Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	St Patrick's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Summerhill, Carrick on Shannon, Leitrim
Type of inspection:	Unannounced
Date of inspection:	12 February 2025
Centre ID:	OSV-0000661
Fieldwork ID:	MON-0044428

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	41

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
Wednesday 12 February 2025	09:00hrs to 17:00hrs	Catherine Rose Connolly Gargan	Lead
Wednesday 26 February 2025	17:40hrs to 22:00hrs	Celine Neary	Lead
Wednesday 26 February 2025	17:40hrs to 22:00hrs	Helena Budzicz	Support

What residents told us and what inspectors observed

This inspection was an unannounced inspection carried out over one day and one evening. The inspectors met with many of the residents and members of the centre's management team and staff team. Inspectors observed that residents were supported by staff to make independent choices about their daily lives and to enjoy a good quality of life in the centre. Residents' feedback regarding the service they received and their quality of life in St Patrick's Community Hospital was positive, and they confirmed that they were content and comfortable living in the centre. Residents told the inspectors that the staff caring for them were kind, thoughtful and always attentive to their needs.

The inspectors observed that residents' accommodation was arranged into three units on the ground floor level. The first floor in the premises was not part of the designated centre and was being utilised by the acute hospital services to provide step-down services for patients discharged from the hospital. The designated centre and the acute hospital services on the first floor shared a common entrance and foyer area on the ground floor and this access was supervised by staff.

Residents' accommodation in St Patrick's Community Hospital was divided into three separate units; the Monsignor Young Dementia Unit, the Dr McGarry Unit, and the Sheemore Unit. Each unit was linked via the main circulating corridors. Although each unit operated independently with assigned staff, efforts were continuing to be made to encourage residents in Dr McGarry and Sheemore units to integrate with each other, especially for the social activities taking place in these units to increase the range and number of activities available for residents on a daily basis.

On the first day of the inspection, residents in Monsignor Young's unit were observed to be facilitated to enjoy fulfilling and meaningful lives. The residents particularly enjoyed live music, and a variety of visiting musicians facilitated lively music sessions for them, including on the first day of this inspection. Staff utilised their very good knowledge of each resident's individual life story and the significant people in their lives to enrich their interactions with residents. Staff also demonstrated their good knowledge of each resident's care needs and their individual preferences and usual routines during their care delivery activities. Staff were observed to be gentle, kind and respectful towards all residents but especially to those residents living with dementia. Staff took a positive approach to supporting residents who experienced responsive behaviours (How residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), and residents were observed to respond positively to these person-centred staff interactions.

The Monsignor Young Unit offered residents a safe continuous walking space around the unit for those residents who were walking with purpose. The circulation corridors were well laid out with several points of interests along the way for residents to stop and engage with. Many of the residents had a background in

farming and the environment was painted and designed with rural scenes painted on the walls and with models of farm animals in the safe outdoor garden to capture the residents' interests.

While residents on Dr McGarry's unit were facilitated to participate in a variety of group and one-to-one social activities, the social activities for residents in the Sheemore unit were mostly focused on meaningful one-to-one interactions to meet the interests and capacities of the residents in this unit who had higher dependency needs. A small number of the more independent residents on Sheemore unit occasionally participated in the group social activities taking place on Dr McGarry unit.

The inspectors observed that many of the residents liked to start their day with Mass streamed from a local church on the televisions in the sitting rooms. There was also a large spacious church close to the reception area, which was accessible to residents through the staff dining room. Although the inspectors were told that some residents liked to go to the church and that residents could avail of refreshments in the staff dining room if they wished, no residents were observed visiting the church or having refreshments in the staff dining room on the days of this inspection.

The inspectors observed that residents on Sheemore and Dr McGarry units had unrestricted access to safe outdoor areas. The spacious outdoor area adjacent to the Sheemore unit was partially covered for the residents' comfort and shelter. Outdoor seating was provided among the raised flower beds. Two outdoor areas were available to residents on the Dr McGarry. Both areas had outdoor seating, plants and outdoor ornaments in them.

On the second day, the inspectors attended the centre during the evening time, and as part of the inspection, they reviewed staffing levels during the evening and at night time. Inspectors found that the current staffing levels on these two units meant that while staff were attending to those residents who required the assistance of two staff, there was no staff then available on the units to supervise or provide assistance to the other residents, if they called for assistance. From a review of documentation and speaking with staff, the inspectors found that seven residents on the Sheemore unit and four residents on Dr. Mc Garry unit, required the assistance of two members of staff. Furthermore, staff informed the inspectors that because of the current staffing levels, when the nursing staff on duty in the Sheemore unit required assistance with administering controlled medications, a second nurse was sourced from the step-down facility on the first floor, which was not part of the designated centre.

This inspection found that, with a few exceptions, the general environment and residents' communal and bedroom accommodation was well-maintained and visibly clean. The inspectors observed that painting and decoration had been used to support residents in identifying key areas. Colour coding and vinyl prints were used to identify toilet doors and bedroom doors to support residents with orientation and way finding in all three units. For example, each resident's bedroom door was designed differently in the Monsignor Young dementia unit to replicate a domestic

front door, and this enhanced residents' accessibility and assisted them with way-finding. Memorabilia familiar to residents such as dressers, crockery, tea-sets, ornaments, flower pots and other items were used in the communal areas to create a homely and comfortable environment for residents.

Residents' bedrooms and communal accommodation were provided on the ground floor level throughout. Many residents had personalised their bedroom with their family photographs, artwork and other personal items. Residents told the inspectors that their bedrooms were comfortable and their choices regarding when they went to bed and when they got up each morning were always respected by staff. The inspectors observed that each resident was provided with a television in their bedroom for their personal viewing and listening. However, two residents told the inspectors that they did not have discrete listening equipment available to them and one resident was worried that their television would disturb the other resident sharing the bedroom.

Residents told the inspectors that they felt 'very safe' and 'had no worries' and they would speak to a staff member or their family if they had any concerns or were dissatisfied with any aspect of the service they received.

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

Capacity and capability

This inspection found that care and services provided for residents were well managed, had improved since the last inspection and ensured that the service provided for residents met their needs. Notwithstanding the significant fire safety and refurbishment works the provider had recently completed in the centre further improvements were required in the oversight of fire precautions in respect of fire door checks. Improved oversight and focus by the provider is now required to ensure that residents are protected from risk of fire and compliance with Regulation 28: Fire precautions is maintained.

This unannounced inspection was completed to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors also followed up on the actions the provider had committed to take in their compliance plan following the previous inspection in March 2024, in addition to the statutory notifications and other information received since the last inspection.

The registered provider of St Patrick Community Hospital is the Health Service Executive (HSE). As part of a national provider network, the service benefits from access to and support from the HSE national resources such as community health organisation management teams (CHO) resources and expertise, staff training and

development, clinical practice development, human resources, finance and information technology.

The centre's local management structure consisted of a person in charge supported by an assistant director of nursing (ADON) and clinical nurse managers (CNMs) on each of the three units. However, this was not in line with the designated centre's statement of purpose and conditions of registration, as the person in charge was also involved in the governance, operational management and administration of a step-down unit on the first floor that was not part of the designated centre.

Established governance and management processes were in place with oversight of key areas in clinical care and support services for the residents. Resident's feedback was sought and was used to inform quality improvement plans including an annual review of the quality and safety of the service.

The provider had ensured there was adequate numbers of staff available with appropriate skills to ensure that residents' needs were met during day time hours. However, further to the findings of the last inspection, the provider had not increased night-time staffing to ensure that there were adequate staff available to meet residents' needs on Dr McGarry and Sheemore units. This repeated finding requires further review to ensure there are adequate numbers of staff available to meet residents' needs for support and supervision at all times.

Records reviewed by the inspectors showed that staff had appropriate Garda vetting in place before they commenced working in the designated centre.

The person in charge had a system in place to monitor staff training and all staff were facilitated to complete mandatory training. A programme of professional development training was made available to all staff to ensure that they had the necessary skills and competencies relevant to their roles, to meet the complex needs of residents. Staff were appropriately supervised and the inspectors' observations of staff practices and discussions with staff gave assurances that they were familiar with residents' needs.

Records were held securely and records that were required to be held in the centre were made available to the inspector for the purpose of this inspection.

Arrangements for recording accidents and incidents involving residents in the centre were in place and were notifications as required by the regulations were notified to the Health Information and Quality Authority within the specified time-frames.

The centre's policies and procedures had been updated and were accessible to all staff working in the centre. However, the centre's own fire safety policy was not being fully implemented in respect of the routine monitoring of fire doors. This finding is discussed further under Regulation 28: Fire precautions.

Regulation 14: Persons in charge

The person in charge commenced in this role on 26 February 2024 and their qualifications and experience met the requirements of the regulations. The person in charge had previously worked in this role in the designated centre from October 2022 to June 2023. They were well-known to residents and staff.

Judgment: Compliant

Regulation 15: Staffing

Although, there sufficient were staff available during the days of the inspection, the inspectors were not assured that the numbers of staff available each night in Dr McGarry and Sheemore units were adequate to meet residents' assessed needs. The inspectors were informed that there was a process in place to review night time staffing levels and during times of increased staffing needs, additional night staff were sourced by management. However this inspection found that;

- The majority of residents in Sheemore and Dr McGarry units were assessed as needing two staff to assist them with their personal care and repositioning needs while in bed. As only two staff were available on each of these units between 20.00hours and 08.00hours this meant that when the two staff were providing care for these residents in their bedrooms, there were no other staff available on the units to respond to the other residents' needs for supervision and assistance.
- Furthermore, nurses from the step-down unit on the first floor which was not part of the designated centre, were called to support nursing staff in Sheemore unit with administering controlled medicines which required two nurses under misuse of drugs legislation. This arrangement did not ensure there were sufficient nursing staff working in the designated centre between 20.00hours and 08.00hours to meet residents' medication needs during the night. This is a repeated finding from the last inspection in March 2024.

Judgment: Substantially compliant

Regulation 16: Training and staff development

All staff had attended up-to-date mandatory training on fire safety, safeguarding residents from abuse and safe moving and handling procedures. The person in charge had ensured that all staff working in the centre attended professional development training, as necessary, to update their skills and knowledge to competently meet residents' needs.

Staff were appropriately supervised according to their individual roles.

Judgment: Compliant

Regulation 21: Records

Records as set out in Schedules 2, 3 and 4 were kept in the centre and were made available to the inspectors. Records were stored securely and the policy on the retention of records was in line with regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not ensured that the management structure in the designated centre was in line with the centre's statement of purpose and conditions of the centre's registration. The inspectors confirmed that the person in charge was involved in the governance, operational management and administration of the health care step-down unit, which was not part of the designated centre.

Although the provider had systems in place to monitor the quality and safety of the service, improved oversight by the provider was necessary to ensure these systems were effective. For example;

- The environmental audits did not ensure that all areas of the centre were well maintained.
- The provider's review of night-time staffing levels did not ensure that there were adequate nursing and care staff rostered to work in the designated centre between the hours of 20.00 hours and 08.00 hours.
- The provider's oversight and management of fire safety in the centre was not effective, and risks to residents safety in the event of a fire in the centre were not effectively mitigated. This inspection found that fire door checks were not being carried out effectively, and as a result, residents' fire safety was not assured. The findings of this inspection are discussed further under Regulation 28: Fire precautions.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of accidents and incidents involving residents in the centre was maintained. Notifications and quarterly reports were submitted as required and within the time-frames specified by the regulations.

A review of notifications found that the person in charge of the designated centre notified the Chief Inspector of any notifiable outbreaks of infection as set out in paragraph 7(1)(e) of Schedule 4 of the regulations, within three working days of their occurrence.

Judgment: Compliant

Quality and safety

The inspectors found that residents were provided with good standards of nursing and health care in line with their assessed needs. Residents rights' were respected and care and supports were informed by the residents' individual needs and preferences for care and daily routines.

Although some improvements were required the inspectors found that overall, residents were protected from the risk of infection. The provider continued to manage the ongoing risk of infection while protecting and respecting the rights of residents to maintain meaningful relationships with their visitors and friends.

The provider had completed significant fire safety works in recent years to ensure the safety of residents in the event of a fire emergency; however, this inspection found that fire door checks in the centre were not completed in line with the provider's own policies and procedures and as a result a number of deficiencies in the fire doors had not been identified and addressed.

Residents were provided with good standards of nursing care and timely health care to meet their clinical needs. Residents' records and their feedback confirmed that they had timely access to their general practitioners (GPs), specialist medical and nursing services, including psychiatry of older age and health and social care professionals as necessary. Residents' care plans were detailed and reflective of their individual preferences and wishes regarding their care and support. Care plans were regularly updated and residents or, where appropriate, their families were consulted with regarding any changes in their care interventions.

Residents were provided with opportunities to participate in a varied and meaningful social activities programme to meet their needs on this inspection. Residents who remained in their bedrooms had equal access to social activities that interested them and that were in line with their individual capacities.

Residents were supported to practice their religion and clergy from the different faiths were available to meet with them as residents wished. Residents were supported to speak freely and provide feedback on the service they received.

The layout of residents' bedrooms and communal areas met residents' needs. For the most part, the residents' living environment was well maintained. The provider had upgraded residents' wardrobes since the last inspection. However, in some bedrooms, residents' lockers were not easily accessible to them.

Measures were in place to safeguard residents from abuse and residents confirmed that they felt safe and secure in the centre. Staff had completed up-to-date training in prevention, detection and response to abuse. Staff who spoke with the inspectors were knowledgeable regarding the reporting arrangements in the centre and their responsibility to report any concerns they may have regarding residents' safety.

Residents' meetings were regularly convened and issues raised as needing improvement were addressed. Residents had access to local and national newspapers, radios and televisions.

There was a positive approach to care of residents predisposed to experiencing episodes of responsive behaviours (How people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). A number of residents experienced episodes of responsive behaviours. The inspectors found these residents were well-supported on this inspection, including with additional one-to-one staffing in place to ensure their safety. A minimal restraint environment was promoted, and the procedures that were in place were in line with the national restraint policy guidelines.

Regulation 11: Visits

There were no restrictions on residents' family and friends visiting them, and practical infection and control precautions were in place to protect residents from risk of infection. Residents told the inspectors that their visitors were always welcomed and that they were able to meet with their visitors in a private area outside of their bedrooms as they wished.

Judgment: Compliant

Regulation 12: Personal possessions

The provider had upgraded residents' wardrobes since the last inspection, and this ensured each resident could maintain control of their personal clothing and belongings. However, the inspectors observed that a number of residents either did not have a bedside locker available to them or their locker was placed at a distance

away from their beds. This meant that some residents were not provided with a locker to store their personal possession, and other residents who did have a bedside locker could not easily access their personal possessions stored in their locker because it was located away from the bedside.

Judgment: Substantially compliant

Regulation 17: Premises

A small number of minor repairs were necessary to ensure the premises met the requirements of Schedule 6 of the regulations. For example;

- A small area of the floor covering the corridor on Monsignor Young's unit was missing.
- Paint on the surface of a small number of doors on the Sheemore unit was damaged and missing.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider mostly met the requirements of Regulation 27: Infection control and the National Standards for infection prevention and control in community services (2018). However, further actions were required to ensure residents were effectively protected from the risk of infection. For example;

- Access to hand hygiene sinks in the cleaner's rooms in Monsignor Young and Sheemore's units was partially obstructed.
- Clean unused linen bags were stored on an open shelf in the sluice room. This posed a risk of cross contamination.
- Linen bags were stored on the floor in the linen room, and this did not support effective floor cleaning.
- Outdoor clothing and three dressing gowns were stored in the clean linen room and posed a risk of cross contamination.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Assurances regarding residents' safety in the event of a fire in the centre were not adequate as follows;

- The inspectors found that there were gaps in the closure of a number of cross-corridor fire doors, and two cross-corridor fire doors did not fully close.
- Intumescent strips on two fire doors were painted over, and therefore were not effective.
- Evidence was not available that the function and integrity of the fire doors were checked as part of the weekly checks of key fire safety equipment. Therefore, adequate assurances were not available that an effective system was in place to identify fire doors that were not functioning as required and that smoke and fumes would not be effectively contained in the event of a fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents' needs were comprehensively assessed within 48 hours of their admission and regularly thereafter. Staff used a variety of accredited assessment tools to assess each resident's needs, which included assessment of the risk of falling, malnutrition, pressure-related skin damage, and residents' support needs to ensure their safe mobility, among others.

These assessments informed residents' care plans, which detailed each resident's care needs and the care interventions staff were completed to meet their needs. This information was person-centred and reflected each resident's individual care preferences and usual routines.

Residents' care plans were regularly updated in consultation with residents and their representatives, as appropriate.

Judgment: Compliant

Regulation 6: Health care

Residents' nursing and healthcare needs were met to the required professional standards, and residents had timely access to their General Practitioners (GPs). An on-call GP service was available to residents out-of-hours as needed.

Residents were appropriately referred to health and social care professionals, specialist medical and nursing services, including psychiatry of older age, community

palliative care and tissue viability specialists and their recommendations were implemented.

Residents were supported to safely attend out-patient and other appointments to meet their ongoing healthcare needs.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

A positive and supportive approach was taken by staff with their care of a number of residents who were predisposed to experiencing episodes of responsive behaviours (How people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were facilitated to attend training to ensure they had up-to-date knowledge and skills in meeting the support and care needs of residents who experienced responsive behaviours.

Inspectors found there was a commitment to minimal restraint use in the centre, and the national restraint policy guidelines were implemented. Alternatives to restrictive equipment used were assessed, and procedures were in place to ensure they, and any other arrangements did not pose inappropriate or prolonged restrictions on residents.

Judgment: Compliant

Regulation 8: Protection

The provider had policies and procedures in place to safeguard residents from abuse. Staff were facilitated to attend up-to-date safeguarding residents from abuse training. Staff were aware of the reporting procedures and of their responsibility to report any concerns they may have regarding residents' safety in the centre. Residents confirmed to the inspectors that they felt safe in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights and choices were mostly respected. However,the location of one resident's television in a multi-occupancy bedroom in Monsignor Young unit did not ensure they could view it from their bed-space.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

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

Inspection ID: MON-0044428

Date of inspection: 26/02/2025

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 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
To ensure compliance:

- The registered provider completed a staffing review of the designated center on the 18/03/2025, following this review approval has been sought and granted for additional staffing resources on night duty on the ground floor units. This has been implemented and in place from the 21/04/2025.
- Staffing will be kept under review by the Registered Provider on an ongoing basis and will continued to be reviewed as part of the governance and compliance visits to the center.
- The Person in Charge completes a daily and weekly review of staff rosters to ensure that the number and skill mix of staff provided is appropriate to ensure that the residents assessed care needs are met to a high standard.
- The Person in Charge or deputy review staff supervision on a daily basis on their safety walk around to ensure adequate supports are in place for residents.
- All current vacant posts are being backfilled with agency staff and all HR recruitment processes are being followed.
- The Registered Provider will continue to monitor staffing, resources and the supervision of residents on an ongoing basis to ensure that the services provided are safe and meet the assessed needs of all residents within the centre.
- This will continue to form part of the Registered Provider meetings, compliance visits and governance arrangements in place within the designated center.
- The Registered Provider with Person in Charge have reviewed medication practices within the designated center on the 18/03/2025. This review has determined that there are at all times sufficient numbers of suitably qualified staff in the designated centre to support safe medication practices.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure compliance:

- The Registered provider and Person in Charge have reviewed the Designated centre Statement of purpose. The Statement of Purpose has been updated on 14/05/2025 to ensure it reflects the governance and management within the designated centre. An application to vary Condition 1 has been submitted to the Regulatory Body on the 14/05/2025 for review. Await approval of same.
- The Registered Provider has completed a review of the environment within the designated centre on the 17/02/2025. Following this review, any outstanding maintenance issues had been completed by 01/04/2025.
- A Cyclical maintenance program in conjunction with HSE maintenance and Estates is in place to ensure the ongoing maintenance of the premises and ensure ongoing maintenance of the designated centre.
- The Person in Charge completes a daily walk around to ensure the appropriate and safe storage and handling of healthcare related items. This is communicated to all staff through safety pause.
- The Registered Provider completed a night-time staffing review of the designated centre on the 18/03/2025. Following this review approval has been sought and granted for additional staffing resources on night duty on the ground floor units. This will be in place from 21/04/2025.
- The Person in Charge completes a daily and weekly review of staff rosters to ensure that the number and skill mix of staff provided is appropriate to ensure that the residents assessed care needs are met to a high standard.
- If at any point the Person in Charge or deputy require additional resources this will be supported by the Registered Provider and put in place immediately.
- The Registered Provider reviews and monitors all areas of governance and management within the designated centre on an ongoing basis as part of their governance and compliance visits and meetings as the Provider.
- This review encompasses staffing, resources, Infection prevention and control, fire safety and all areas pertaining to Quality, risk and patient safety.
- The Registered Provider and Person in Charge completed a fire safety review within the designated centre on 17/02/2025. Additional daily fire escape route checklist for cross-corridor fire door checks has been implemented since 17/02/2025. The issues identified have been escalated to HSE maintenance team on 20/02/2025.
- Completion of weekly FSR 7 and six monthly FSR 6 record is being completed as per HSE Fire Safety guidelines and requirements (Fire safety register), if any actions identified/required with the details of fault and action taken/escalated. And evidence of completion is documented in the fire record.
- The Registered Provider as part of their onsite visits reviews fire doors and all aspects of fire safety within the designated Centre as part of governance and compliance visits.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
To ensure compliance with Regulation 12:

- The Person In Charge completed a review of resident's multi occupancy bedrooms on 19/02/2025 including the layout within the bedroom This review focused on ensuring all residents had access to their bedside lockers. This was completed on 19/02/2025 and residents now have access to bed side lockers. This will be kept under review by the Person in Charge.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure compliance:

- The Registered Provider has reviewed any outstanding maintenance and environmental issues on 19/02/2025.
- A Cyclical maintenance program in conjunction with HSE maintenance and HSE estates is in place to ensure the ongoing maintenance of the premises.
- The damaged flooring identified during inspection has been repaired in Monsignor Young Unit on the 20/02/2025. A system is in place to report and action maintenance issues in a timely manner.
- The surface on doors have been repainted on Sheemore Unit on the 19/03/2025

Regulation 27: Infection control	Substantially Compliant

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

To ensure compliance:

- The Registered provider and person in charge completed a review of IPC practices on the 19/02/2025 and in particular storage and use of linen rooms.
- Following this review the storage of linen bags and the use of linen rooms have been reviewed and are used solely for their designated purpose, all equipment is stored in accordance with best IPC practice. This was completed on 19/02/2025.
- The Person in charge on the 12/02/2025 immediately removed the clean unused linen bags once identified during inspection and stored them correctly.
- The person in charge on the 13/02/2025 communicated to all staff the necessity to ensure good IPC practices in respect of storage of linen bags.
- This is being kept under review by the Person in Charge.
- On the 12/02/2025, once identified the access to the sink in the housekeepers room was reviewed and the obstruction was removed.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
To ensure compliance:

- The registered provider in conjunction with the HSE Fire Officer and Person in Charge completed a fire safety review within the designated center on 17/02/2025.
- Following the fire safety review, Additional daily fire escape route checklist for cross-corridor fire door checks has been implemented since 17/02/2025. The issues identified have been escalated to HSE maintenance team on 20/02/2025.
- A fire safety maintenance repair programme has commenced week 07/04/2025. This will address any/all identified fire safety remedial works. These works will be completed by 31/05/2025.
- The FSR 7, weekly and FSR 6, Six Monthly fire door checks are recorded and are compliant as per HSE Fire safety Guidelines and requirements (HSE Fire Register), if any actions are identified/required these are documented and actioned. Evidence of completion is documented in the Fire register.
- Ongoing monthly fire drills are completed and shared learnings takes place on all units after these simulations.
- The Registered Provider ensures that a Fire maintenance contract is in place within the designated Centre and that as per the HSE fire safety handbook.
- Six monthly fire door checks are completed on all Fire doors and a record maintained of same.
- The Registered Provider as part of their governance and management reviews all aspects of Fire safety within the designated center.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To ensure Compliance:

- The Registered Provider and Person in charge had reviewed resident’s rights on 17/02/2025 in relation to the location of televisions in Multi occupancy rooms. The beds/televisions have been reconfigured in consultation with the residents to ensure that residents can view the televisions from their bed space.
- Wireless headsets have been purchased and are now readily available on all the units from the 17/02/2025 for residents use.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	19/02/2025
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	21/04/2025

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.	Substantially Compliant	Yellow	19/03/2025
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	14/05/2025
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	21/04/2025
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are	Substantially Compliant	Yellow	19/02/2025

	implemented by staff.			
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	20/02/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/05/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	17/02/2025