents to mobilise safely and independently. The building was warm and comfortable for residents, and the premises was appropriately decorated. Inspectors observed that some floor coverings on corridors were in a poor state of repair. In addition, radiator covers in some residents bedrooms, were visibly damaged. While there were storage areas available in the centre, the organisation of storage did not ensure the appropriate storage of equipment within the centre. Inspectors observed linen trolleys and catering equipment stored along corridors, while clinical and catering items were stored in the cupboards in a sitting room.

Inspectors observed that a number of fire doors contain gaps, and essential smoke seals had been painted over. This compromised the function of fire doors to contain the spread of smoke and fire in the event of a fire emergency. Oxygen was inappropriately stored in a number of locations within the centre, and inspectors observed a large volume of stock and equipment stored under an escape stairs. These items were removed from the area by staff during the inspection. Some fire doors were observed to be held open by pieces of furniture. This would reduce the effectiveness of the fire doors to contain smoke or fire in the event of an emergency. Corridors were found to be cluttered with line trolleys, and in some

areas this obstructed corridors used as a means of escape by residents and staff in the event of a fire emergency.

Overall, the centre was found to be clean and tidy with the exception of sluice rooms, storage areas, and a small number of bathrooms and showers. Infection prevention and control measures had been brought into line with the updated national guidelines, with respect to COVID-19. Residents told the inspectors that it was a relief to see staff and visitors faces again, and that the removal of masks made them feel as though life had returned to normal.

Inspectors spoke with a number of residents with regard to their experience of living in the centre. Residents complimented the staff who 'never left them waiting long' and 'were always there when they were needed'. Residents told the inspectors that staff frequently spent time sitting with them, chatting about local news, family, and activities within the centre. Some residents had lived in the centre for over 10 years and felt comfortable, safe and relaxed. They described it as 'like being in your own home'. Inspectors observed interactions between staff and residents that were kind, respectful, and person-centred. Staff were observed engaging with residents respectfully, and assisting residents in a relaxed and attentive manner throughout the inspection.

Residents complimented their bedroom accommodation and described it as 'comfortable and homely'. Residents had appropriate storage facilities to display their personal possessions such as photographs, ornaments, and other personal items of significance.

Residents personal clothing was laundered off-site by an external service provider. Residents reported their satisfaction with the service and commented that staff supported them to fold and put away their clothing neatly in their wardrobes.

The dining experience was observed to be a pleasant, sociable and relaxed occasion for residents. Residents had a choice of meals from a menu that was updated daily. Residents complimented the aroma of baking of breads and scones that were described as high quality, and were provided to residents at their request. Staff were observed providing residents with assistance and support with their meals while also adding to the social experience of mealtime through sitting with residents and discussing local news. Residents told the inspector that they enjoyed this quality time with the staff.

There was an active residents committee that met with the staff and management on a monthly basis to provide feedback on the quality of the service. The management took this opportunity to consult residents about changes to the service they received. This included discussions about the multi-disciplinary team who provided services to the residents, staffing, activities, and other service available to residents such as independent advocacy services. Residents told inspectors that they were encouraged to express any concerns or complaints that may have and were confident that any issues raised would be addressed promptly.

Residents told the inspectors that they enjoyed the activities programme on offer that included music, games, baking, and knitting. They were also provided with

opportunities to go on outings to local shops and amenities. A number of residents told the inspectors that chatting with staff and reminiscing was one of the most enjoyable activity they did.

There was twice weekly access to religious services in the centre. The centre had a Chapel that some residents described as a calm area to sit and reflect. Residents were provided with access to local and national newspapers, radio, and television.

The following sections of this report detail the capacity and management of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This was an unannounced risk inspection carried out by inspectors of social services to;

- monitor compliance with the Heath Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).
- follow up on the action taken by the provider to address the non-compliance from the last inspection in October 2022.
- inform a decision in relation to an application to vary a condition of the registration of the centre, to register seven beds in a newly constructed extension, and reduce the occupancy of four multi-occupancy bedrooms in the existing designated centre.

The findings of this inspection were that the provider had taken some action following the previous inspection to ensure resident's contracts of care reflected the services provided to residents, and that all residents had appropriate access to call bell facilities. While the provider had established management systems in place to monitor the quality and safety of the service, inspectors found that the systems in place to provide oversight of the maintenance of the premises, infection prevention and control, and fire safety required further action to achieve compliance with the regulations. Inspectors identified non-compliance with Regulation 28, Fire precautions, with regard to the containment and management of fire. On the day of inspection, inspectors found that the inappropriate storage of oxygen cylinders and storage practice in the centre posed a significant fire risk to residents. The provider took immediate action to address those risk when identified to them.

The Health Service Executive (HSE) is the registered provider of Raheen Community Hospital. There was an established and clearly defined organisational structure in place, with identified lines of accountability and authority. The governance and management was well organised and the centre was adequately resources to deliver a safe and effective service to residents, in line with the centre's statement of purpose. The person in charge was supported by a general manager who provided oversight of the centre. Within the centre, the person in charge was supported

clinically, and administratively, by two clinical nurse managers. The service was also supported by a full complement of staff that included nursing and healthcare staff, activity coordinators, housekeeping, laundry, catering, administration, and maintenance staff.

The provider had a number of management systems in place to monitor and quality and safety of the service provided to residents. This included collecting key clinical information to support the monitoring of the quality of care received by residents such as the incident of falls, wounds, residents nutritional care, weight loss, restrictive practices, and antimicrobial usage. A schedule of audits further supported the management team to evaluate the quality of the service and included audits of infection prevention and control practices, fire safety measures, medication management, clinical documentation, and the residents' dining experience. Information gathered from audits was used to inform the development of time-bound, quality improvement action plans. There was evidence that quality improvement action were discussed, and delegated to staff in their relevant departments to ensure the required improvement actions were completed. The progress of improvement actions were reviewed at management, staff, and residents scheduled meetings. However, inspectors found that the systems to provide oversight of the safety of the service required action to ensure residents were protected from fire risks, and the risk of infection.

Risk management systems were guided by a centre-specific risk management policy. As part of the risk management strategy, a risk register was maintained that included clinical and environmental risks to the safety and welfare of residents. Actions were implemented to mitigate the risk of harm to residents. A record of incidents involving residents, staff and visitors was maintained and there was evidence that this information was analysed to improve the quality of the service and prevent incidents from recurring.

The annual review for 2022 had been completed, in consultation with the residents, and quality improvement plan was in progress for 2023.

The centre had sufficient resources to ensure the effective delivery of good quality care and support to residents. On the day of the inspection, the centre had a stable and dedicated team which ensured that residents benefited from continuity of care from staff who knew them well. Staff had the required skills, competencies, and experience to fulfil their roles. The person in charge, and clinical nurse managers provided clinical supervision and support to all staff.

There were systems in place to induct, orientate and support staff. There was a comprehensive training and development programme in place for all grades of staff. Staff were facilitated to attend training, commensurate to their role. This included safeguarding of vulnerable people, supporting residents living with dementia, and patient moving and handling. While all staff had attended training specific to fire safety, the inspector observed that some staff did not demonstrate an appropriate awareness of the centre’s fire safety procedures.

Record keeping systems ensured that records were securely stored, accessible, and

maintained in line with the requirements of the regulations.

Inspectors found there was a lack of emergency lighting and directional signage from a fire exit and along an external route to ensure a safe passage of escape away from the building to a fire assembly point, particularly at night time hours. An external route to a fire assembly point was not suitable for residents who may not be mobile as the ground was uneven, steep and was unsteady underfoot due to a gravel finish. Internally, the inspectors found that fire doors were missing fire rating identification tags, room labels and on some fire doors had smoke seals that had been painted over, which rendered them ineffective. The majority of fire doors were well fitted. However, a compartment fire door would not close fully when released by the inspectors as it was stopped by the floor finish. Gaps were noted on a fire door located at bedroom two and a cross - corridor door. Furthermore, furniture in a lobby obscured fire extinguishers from view.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The application to vary a condition of registration was made and the fee was paid.

Judgment: Compliant

Regulation 15: Staffing

On the day of inspection, the staffing numbers and skill mix were appropriate to meet the needs of residents in line with the statement of purpose. There were satisfactory levels of healthcare staff on duty to support nursing staff. The staffing compliment included laundry, catering, activities staff and administration staff. There was adequate levels of staff allocated to cleaning of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Training records reviewed by the inspector evidenced that all staff had up to date mandatory training in safeguarding of vulnerable people, fire safety and manual handling. Staff had also completed training relevant to infection prevention and control.

There were arrangements in place for the ongoing supervision of staff through senior management presence and through formal induction and performance review

processes.

Judgment: Compliant

Regulation 21: Records

Record keeping and file management systems ensured that records set out in Schedule 2, 3, and 4 of the regulations were kept in the centre and available for inspection.

A sample of staff personnel files reviewed evidenced that the requirements of the regulations were met. Records contained a valid An Garda Síochána (police) vetting disclosure.

Records requested, with regard to the medical and nursing care provided to residents, were maintained in a manner that was safe and accessible and accurately detailed the care and treatment provided to residents.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place to provide effective oversight in the areas of infection prevention and control, the maintenance, and management of the premises, and fire precautions required strengthening to ensure full compliance with Regulation 23: Governance and management.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

All residents were issued with a contract for the provision of services. The contracts outlined the services to be provided, accommodation type, and the fees, if any, to be charged for such services.

Judgment: Compliant

Quality and safety

Inspectors found that the care and support provided to residents was of a satisfactory standard. There was a person-centred approach to care, and residents' rights, wellbeing, choices, and residents independence were supported and promoted. Residents were satisfied with the quality of care they received and felt comfortable and safe living in the centre. While the provider had addressed a number of areas of non-compliance since the previous inspection, action was required to ensure full compliance with Regulation 17: Premises, Regulation 27: Infection control, and Regulation 28: Fire precautions.

Residents' needs were assessed on admission to the centre through validated assessment tools, in conjunction with information gathered from the residents and, where appropriate, their relatives. This information informed the development of person-centred care plans that provided guidance to staff with regard to residents specific care needs and how to meet those needs. Care plans detailed the interventions in place to manage identified risks such as those associated with impaired skin integrity, risk of malnutrition, and falls. Residents social activity care plans provided sufficient detail to direct staff regarding the interventions required to meet the residents social activity preferences. Care plans were initiated within 48 hours of admission to the centre and reviewed every four months, or as changes occurred, in line with regulatory requirements.

A review of residents records confirmed that residents were provided with appropriate, and timely, access to medical care. Residents were provided with access to their general practitioner for in-person reviews as required, or requested. Arrangements were in place for residents to access the expertise of other health and social care professionals through a system of referral. The recommendations of health and social care professionals was observed to be implemented and reviewed to ensure best outcomes for residents.

Residents nutritional and hydration needs were met. Arrangements were in place to ensure residents received a varied and nutritious menu based on their individual food preferences and dietetic requirements. Residents nutritional care needs were assessed on a monthly basis. This consisted of monitoring residents weights, their nutritional intake, and when indicated, referral to dietitian and speech and language services for further assessment and support.

The provider had a number of assurance systems in place to prevent and control the risk of infection in the centre. A single use, colour-coded, mop and cloth systems was in operation. Cleaning agents were appropriate for healthcare settings and housekeeping staff demonstrated the procedure for cleaning the centre. However, inspectors found that sluice rooms, storage areas and some en-suite bathrooms were not cleaned to an acceptable standard and daily cleaning records were not consistently signed. This meant that the provider could not be assured that all areas were cleaned according to the schedule. Further findings are discussed under Regulation 27, Infection control.

The design and layout of the centre was appropriate for the number and needs of

the residents. However, some areas of the centre were found to be a poor state of repair and action was required to ensure the designated centre conformed to all matters, as set out in Schedule 6 of the regulations. This is discussed further under Regulation 17: Premises.

The inspectors reviewed the arrangements in place relating to fire safety. The Inspectors found that documentation in terms of regular in-house fire safety checks in the centre were completed and recorded. There were daily, weekly and monthly checklists which included for example, testing of fire equipment, fire alarm testing, emergency lighting, means of escape and fire exit doors, all of which were up to date. The centre was equipped with a fire detection and alarm system which covered all areas with fire detection.

Notwithstanding this, while regular checks were being carried out, some fire risks had not been identified. For example, the inspectors noted a number of deficiencies in regard to directional signage in corridors, fire doors, and inappropriate storage practices. Service records were available for the various fire safety and building services and these were all up to date, however the annual certificate for the emergency lighting system was not available for review.

The inspectors found uncertainty over fire-containment measures, visual deficiencies in the building fabric and fire doors, inappropriate location of oxygen cylinders and flammable material in escape routes, and poor directional signage. This is outlined in more detailed under Regulation 28: fire precautions.

Residents told the inspectors that they felt at home in the centre and that their privacy and dignity was protected. Residents were free to exercise choice about how to spend their day and were encouraged to enjoy and participate in activities in the wider community. Residents were provided with opportunities to attend monthly meetings to discuss the organisation of the service and provide feedback on the quality of the service received. Satisfaction surveys were carried out with residents and relatives and reflected a high level of satisfaction with the service provided.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 12: Personal possessions

Inspectors found that residents living in the centre had appropriate access to and

maintained control over their personal possessions. Residents were provided with adequate space to store and maintain their clothing and personal possessions. Residents were encouraged to personalise their private accommodation with items of significance. Residents reported being satisfied with their bedroom accommodation.

Residents personal clothing was laundered by an external service provider. Residents reported their satisfaction with the service provided. Arrangements were in place to ensure clothing did not become misplaced, damaged or lost.

Judgment: Compliant

Regulation 17: Premises

Inspectors observed that there was action required in some area of the centre to ensure compliance with Regulation 17: Premises. For example;

- there was a number of maintenance issues including damaged floor coverings, radiators, and visibly damaged painted, and tiled, walls.
- Storage facilities were not appropriately managed resulting in the inappropriate storage of resident equipment along corridors.
- Ventilation fans were not functioning correctly in the sluice room or a storage area. As a result, the adjacent corridor and sitting room were malodorous.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with wholesome and nutritious food choices for their meals and snacks, and refreshments were made available at the residents request. Menus were developed in consideration with residents individual likes, preferences and, where necessary, their specific dietary or therapeutic diet requirements, as detailed in the resident's care plan.

Menus were displayed in suitable formats and in appropriate locations so that residents knew what food choices were available at mealtimes. There was adequate numbers of staff available to supervise and assist residents with their meals.

There were adequate arrangements in place to monitor residents at risk of malnutrition or dehydration. This included weekly weights, maintaining a food intake monitoring chart and timely referral to dietetic and speech and language services to ensure best outcomes for residents.

Judgment: Compliant

Regulation 27: Infection control

Action was required to ensure that infection prevention and control procedures were consistent with the National Standards for Infection Prevention and Control (IPC) in community settings published by HIQA. This was evidenced by;

- The management of sluice rooms did not ensure that clean and dirty equipment was appropriately segregated to minimise the risk of cross contamination. For example, there was large volumes of clean equipment stored on a drainage boards which created a risk of cross contamination.
- A laundry area did not have appropriate facilities in place to support effective infection prevention and control measures. For example, there was no dirty to clean flow, the areas was visibly unclean, and there were no hand hygiene facilities within the area.
- A number of areas were observed to be unclean on the day of the inspection, a number of shower drain covers and toilet areas, a small number of raised toilet seats and commodes, a the laundry room and sluice room.
- Mobility aids, shower chairs, and other pieces of equipment were stored within the communal bathrooms. This increased the risk of cross infection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

At the time of the inspection, improvements were required by the provider in order to comply with the requirements of Regulation 28: Fire precautions.

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

- The inspectors observed inappropriate storage practices of oxygen cylinders in two separate areas of the centre. In a nurses station, the inspectors found seven oxygen cylinders. There was a large opening in the wall of this room that faced onto a protected corridor, which would be used by staff and residents in the event of an fire evacuation. Containment measures were significantly comprised. This presented a potential fire risk-, if a fire did develop, it would be accelerated by the presence of these cylinders and would have a significant impact on the ability for residents and staff to use this corridor in the event of a fire.
- In another corridor that lead to a final fire exit, the inspectors again found an oxygen cylinder unsecured. An immediate action was given to the person in charge to remove and the oxygen cylinders from these areas and this as

confirmed by the inspectors to have been carried out before the end of the inspection.
- A number of fire doors were found to be propped open by a chair, which compromised the function of the closing mechanism. This could result in the potential for fire and smoke to spread in the event of a fire.

Arrangements for providing adequate means of escape including emergency lighting required improvement. For example:

- Designated escape routes from some bedroom areas were via another room in order to reach a final fire exit that lead to the outside. This was evident in Sunflower, were a secondary route of escape from this room was through a sitting/dining room in order to reach a final fire exit. Furthermore, the fire exit from this room was obstructed by a privacy curtain and a large food trolley.
- In Oak 2, the primary means of escape from this bedroom was through a conservatory in order to reach a final fire exit. This requires a review by a competent fire consultant to ensure the centre is provide with suitable protected means of escape.
- There was a lack of directional signage (running man signage) throughout the existing centre in corridors and fire exit routes to direct and illuminate the route of escape in the event of a fire evacuation.
- Some of the directional signage that was in place gave incorrect direction to a final fire exit. This resulted in confusion as it was unclear which direction to take in order to reach a final fire exit. This could have a significant impact as it would cause a delay and confusion in the event of a fire emergency. This requires a review by a competent fire consultant to ensure the centre is provide with suitable directional signage throughout.
- Externally, the inspectors were not assured that suitable emergency lighting was provided along some external routes to illuminate the route of escape in the event of a fire evacuation, particularly at night-time. This was evidenced by the lack of green indicator LEDs on the existing light fittings.

Arrangements for maintaining fire equipment, means of escape and the building fabric required improvement:

- Inspectors observed a full width curtain and curtain pole was installed above a final fire exit. This could potentially obscure a fire exit and delay egress from the centre in the event of a fire.
- Corridors were cluttered in some area of the centre. Trolleys were stored along means of escape on the ground and first floor at the entrance to a staircase.
- There was inappropriate storage practices under a staircase that was a protected means of vertical escape from the first floor. This created a fire risk and could compromise a protected means of escape in the event of a fire. The management took immediate action when the risk was identified to them.
- Within a communications room, the inspectors observed some penetrations through the fire-rated ceilings (ceilings built in a way to provide a certain amount of fire resistance time), and these required appropriate fire sealing

measures.

- A review of fire equipment in the centre found that service records with regard to the maintenance and testing of the fire alarm system, emergency lighting and fire-fighting equipment were maintained and available for review. However the annual servicing certificate in regard to the emergency light system was not available for review on the day of the inspection and was requested by the inspectors to be submitted for review.

Arrangements for containing fire in the designated centre required improvement. For example:

- A number of areas along protected corridors and between some bedrooms were fitted with glass screens. The inspectors were not assured these screens provided the appropriate fire containment measures in the event of a fire.
- A number of fire doors had gaps at the bottom and between doors, which were over the maximum allowable tolerance.
- A sluice room door appeared to have been modified with a ventilation grill that did would not contain the passage of fire and smoke.
- Cold smoke seals had been painted over in a number of locations, which rendered them ineffective to prevent the passage of smoke.
- A number of fire doors did not meet the criteria of a fire door. These deficiencies posed a significant risk to residents in the event of a fire.

The provider gave a commitment to arrange an assessment of the fire doors to be carried out by a competent person.

Although staff were documented as having up to date fire safety training, the practices observed during inspection, and lack of awareness by some staff of the centres fire evacuation procedures, did not provide assurance that the fire safety training provided, captured the full extent of the requirements of the regulations.

While simulated evacuation drills were taking place, a fire drill had not been carried out on the largest compartment when staff resources are at the lowest.

While all residents had a personal emergency evacuation plan (PEEP) in place, some records did not provide adequate information with regard to the resident's ability to recognise and respond to the sounding of the fire alarm.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans were developed following a comprehensive assessment of need and were reviewed at four month intervals, in consultation with the residents and, where appropriate, their relatives. Care plans detailed the interventions in place to managed identified risks such as those associated with impaired skin integrity, risk

of falls, and risk of malnutrition.

Judgment: Compliant

Regulation 6: Health care

Residents had access to appropriate medical and health and social care professional support to meet their needs. Residents were supported to access their general practitioner (GP).

Services such as physiotherapy, speech and language therapy, occupational therapy, tissue viability nursing expertise and dietitian services were available to residents through a system of referral. A sample of records reviewed evidenced that residents received a satisfactory standard of evidenced based care and support with, for example, wound care.

Judgment: Compliant

Regulation 9: Residents' rights

Staff demonstrated an understanding of residents' rights and supported residents to exercise their rights and choice. Residents' choice was respected and facilitated in the centre.

Residents attended regular meetings and contributed to the organisation of the service. Residents confirmed that their feedback was used to improve the quality of the service they received. This included reviewing and contributing to the activities programme.

There were facilities for residents to participate in a variety of activities, in line with their interest and capabilities. Residents complimented the provision of activities in the centre which included outings to the local villages, towns and amenities.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Raheen Community Hospital OSV-0000611

Inspection ID: MON-0039926

Date of inspection: 16/05/2023

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
Actions completed:

The management system in place to provide effective oversight in the areas of infection prevention and control, management of the premises and fire precautions has been reviewed. On site visits have recently been carried out by Maintenance Manager and Fire Prevention Officer. Action plans have been put in place to address issues in consultation with Registered Provider Representative and Person in Charge.</td></tr>
<tr><td>Regulation 17: Premises</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 17: Premises:
Actions completed:
A schedule of works has been put in place to address maintenance issues including damaged floor coverings, radiators and visibly damaged painted and tiled walls. Flooring specialist has been contacted, the floor type and colour have been selected.

Additional Storage option has been identified and is in the process of being installed to prevent inappropriate storage of equipment. This will be subject to Application to Vary to include in the floor plan of the designated centre.

Actions to be completed:
The functioning of ventilation fans in a sluice room and storage area will be included in the maintenance schedule</td></tr>
</table>

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Actions completed:

Clean and dirty equipment has been appropriately segregated.
Regular liaison with staff to ensure proper segregation of dirty and clean equipment to prevent cross contamination is being undertaken by nurse management.
Safety pause is conducted and staff informed and prompted to ensure same.
Frequent checks are done to monitor and ensure that clean equipment is stored separately.

Cleaning staff have been advised to ensure that the area is always clean and signed, especially toilets, sluice room, laundry room.
Safety pause is conducted to prompt staff to make sure to clean the area after patient care. Spot checks are carried out in sluice rooms and laundry rooms to ensure proper cleaning has taken place.
All equipment has been removed from the communal bathroom and stored separately.
Safety pause includes reminding staff that shower chairs and mobility aids are not to be stored in communal toilets. Spot checks are done to ensure same.

Actions to be completed:

The proposed decision to grant the application for the variation of Condition 1 for the registration of the designated centre to include an extension comprised of seven bedrooms (3x single, 2 x twin rooms), a new communal day room, laundry area, housekeeping and equipment store room will enhance the environment to address infection prevention issues.

The new laundry area will provide a dirty to clean flow. This additional area consists of a washing machine and dryer to wash cleaning utensils and mop heads. Residents' personal laundry is contracted out to a local laundry. Regular reference takes place at Safety pause to ensure this area is covered when cleaning.

A maintenance schedule is in place to address flooring/tiles/grouting in two sluice rooms.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire Actions:
The small Oxygen cylinders were removed from the nurse's station on the day of inspection to an outside area. The nurse's station is no longer in use for containment of oxygen cylinders.
Work is being progressed by Maintenance Department to provide an alternative well ventilated outside secured area for containing Oxygen Cylinders. There will be no unsecured oxygen cylinder storage.
Daily inspection of the fire doors continues to be carried out. No fire doors are propped open which could compromise the function of the closing mechanism.

Adequate Means of Escape, Action:
Sunflower: Directional signage of the Primary Designated escape route from Sunflower room was replaced by a fire safety company. Privacy curtain and food trolley have been removed from the secondary route of escape.

The Fire Prevention Officer has reviewed Sunflower. The basis for compliance for which the Sunflower bedroom layout is established as per Inner Room and Access Room of the Irish Building Regulations, Technical Guidance Document , Part "B".

An Inner Room is defined as: a room from which escape is possible only by passing through an access room. An Access Room is defined as: Room through which passes the only escape route from an inner room.

The Sunflower room is not considered as an inner room and does not have egress that is only possible by passing through an access room. The Sunflower room has alternative escape routes for means of escape purposes .ie.
1) Egress to a corridor leading to adjacent compartments
2) Egress route via the conservatory area which provides egress to a final exit to open air.

The Sunflower alternate egress routes were annotated on a FSC drawing as part of a FSC application to Clare Fire Service. The scenario of having an alternative secondary route through another room is deemed satisfactory.

Oak 2- Fire Prevention Officer has reviewed Oak 2. The bedroom to Oak Ward is not considered as an Inner Room. The bedroom to Oak Ward has an egress route leading to an adjacent protected lobby/ corridor.

Any obstructions that inhibit egress to designated final exits have been removed.

Fire Safety Company has reviewed directional signage in corridors and fire exit routes to direct and illuminate the route of escape in the event of a fire evacuation.
Fire Safety company has reviewed the directional signage to ensure correct direction to a final fire exit throughout the existing center
Emergency Bulk head lights have been replaced externally providing adequate emergency lighting.
On the new build there are pedestal emergency lights along the pathway leading to an

assembly point. Front entrance has car park light.

Maintaining Equipment: Actions
The full width decorative curtain on a curtain pole above a final fire exit located at each side of the door has been removed to ensure it will not potentially obscure a fire exit and delay egress from the centre in the event of a fire.
Maintenance Department will ensure appropriate fire sealing measures are undertaken for penetrations highlighted within the communication room.
Maintenance Department has sourced appropriate storage area for trolleys and equipment.
The annual servicing certificate in regard to the emergency light system was submitted to the regulatory authority at request of the inspectors. Emergency light system certification will be forwarded to Person in Charge in Quarter 1 of each year to file on site.

Containing Fire in the Designated Centre Improvement: Actions
A number of areas along protected corridors and between some bedrooms were fitted with privacy glass screens. The Fire Prevention Officer has reviewed same. Glazed screens were installed at construction stage of building and have not been altered since their installation. Glazed screens have been maintained to the level of installation and no retrospective review of the glazed screens undertaken.
The use of Georgian Wired Glass is a historical method for providing fire rated glazing within fire doors and thus in keeping with the construction methods available when the 'existing designated centre' was originally constructed.
Estates Department has engaged a third party to undertake a review of the internal glazing to walls and doors within the existing portion of the building. The existing glazing materials, methods of construction, standards and maintenance are as per the initial design of the building.
A number of glazed screens were identified and annotated on the Fire Safety Certificate floor plans and in Fire Safety Certificate Compliance Report that were submitted and granted to Clare Fire Service. File Reference number FA2014/064/7.
The Fire Prevention Officer has reviewed the fire doors . A third party vendor competent in the assessment of fire doors shall be engaged to undertake a review of the fire doors in the existing portion of the building. Ventilation grill will be reviewed as part of fire door assessment. Provisional options include:
- Installation of intumescent grille within opening to door that is compliance with fire door certification OR
- Door to be replaced.

Cold smoke seals that had been painted over in a number of locations, which rendered them ineffective to prevent the passage of smoke will be replaced by Maintenance Team.

The Fire Prevention Officer will compile a consolidated floor plan of the overall as-built building. This will include a consolidated floor plam of the original existing building and the recently constructed extension.
All staff were documented as having up to date fire safety training, lack of awareness by

some staff of the fire evacuation procedures was addressed at handovers and safety pause to provide assurance that the fire safety training provided captured the full extent of the requirements of the regulations.
A Fire drill had been carried out on the largest compartment when staff resources were at the lowest dated October 2022 with the minimum of 3 staff on duty, a copy filled in the fire register folder at time of inspection.

A fire evacuation drill of the largest compartment was submitted following the inspection.

A simulated night time fire evacuation drill was completed on 25th July 2023 of the largest compartment with night time staffing .
All residents have a personal emergency evacuation plan (PEEP) in place, records will incorporate adequate information with regard to the resident's ability to recognise and respond to the sounding of the fire alarm.

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2023
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.	Substantially Compliant	Yellow	20/05/2023
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	20/05/2023

	associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	16/05/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	13/07/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	23/07/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	18/05/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire	Substantially Compliant	Yellow	18/05/2023

	prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	18/05/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	15/09/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where	Substantially Compliant	Yellow	18/05/2023

	necessary in the event of fire, of all persons in the designated centre and safe placement of residents.			