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 Ita's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Gortboy, Newcastlewest, Limerick
Type of inspection:	Unannounced
Date of inspection:	05 May 2022
Centre ID:	OSV-0000664
Fieldwork ID:	MON-0036491

About the designated centre

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

The service at St Ita's Community Hospital is provided by the Health Service Executive (HSE) and the centre is located in Newcastle-West, Co. Limerick. The centre is registered for an operational capacity of 66 residents, providing respite and palliative care as well as continuing care for long-stay residents. Nursing care is provided mainly for older people over 65 years of age with needs in relation to age related and degenerative neurological diseases. Care is provided across three residential units for residents with dependency levels ranging from low to maximum. Dementia-specific care is provided in a separate unit that accommodates up to 12 independently mobile residents. Care plans are developed in accordance with assessments and residents are provided with access to a range of allied healthcare services. Private accommodation is provided where possible within the constraints of the existing building which is over 100 years old in some parts. Residents are provided with opportunities for activation and social interaction including engagement with local community activity groups.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	59

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
Thursday 5 May 2022	09:00hrs to 17:00hrs	Sean Ryan	Lead
Friday 6 May 2022	07:45hrs to 17:00hrs	Sean Ryan	Lead
Thursday 5 May 2022	09:00hrs to 17:15hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

Overall, residents living in St. Ita's Community Hospital received a high level of evidenced-based care. Residents expressed their satisfaction living in the centre and described the centre as welcoming and comfortable. Residents told the inspectors that staff were responsive to their needs and provided support and care to them in a kind and polite manner.

On the day of inspection, the centre was recovering from an outbreak of COVID-19 that affected a number of residents and staff. The inspectors were guided through the infection prevention and control measures on arrival to the centre. Following an introductory meeting, inspectors walked through the centre with the management team and spent time speaking with residents and staff. The centre is comprised of three distinct units called Bluebell, Camelia and Orchid.

Inspectors observed a relaxed and unhurried approach by staff when assisting residents with their morning care needs. Breakfast was served to residents in their bedroom and staff provided assistance to residents with their nutritional needs. Overall, the atmosphere on the mornings of inspection was observed to be calm.

Inspectors spoke with a number of residents in their bedrooms who expressed their satisfaction with the quality of care they received. Residents were complimentary in their comments about the management and the staff. Residents told the inspector that staff supported them in many aspects of their daily life and that there was attentive medical care available in the centre. Residents described how the COVID-19 pandemic impacted on their life and residents spoke of how they 'struggled' with being away from their family. Residents told the inspector that restrictions were now minimal and that they could receive visitors even if an outbreak occurred. In all responses from residents, the support and reassurance staff provided to residents during the pandemic was complimented. Some residents discussed the refurbishment of the Camelia unit and looked forward to the new bright flooring, painted walls and additional storage for their personal possessions.

Inspectors observed that the centre was bright, spacious and generally laid out well to meet the needs of the residents. Residents accommodation was predominantly comprised of shared bedrooms. Camelia unit was undergoing refurbishment works on the floor linings and residents welcomed and complimented the works carried out to date. Inspectors acknowledged that the provider had taken some action to improve storage facilities for residents personal clothing in multi-occupancy bedrooms since the previous inspection. However, while refurbishment works had progressed on Camelia, inspectors found that residents bedrooms and communal areas were not maintained in a satisfactory state of repair on Bluebell and Orchid. Walls and floors were visibly damaged and some furniture was torn. Inspectors observed the condition of one en-suite bathroom in Bluebell to be in a poor state of repair. Parts of the shower lining and plaster was falling down off the wall. Immediate action was taken by the provider when the issue was brought to their

attention. Residents had access to secure enclosed gardens that were appropriately furnished and well maintained. The garden in Orchid was not accessible to residents due to maintenance works on footpaths and the roof. Alternative arrangements were in place to facilitate the residents to access gardens during these planned works.

Some residents told the inspector that they were satisfied with their bedroom accommodation but looked forward to having more space to display photographs of family and friends, cards and ornaments when refurbishment works were completed. However, residents were unsure as to when those facilities would be provided. Inspectors observed that there was inadequate space for residents personal possessions such as cards and ornaments in multi-occupancy bedrooms. In contrast, bedrooms in Orchid provided residents with suitable wardrobe and shelving space. Bedrooms were observed to be personalised to each individual residents interests and preferences. Inspectors observed that residents personal toiletries and toothbrushes were not segregated or labelled in shared bathroom facilities and as a result staff were unsure who owned those items.

Inspectors observed the residents dining experience. A small number of residents from Bluebell and Camelia attended the dining room for meals. Most residents had their meals in their bedroom. Staff were available to provide discreet assistance and support if needed. However, inspectors observed that there was limited social engagement between staff and residents during meal times. Food was freshly prepared and was observed to meet the nutritional requirements of residents. Residents complimented the quality of the food they received and confirmed the availability of snacks and refreshments.

Most residents in Bluebell and Camelia were observed to spent most of their day in their bedrooms. Over the two days of inspection, only a small number of resident were observed in the communal dayrooms and dining rooms. Some residents were watching television while others were observed sitting in silence. In contrast, the majority of residents in Orchid spent their day in the dayroom where they were supervised by a member of staff. The provider had installed an interactive sensory projector for residents to play interactive games on. However, this was not observed to be used during the inspection.

Inspectors spoke with a number of residents in their bedrooms and communal rooms throughout the two days of inspection. Residents were complimentary of the management and staff and expressed their satisfaction with the quality of care they received. Residents told inspectors that staff were attentive to their needs and that they were satisfied with the time taken to answer their call bells. Residents were supported by staff to maintain their individual style and appearance and could exercise choice with regard to their preferred choice of clothing. Inspectors observed that staff spoke to residents in a positive, respectful and caring manner and it was evident that staff knew residents well.

Residents were facilitated to attend group activities in the parlour room, adjacent to the Camelia unit, with a dedicated activities staff member. Residents were observed enjoying group activities in the parlour room situated adjacent to the Camelia unit.

The management team told inspectors that healthcare staff provided 'bedside' activities to residents who did not wish to attend group activities. Some residents told the inspector that 'bed side' activities were not provided. Inspectors observed that residents who did not attend group activities did not have equal access to meaningful activities when in their bedrooms or communal dayrooms on each unit.

The following sections of this report details the findings in relation to 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 over two days by inspectors of social services to;

- monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended)
- follow up on actions taken by the provider to address issues of non-compliance found on the last inspection in December 2020.
- follow up on notifications and information submitted by the provider and person in charge to the office of the Chief Inspector.

The Health Service Executive (HSE) is the registered provider of this centre. While there was an established governance and management structure overseeing the quality and safety of the service, the findings of this inspection were that the registered provider did not have effective oversight of the systems in place to appropriately manage risk. Inspectors found that when risks were identified and escalated by the person in charge to the senior management for further action and assurance, actions was not taken within an acceptable time-frame. Additionally, the oversight systems for the maintenance of the premises were not sufficiently robust and this impacted on the quality and safety of the service provided to residents.

On this inspection, non-compliance was identified with with Regulation 23, Governance and management, Regulation 16, Training and staff development, Regulation 27, Infection control and Regulation 17, Premises. Action was also required to comply with;

- Regulation 21, Records
- Regulation 28, Fire precautions

Inspectors found that the condition of a wall in a resident's bathroom posed a significant risk of injury to a resident. The provider took immediate action to address this risk when identified to them. Alternative bathroom facilities was made available to the residents concerned.

There was an established and clear organisational structure with clear roles and

responsibilities identified. The person in charge was supported by a general manager who provided oversight of the centre. Additional clinical and administrative support was in place for the person in charge in the form of two assistant directors of nursing. The clinical management team provided effective oversight and support to a team of nursing, healthcare and support staff on each of the three units. The management team had a positive attitude and were committed to ensuring residents received a good quality of care in a safe environment. Inspectors found that the management team were proactive in identifying areas for quality improvement in the service and taking action to address risks within their scope. There was evidence that risks were escalated to senior management for further action. The annual review of the quality and safety of the service for 2021 had been completed in consultation with the residents.

There was regular governance meetings taking place between individual departments in the centre and senior levels of management. Committee meetings specific to infection prevention and control (IPC) were held regularly and topics such as COVID-19 and IPC best practice were discussed. A pharmacist had joined the committee to support and anti-microbial stewardship and surveillance in the centre.

There were management systems to monitor the quality and safety of the service. Clinical and environmental audits were complete by the management team. The audits included reviews of fire safety, falls, restrictive practices and a variety of infection prevention and control audits. Improvement action plans were developed, displayed on notice boards for staff and residents, and assigned to staff in their areas of responsibility to ensure actions were implemented and completed. Quality assurance systems were in place to monitor the quality of care provided to residents through analyses of daily information in relation to pressure wounds, incidents involving residents and residents nutritionally at risk.

Local risk management systems were effectively implemented and monitored by the person in charge through maintaining a risk register. Apart from the risk associated with the residents bathroom, inspectors found that risks were appropriately identified, recorded in the risk register with controls put in place to mitigate the risk of harm to residents. Where necessary, risks were escalated to senior management for further action but, as previously stated, risks were not acted upon in a timely manner to ensure the safety and welfare of residents.

The staffing levels during the day were appropriate for the size and layout of the centre and the assessed needs of the residents. A review of the rosters found that there was a good skill-mix of staff nurses and multi-task attendants (MTAs) who were employed for caring, catering and cleaning duties. These duties were segregated on a daily basis so that an MTA only carried out one specific role on any one day. There was inadequate staffing levels at night time. Analysis and trending of incidents involving residents identified that the staffing resource at night time were not adequate. The person in charge had escalated this risk to senior management but additional staffing resources had not been implemented.

Staff training records evidenced that staff were facilitated to attend training relevant to their role. Inspectors identified some gaps in the training records for fire safety,

safeguarding of vulnerable adults and infection prevention and control (IPC). Infection prevention and control training and practice was supported by the community nurse specialist. There were two infection control link nurses within the staffing cohort to promote, supervise and support IPC practice in the centre. Inspectors observed that staff were appropriately supervised and supported by the management team to provide safe care to residents. Inspectors found that the supervision of staff to implement the activities schedule for residents was not effective. This is discussed further under Regulation 16, Training and staff development.

A sample of staff personnel files were reviewed by inspectors. There was evidence that each staff member had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 on file prior to commencing employment. However, record keeping and file management systems did not ensure that all staff files were maintained in line with regulatory requirements. Two staff file were not retained in the centre and documents in respect of Schedule 2 of the regulations were not available to review. .

The management of complaints was in line with the requirements of the regulation and there was an effective complaints procedure in place.

Regulation 15: Staffing

On the day of inspection, there was adequate staff available to meet the needs of the residents taking into consideration the size and layout of the building.

The failure of the registered provider to ensure sufficient staffing resources were in place to ensure the on-going safe and effective delivery of care to residents is actioned under Regulation 23, Governance and management.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors found that some staff did not have access to appropriate training. For example, a review of staff training records found that there were some gaps in attendance for fire safety, safeguarding of vulnerable people and Infection prevention and control.

Staff demonstrated poor knowledge in relation to fire safety procedures.

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of all residents. This was evidenced by;

- poor supervision of staff to implement the activities schedule for residents on each of the three units.
- inadequate arrangements in place for the supervision of cleaning staff and implementation of the cleaning procedure.

Judgment: Not compliant

Regulation 21: Records

The management of records was not in line with regulatory requirements. For example;

- Two staff personnel files were were not kept in the designated centre and were therefore not available for inspection as required by Schedule 2 of the regulations.
- Records of referrals to allied health and social care professionals were not consistently maintained.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure that the service had sufficient staffing resources in place to;

- meet the assessed care and supervision needs of the residents at night time. The person in charge had established a requirement for additional staffing at night and escalated the risk to senior management in March 2022. However, the additional staffing resource had not been put in place.

Governance and management systems were not effectively monitored. This was evidenced by;

- poor oversight of the maintenance of the premises. Maintenance records, with regard to the premises and fire safety, evidenced that maintenance issues identified in March 2022 had not been addressed. For example, repairs had not been carried out on hand towel dispensers, residents furniture and damaged wall mounts for fire extinguishers had not been replaced.
- poor oversight of the cleaning schedule to ensure a satisfactory quality of environmental hygiene was maintained.
- Record-keeping and file management systems did not ensure that staff personnel files were maintained on site and available for inspection.

The registered provider had not ensured that risk management systems were

effectively monitored. This was evidenced by;

- Fire risks escalated to senior management in October 2021 by the person in charge had not been addressed. This included issues with fire doors and requests for assurances with regard to fire containment.
- Premises issues, that impacted on the quality and safety of the service provided to residents, had not been actioned in a timely manner.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifable events, as set out in Schedule 4 of the regulations, were notified to the Chief Inspector within the required time frame.

Judgment: Compliant

Regulation 34: Complaints procedure

The centre had a complaints procedure that outlined the management of complaints and the key personnel involved in complaints management. A review of the complaints register evidenced that all complaints were recorded, acknowledged, investigated and the outcome communicated to the complaints, in line with the requirements of the regulation.

Judgment: Compliant

Quality and safety

Overall, residents in St. Ita's Community Hospital were in receipt of a satisfactory quality of care from staff that were responsive to their needs. The provider had taken some action since the previous inspection with regard to progressing refurbishment works in the centre and providing some residents with larger wardrobe space for personal clothing. However, further action was required with regard to the premises, fire precautions and infection prevention and control.

Staff demonstrated appropriate knowledge of the individual care needs of the residents. Resident's health and social care needs were assessed through a variety of validated assessment tools that informed the development of care plans in consultation with the residents and, where appropriate, their relatives. Inspectors

found that action had been taken, since the previous inspection, to ensure residents end-of-life care plans described residents end-of-life care wishes and preferred medical interventions.

Residents had access to medical care and referral systems were in place for residents to access allied health and social care professionals for additional support and expertise.

On the day of inspection, refurbishment of the Camelia unit was underway and new floor coverings were being installed. Large wardrobes had been installed in some of the multi-occupancy bedrooms to provide residents with adequate storage for personal clothing. However, there was inadequate bedside storage and space for residents to display cards, photographs and ornaments. The inspectors observed that floors, walls and some furniture in both the Bluebell and Orchid unit were not maintained in a satisfactory state of repair. Some floors were lifting and torn. This presented a trip hazard for residents. Further findings are discussed under Regulation 17, Premises.

There had been a recent COVID-19 outbreak in the centre and all residents had recovered. There was one suspected case of COVID-19 in the centre during the inspection. Prompt action was taken by the provider who put measures in place to prevent onward transmission of the virus. Staff were aware of their role in minimising the spread of infection to other areas of the centre. The centre had infection prevention and control policies which covered aspects of standard precautions, transmission-based precautions and guidance in relation to COVID-19. Inspectors found that the environment was observed to be tidy. Inspectors acknowledged that refurbishment of areas in Camelia unit which included bedrooms, flooring and the clinical room was in progress. In addition, an arrangement was in place to have all curtains and blinds replaced in the centre. However, there were insufficient supervision arrangements in place to ensure that the environment and equipment were decontaminated and maintained to minimise the risk of infection. Further findings in relation to poor infection prevention and control are outlined under Regulation 27, infection control.

Arrangements were in place for the testing and maintenance of the fire alarm system, emergency lighting and fire-fighting equipment. All records were made available for review and were up-to-date. Due to wide bedroom doors and wide corridors, residents could be evacuated in their beds which contributed to satisfactory evacuation time in the drill records reviewed. Action was required with regard to the maintenance and repair of some fire doors to ensure that appropriate systems of fire and smoke containment were in place.

Inspectors observed that the interactions between residents and staff was kind, polite and person-centred. Residents were provided with opportunities to voice their opinion and give feedback on the quality of the service at scheduled resident forum meetings. Feedback surveys had been completed in 2021 and evidenced an overall satisfaction with the quality of the care residents received.

Residents were supported to continue to practice their religious faiths. Residents

were observed to have access to newspapers, radios and televisions.

There was a comprehensive daily activity schedule in place. Inspectors observed residents attending group activities with the dedicated activities staff member and residents were observed enjoying group activities and socialising with fellow residents. However, residents who did not participate in group activities were observed to spend long periods in their bedroom without social engagement or meaningful activities.

Regulation 11: Visits

The centre was facilitating visiting in line with the centre's visiting policy.

Judgment: Compliant

Regulation 17: Premises

Action was required by the registered provider to comply with the requirements of Schedule 6 of the regulations. This was evidenced by;

- An en-suite shower room in a multi-occupancy bedroom was in a very poor state of repair, with the shower lining and the plaster falling from the wall of the shower unit. This posed an immediate risk to resident safety. The provider committed to addressing the risk immediately following the inspection.
- There was inadequate storage facilities in multi-occupancy bedroom accommodation on Bluebell and Camelia for residents to store personal possessions. For example, there was limited shelving space for residents to display photographs, cards and ornaments.
- The layout of some bedrooms did not meet the needs of the residents. For example, some bedrooms had not been reconfigured to provide residents with additional usable space following a reduction of beds in the rooms.
- There were walls, doors and frames in all three units that were not maintained in a satisfactory state of repair. For example, paint was chipped from bedroom and corridor walls, plaster exposed, and doors and frames were visibly damaged.
- Floor coverings in many areas such as corridors, residents bedrooms and en suites were visibly torn, damaged and lifting. This created a trip hazard to residents. This was evident on Bluebell and Orchid.
- Ventilation was poor in sluice rooms resulting in a poor odour in and around these rooms.
- Equipment was not maintained in working order. For example, a bedpan pulping machine in one sluice room was out of order for a period of months

and had not been progressed to repair. This contributed to the odour in one sluice room.
- Damaged items of resident's furniture had not been repaired.
- There was no communal toilet or shower facilities on Bluebell. This meant that residents would have to travel considerable distance from the dayroom or dining room to use en-suite facilities. This impacted on their choice, privacy and dignity particularly when en-suite facilities were out of order.

Judgment: Not compliant

Regulation 26: Risk management

The centre had an up-to-date risk management policy in place, which included all of the required elements as set out under Regulation 26.

The failure of the provider to identify and manage risk, in accordance with the centre's own policy is actioned under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 27: Infection control

The provider did not ensure that infection prevention and control procedures were consistent with the national standards for infection prevention and control in community services published by the authority. This was evidenced by;

- The premises was in a poor state of repair and this impacted on effective cleaning. For example, surfaces, floors, furnishings, doors and skirting were damaged and not clean on inspection.
- Clinical areas, such as the treatment room on Camelia unit, were poorly maintained. Work surfaces were significantly damaged and could not be cleaned to an acceptable standard.
- Although the inspector was informed that the cleaning trollies were included within the cleaning schedule, two were seen to be visibly dirty.
- Residents toilet aids were not clean on inspection. Three commodes inspected were stained and visibly unclean.
- Resident's equipment was not stored in a manner that reduced the risk of cross contamination. For example, while residents had individual slings, they were stored on top of one another on hoists that also had resident's clothing on top of them.
- The laundry area was visibly unclean with high levels of dust and debris. The sinks and drainers were covered in lime scale. The windows were in poor

condition with high levels of dirt present.

Standard precautions and transmission-based precautions were not effectively and consistently implemented. This was evidenced by:

- The external waste holding area was not locked to prevent unauthorized access for the duration of the inspection.
- Resident personal hygiene products were stored on a clinical hand hygiene sink in one resident's room.
- On Bluebell unit: the housekeeping room did not have hand towel dispenser, soap or alcohol dispenser and there were holes in the walls.
- In one sluice room a hand towel dispenser was stored on a sink edge while awaiting re-hanging. This posed a cross-infection risk.

Judgment: Not compliant

Regulation 28: Fire precautions

Action was required by the registered provider to comply with fire precautions in the centre. This was evidenced by;

- Some fire doors contained gaps while others were visibly damaged. This compromised the function of the fire doors to contain smoke in the event of a fire emergency.
- One emergency exit was not easily opened. This posed a risk to residents and staff in the event of an emergency.
- Some fire extinguishers were stored on the floor where wall mounts were damaged and the procedures on their use were not displayed.
- Some staff did not display an appropriate knowledge of emergency procedures, including evacuation procedures.

The failure of the registered provider to act on fire safety issues, identified by the person in charge in October 2021, is actioned under Regulation 23, Governance and management.

Judgment: Substantially 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. There was sufficient information to guide the staff in the provision of health and social care to residents based on residents individual needs and preferences.

Judgment: Compliant

Regulation 6: Health care

Residents had access to medical assessment and treatment by their general practitioner (GP) and allied health and social care professionals as required under Regulation 6. The inspector found that the advice given by health and social care professionals was acted upon which resulted in good outcomes for residents.

Judgment: Compliant

Regulation 9: Residents' rights

Overall, the inspectors found that the staff made satisfactory efforts to ensure the residents' rights were upheld in the designated centre. Staff were observed to engage in positive, person-centred interactions with residents.

There was an activity schedule in place. Some residents were observed to be socially engaged in group activities with the activities staff throughout the days of the inspection. However, while residents were supervised by staff in their bedrooms and communal dayrooms, there was limited social engagement observed. The allocation and supervision of staff to provide meaningful activities for residents is actioned under Regulation 16: Training and staff development.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St Ita's Community Hospital OSV-0000664

Inspection ID: MON-0036491

Date of inspection: 06/05/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Action completed since inspection 05/05/2022 :
• All agency staff are issued with an induction pack that includes a fire procedure plan. Following inspection, CNMs have re-checked the ward induction packs and have ensured all agency staff have been reminded of fire evacuation procedures as part of their induction and have signed the fire plan procedure in the induction packs.
• All staff on Units have been informed and reminded in Ward Safety Pauses of Ward fire procedures and evacuation.
• All Units have a comprehensive record book in place since April 2021, which details daily cleaning schedules in all units. The schedules include deep cleaning, flushing guidelines, IPC color coding, Covid cleaning guidelines and equipment cleaning schedules. The books are signed daily by the person in charge of the ward.
• Following inspection, CNMs are now required to sign off weekly the cleaning schedules in the books to ensure cleaning standards have been achieved as per cleaning schedules in place.
• The ADoN will audit the cleaning record schedules in the books as part of our environmental audits to ensure compliance. This audit is live on our new IPC auditing system.

Actions to be completed:

• The CNMs will review and monitor the social activities/interactions of staff and resident in liaison with activity co coordinator.
• The CNM will complete a QUIS (Quality of Interactions Schedule) audit by July 30th in

their departments. The observational audit will observe staff and residents social interaction. A review of the Audit will be written up by the CNM and a quality improvement plan will be implemented and will guide and support the scheduled activities program in the hospital. Further Audits will be conducted quarterly following this and will be peer reviewed and further discussed at CNM meetings. Action to be completed: 30/07/2022

• On review of training matrix, further training dates have been organized as follows:
Classroom teaching :

• Safeguarding :24/06/22, 25/07/22
• Fire training: 16/8/22, 13/09/2022, 11/11/2022
• Infection prevention and Control : 11/08/2022, 08/09/2022 (IPC)

In addition, staff will also be requested to submit online certificates of courses completed on the above Mandatory trainings as further assurance.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Action completed since inspection 05/05/2022 :

• All records of referrals to allied health are recorded in nursing care plans.
• An audit of compliance was carried out on the 11/06/2022.
• Communication of audit was disseminated and recorded to ward teams via CNMs.
• Staff records have been reviewed and audited on an ongoing basis and regulatory information requirement is in place for all staff.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Actions completed since inspection 05/05/2022 :
As per Regulation 16:

• All units have a comprehensive record book in place since April 2021 which details daily cleaning schedules in all units. The schedules include deep cleaning, flushing guidelines, IPC color coding, Covid cleaning guidelines and equipment cleaning schedules. The books are signed daily by the person in charge of the ward.
• Following inspection, CNMs are now required to sign off weekly the cleaning schedules in the books to ensure cleaning standards have been achieved as per cleaning schedules in place.

• The ADoN will audit the cleaning record schedules in the books as part of our environmental audits to ensure compliance. This audit is live on our new IPC auditing system.
• Staff Records have been reviewed and audited on an ongoing basis and regulatory information \requirement is in place for all staff.
• A Fire Consultant has visited the site since the HIQA inspection in May 2022 and has carried out a review of the building. This included a review of the fire doors and remedial works will be carried out. The process for escalating issues and concerns is under review.

Actions to be completed:

• A review of the staffing skill mix has taken place. Further review has commenced to put the additional resources in place .Action to be completed by August 30 2022
• A meeting with maintenance personnel was held 17th June 2022 in regards to the premises, fire safety, and general oversight of maintenance work. A schedules of works has been developed to include painting, plastering and flooring. These works have commenced and the expected completion date is 30/09/2022.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Actions completed since inspection 05/05/2022 :
• The risk identified in the en-suite shower room in a multi occupancy bedroom was addressed immediately and works completed within 24 hours of inspection.
• The odor in Bluebell sluice room has been identified and the drain cleared, no further odor noted.
• The out of order of bed pan washer identified on Inspection is now fixed.

Action to be completed:
• A meeting with maintenance personnel was held 17th June 2022 in regards to the premises, fire safety, and general oversight of maintenance work. A schedules of works has been developed to include painting, plastering and flooring these works have commenced. Expected completion date is 30/09/2022
• Additional furniture including chairs will be purchased for the replacement of damaged furniture. Completion date: 30/09/2022.
• A review of the additional space freed up in bedrooms, following reconfiguration of beds, will provide space for some of the new furniture purchased, thus enhancing the residents' bedrooms. Completion date: 30/09/2022.
• Overall review of the residents' storage space for personal items will be undertaken and additional shelving installed. Completion date: 30/09/2022.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Actions completed since Inspection 05/05/2022:
• All cleaning trolleys inspected and cleaned to acceptable IPC standard.
• Toilet aids cleaned and stored correctly.
• Residents slings stored away in appropriate storage area.
• Laundry area has been cleaned and recorded in record book daily cleaning.
• ADoN inspecting Laundry room weekly to ensure compliance.
• In addition, the laundry service has been outsourced and residents' personnel laundry is completed off site. Laundry activity is now minimal.
• External waste holding area locked and keys held on wards.
• Personal hygiene products found on hand hygiene sink removed and resident and staff reminded of correct storage
• Bluebell Unit's housekeeping room and sluice room have towel dispenser, soap dispenser and bin in place, drains cleaned to prevent smell.
• All staff reminded by CNMs of cleaning policy and requested to re-read same and sign.

Actions to be completed by 30/08/2022:
• A meeting with maintenance personnel was held 17th June 2022 in regards to the premises, fire safety, and general oversight of maintenance work. A schedule of works has been developed to include painting, plastering and flooring. These works have commenced and the expected completion date is 30/09/2022
• The treatment room in Camellia Unit is awaiting delivery of new clinical units to be installed. Delivery estimated by 30/08/2022

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Action completed since inspection 05/05/2022 :

A Fire Consultant has visited the site for inspections since the HIQA inspection in May. This included a review of the fire doors and remedial works will be carried out.

• All agency staff have been reminded of fire evacuation procedures as part of their Induction to the allocated ward.
• All agency staff are issued with an induction pack that includes a fire exit plan. Following inspection CNMs have rechecked same.
• The fire exit door identified has been fixed.
• Fire extinguishers are now wall mounted.

• Fire safety checklist in place.

Actions to be completed 11/11/2022
• All staff on units have been reminded re ward fire procedures during Safety pause.
• Fire training and evacuation will be completed for staff by 11/11/2022.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	11/11/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/07/2022
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	30/09/2022
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief	Substantially Compliant	Yellow	11/11/2022

	Inspector.			
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.	Substantially Compliant	Yellow	30/08/2022
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	30/09/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/09/2022
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	01/07/2022
Regulation 28(1)(d)	The registered provider shall make	Substantially Compliant	Yellow	11/11/2022

	arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire 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(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	01/07/2022