Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Ramelton Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Back Road, Ramelton, Donegal
Type of inspection:	Unannounced
Date of inspection:	15 July 2025
Centre ID:	OSV-0000615
Fieldwork ID:	MON-0048093

About the designated centre

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

Ramelton Community Hospital is a designated centre registered to provide health and social care to 29 male and female residents, primarily over the age of 65. It is a single-storey building, a short drive from the shops and business premises in the town. Accommodation for residents is provided in single and double rooms, with several communal areas available for residents to spend time during the day.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	25

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 15 July 2025	09:30hrs to 14:30hrs	Helena Budzicz	Lead
Tuesday 15 July 2025	09:30hrs to 17:00hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

The overall feedback from residents who spoke with the inspector was that they were happy and liked living in the Ramelton Community Hospital. Residents spoken with were complimentary of the centre and the care they received.

During the inspection, many examples of person-centred care were observed by inspectors. Residents appeared well-cared for and were dressed in their own styles and preferences. While staff were busy assisting residents with their needs throughout the day, care delivery was observed to be unhurried and respectful. The inspectors saw that staff knocked and greeted residents in a friendly and respectful manner when entering their bedrooms.

Residents had access to a choice of communal spaces, and there was a tastefully decorated oratory in the centre. All communal areas were found to be appropriately decorated, and the inspectors observed that all the floors were clean and well maintained. Bedroom accommodation comprises of single and double bedrooms. Residents' twin-occupancy bedrooms that were viewed by the inspectors were all clean and contained personal storage with photographs. The storage has improved in 14 single-occupancy bedrooms since the last inspection. However, these bedrooms remained not suitable for residents who require assistive devices such as a hoist or specialised large wheelchairs. The inspectors observed that only residents who were independently mobile or required a zimmer frame or rolator for their mobility needs were accommodated in these bedrooms on the day of the inspection.

Residents told the inspectors that they had choice in how they spent their day and that there were opportunities to take in recreational activities should they wish to. The inspectors noted kind and thoughtful interaction between staff and residents at all times during the inspection. It was clear that the residents' needs were well-known to the staff in the centre.

The centre provided residents with consistent access to adequate quantities and choices of food and drink, and residents were complimentary about the quality of food. Mealtimes were observed to be a pleasant and unhurried social occasion for residents. Assistance was provided by staff for residents who required additional support.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

This inspection found that significant focus is required to improve the management and oversight of fire safety for residents in the centre to ensure that all residents are protected from the risk of fire.

This was an unannounced inspection to assess the registered provider's ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and review the registered provider's compliance plan following the previous inspection in October 2024 in respect of the centre's premises. The findings in respect of premises are detailed under regulation 17. Furthermore, a review the registered provider's compliance plan following an inspection in March 2024 in respect of the centre's fire precautions was carried out.

The Health Service Executive (HSE) is the registered provider for Ramelton Community Hospital. As a national provider providing residential services for older people, the designated centre benefits from access to and support from centralised departments such as human resources, accounts, maintenance and information technology. There was a clear governance and management structure in place in the centre, and the management team were supported by a registered provider representative and a manager for older people's services.

The person in charge was supported in their role by a clinical nurse manager. The person in charge also oversaw the work of a team of nurses, health care assistants, administration, maintenance, domestic and catering staff. The person in charge was on a leave and a clinical nurse manager facilitated the inspection.

An inspection of the centre that assessed Regulation 28: Fire Precautions was carried out on 15 March 24. During that inspection, concerns were raised regarding the personal emergency evacuation procedure (PEEPs) documents, which had not accurately reflected the emergency evacuation requirements of several residents. Furthermore, there was insufficient signage to direct staff to the final fire assembly point from a final fire exit point. This current inspection found that the provider now had sufficient signage in place to direct staff to the assembly point and had made improvements to the personal emergency evacuation procedure documents (PEEPs). However, from a review of the PEEPs records, further improvements were required. For example, residents' PEEPs records did not include the post-evacuation supervision requirements of residents.

The oversight of fire safety management systems and the processes to identify and manage fire safety risks were not robust enough to ensure the safety of residents living in the centre. This was evidenced by the presence of inappropriate storage practices of flammable and combustible materials found on this inspection, which required immediate action by the provider. An external smoking area for residents to use was missing a fire blanket, an extinguisher, a suitable metal ashtray and a call bell. These risks, along with additional fire safety risks, are outlined under the quality and safety section of this report.

Weekly audits and fire safety checks on means of escape, appropriate storage, containment and fire prevention were being completed; however, these checks did

not identify issues such as inappropriate storage practices as observed on this inspection and were not in line with the provider's own policy. For example, a review of the centre's fire policy stated that no storage of combustible materials is to be placed in high-risk rooms.

Issues relating to the management of fire safety are detailed under Regulation 23: Governance and Management. Further fire safety issues are detailed under the quality and safety section and Regulation 28: Fire Precautions of the report.

Regulation 23: Governance and management

The oversight of fire safety in the centre was not robust, and did not adequately support effective fire safety arrangements and keep residents safe. For example:

- Fire safety checks in regards to appropriate storage arrangements and fire precautions were not in line with the fire safety policy and did not identify storage issues which impacted on fire safety.
- The providers' in-house fire management systems, such as audits and the fire register, had not identified fire risks and did not fully support the oversight of fire in the centre. These were in regard to storage arrangements, compartmentation measures, fire precautions, fire doors, fire containment, means of escape and evacuation procedures. These are outlined in detail under regulation 28.
- Inappropriate storage practices were found at the underside of a protected escape staircase. A bicycle, wheelchairs and walking aids were found in this area, which created an escape risk. Furthermore, a protected corridor on the first floor was found to be used as a storage area for cardboard boxes, wheelchairs and walking aids. This compromised the means of escape and lacked oversight of fire safety management by the provider.

Judgment: Not compliant

Quality and safety

This inspection found that the management of fire safety, as described in Regulation 23: Governance and Management section of this report, did not fully ensure the safety of residents, staff and visitors. Inappropriate storage, containment measures and evacuation procedures contributed to this risk. In regards to inappropriate storage arrangements, flammable and combustible items were found in an oil tank external store. This was brought to the attention of the senior staff members, and arrangements were made for the immediate removal of these items before the end of the inspection.

The inspectors found non-compliance over fire-containment, visual deficiencies in the building fabric and fire doors, inadequate evacuation planning and means of escape. Other concerns were identified in regards to emergency directional signage and lighting, fire precautions and residents' personal emergency evacuation plans (PEEPS) required a review. These fire safety concerns are detailed further under Regulation 28: Fire Precautions.

The inspectors reviewed the fire safety register and noted that parts of it were well organised. In-house periodic fire safety checks were being completed and logged in the register as required. However, deficiencies identified such as inappropriate storage and containment had not been identified in the in-house routine checks.

Service records were available for the various fire safety and building services and these were all up-to-date.

While overall, the premises at the centre was kept in a good state of repair, a number of areas required a review to conform to the matters set out in Schedule 6 of the regulations. On foot of previous inspection findings, issues were identified in single-occupancy bedrooms numbered 18, 19, 20, 21, 47, 48, 49, 50, 51, 52, 53, 54, 56 and 58 not meeting residents needs. The layout of these single occupancy bedrooms required a review to ensure that these rooms were suitable to meet the criteria for the residents in the centre. This is outlined in detail under Regulation 17: Premises.

Regulation 17: Premises

The current layout of 14 single-occupancy rooms, 18, 19, 20, 21, 47, 48, 49, 50, 51, 52, 53, 54, 56 and 58 rooms does not met the needs for residents who require assistive devices such as a hoist or specialised large wheelchairs as the space available in each room is limited and does not provide sufficient space for the safe use of and moving and handling equipment.

The centre's premises did not conform to the matters set out in Schedule 6 of the regulation. For example:

- A designated clean store room was found to be in use as a multi-purpose storage room for oxygenators, clean laundry, hoists and nursing care items.
- There was a call-bell missing from a hairdresser’s room used by residents.
- Maintenance was required for some fire doors due to surface damage, and a section of architrave was missing.
- Some areas on the first floor had signs of water ingress and required redecoration to improve the appearance. Furthermore, unsightly breaks and holes were noted in walls and ceilings around services that required repair.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had completed a significant amount of fire safety work to the centre in 2023 and was working towards bringing the centre into compliance. Notwithstanding this, the service was non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire, and some fire risks identified required immediate action by the provider. This was evidenced by the following fire risks:

- An external smoking area for residents to use was missing a fire blanket, an extinguisher, a suitable metal ashtray and a call bell. A full bucket of cigarettes was found in this area and was not emptied in a timely manner. A review of the centre's fire policy stated that staff are to empty ashtrays regularly; however, this was not the finding on the day.
- Inappropriate storage practices in relation to, flammable and combustible items were found in an oil tank external store. This was brought to the attention of the senior staff members, and arrangements were made for the immediate removal of these items before the end of the inspection. A review of the centre's fire policy stated that no storage of combustible materials is to be placed in high-risk rooms. However, weekly checks did not find this fire risk.

The means of escape for residents and emergency lighting in the event of an emergency in the centre required improvement. For example:

- While the majority of emergency lighting was present, one emergency directional signage was not illuminated in a maintenance store, and one emergency light at the bottom of a staircase was noted to have a red light, which indicated a fault.

The provider did not provide adequate arrangements for maintaining the fire equipment, means of escape and building fabric. For example:

- The majority of fire doors throughout the ground floor were found to be in a good state of repair. From a sample viewed, three doors were found to be partially missing smoke seals, were fitted with non-fire-rated screws, minor screw holes that required attention, and two doors failed to close when the door release was tested, which was due to the doors catching on the floor finish. A kitchen door was found to open across a circulation corridor, which may potentially obstruct or come into contact with residents or staff as they pass by.
- On the first floor, the staff and administration area had a complete lack of fire doors in several rooms. Furthermore, a number of ceilings were found with holes and utility pipe work that required fire sealing around these penetrations. A ceiling access hatch appeared not to be fire-rated. The lack of fire doors and deficiencies through the fire-rated ceilings created a fire risk

for smoke and fire to spread unhindered. This resulted in a lack of adequate containment on this level of the designated centre. A review of the Fire door checks and records was being carried out; however, the records did not identify these fire door deficiencies.

The registered provider did not ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and in so far as is reasonably practicable, residents, were aware of the procedure to be followed in the case of a fire. For example:

- Personal emergency evacuation plans (PEEPS) were prepared for all residents. The assessments were up to date and included their mobility level and methods of evacuation. Notwithstanding this, the inspectors noted that more details were required for each resident and their assessed needs. For example, the records did not include the post-evacuation supervision requirements of residents, for residents who may be receiving sleeping medication, are hard of hearing or have vision problems. Records or evacuation policies did not account for a resident who required one-to-one 24-hour supervision by one dedicated staff member or that this staff member would have to supervise this resident during any fire event.

The provider failed to provide adequate arrangements for evacuating all persons in the designated centre and safe placement of residents in the event of a fire emergency in the centre. For example:

- Fire drills were being regularly practised based on evacuating two to three residents. However, a fully simulated compartment drill based on the largest compartment when staff resources were at their lowest had not been carried out since November 2023. The registered provider was requested to carry out and submit a drill record based on the above scenario for review. Subsequent to the inspection, the provider submitted a drill for this scenario that indicated an extended evacuation time. This implied a deficit in the evacuation strategy. Therefore, evacuation procedures and systems in place were not adequate to provide a safe and effective evacuation for the residents in the event of a fire.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Ramelton Community Hospital OSV-0000615

Inspection ID: MON-0048093

Date of inspection: 15/07/2025

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. A review of storage was completed. Inappropriate storage practices have been resolved. 2. Items stored at the underside of a protected escape staircase have been removed and are stored in a designated area-completed 17/07/2025. 3. Items stored in a protected corridor on the first floor have been removed and are stored in a designated area-completed 17/07/2025. 4. In-house fire management systems have been reviewed and will be more robust in identifying fire risks going forward as to adequately support effective fire safety arrangements which will assure the safety of all residents.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1. A call bell has been installed in the hairdresser's room-completed on 22/07/2025 2. Maintenance have completed checks on all fire doors and a section of architrave has been re-fitted-completed on 25/07/2025 3. Only Residents assessed as being suitable for the 14 single-occupancy bedrooms are resident there. Residents are monitored for any changes in their condition that may deem them unsuitable for one of the single-occupancy rooms.	

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. The external smoking area now has a fire blanket, a fire extinguisher and a metal ashtray installed. A call bell is also located in the smoking area-completed on 03/09/2025
2. Emergency lighting checked and all in working order-completed 22/07/2025
3. All fire doors have been checked and any issues requiring attention have been resolved-completed 22/07/2025
4. The kitchen doors opening across a circulation corridor are fitted with a vision panel that allows the person opening the door to see if another person is walking past the door at any particular time to ensure the door is not opened across the corridor and to date no such incidents have been reported. A notice on the inside of the door also alerts Staff to check before opening the door and to open it slowly.
5. The first floor area was located outside the designated centre registration previously and as such was outside the scope of the last fire risk assessment and remedial works that followed. An external Fire Consultant has been engaged by the HSE to conduct an independent Fire Risk Assessment specifically for the first floor of the building. The Fire Risk Assessment will be completed by the Consultant by the end of October 2025 and report issued before the end of the year.
6. A new one page Personal Emergency Evacuation Plan (PEEPS) has been developed and implemented for each Resident with all required information contained in same-completed 07/10/2025.
7. Fire Drills are carried out monthly and will now include the largest compartment when Staff resources are at their lowest.

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.	Not Compliant	Orange	31/12/2025
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	25/07/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment,	Not Compliant	Orange	03/09/2025

	suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	22/07/2025
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.	Not Compliant	Orange	22/07/2025
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	07/10/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	22/07/2025
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	22/07/2025

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