Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Baldoyle Residential Services
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	26 August 2021
Centre ID:	OSV-0002340
Fieldwork ID:	MON-0025859

About the designated centre

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

The centre is located in a seaside residential suburb of Co. Dublin and is located on the first floor of a large three storey building. The ground floor of this building comprises of a primary school for children with disabilities, a day care facility for adults and a swimming pool. Administration offices are located on the second floor where outpatient clinics are also held. Access to the designated centre is through a large reception area for the entire building and there is a lift and stairs available to residents. The entire property is owned by St. Michael's House (SMH). The designated centre is divided into two areas, each with their own living areas and kitchen facilities. Eleven residents reside in the centre. Residents are supported by a team of nurses and care staff. The centre is closed to admissions from external agencies as it is classified as a congregated setting. The provider proposed to de-congregate the centre in line with national policy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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 26 August 2021	9:30 am to 6:30 pm	Christopher Regan-Rushe	Lead

What residents told us and what inspectors observed

Overall the inspector observed that residents were being actively engaged and supported to enjoy life in this centre. There was a good ratio of staff to residents, with many residents seen to be being supported on a one-to-one basis. All residents living in the centre were using wheelchairs to aid their mobility. Some residents were independently using electric wheelchairs, while other residents required the support of staff to mobilise throughout the service. The inspector was greeted by the majority of residents on the day of the inspection and saw residents being supported to enjoy various activities throughout the day, both together and as individuals. During the day a party was being held for one of the residents and there was a sense of fun and genuine warmth within the designated centre. It was clear to the inspector, through the various interactions observed between residents and staff, that the residents were being very well cared for and supported by the staff working in the centre.

While the overall support for the residents was observed to be appropriate, kind and respectful; during a walk around of the centre, the inspector noted that there were critical issues with the overall quality and safety of the service. These issues, relating to fire, infection control and the general oversight of the designated centre meant that the focus of the inspection was changed from a monitoring inspection to a risk-based inspection.

Outlined in the body of this report are critical observations and findings which resulted in the provider being required to take immediate action to ensure the safety of the residents in the event of a fire. Concerningly, this report also highlights the failure of the provider to take action in line with their previously submitted compliance plan, to ensure adequate fire safety measures were in place. Issues were also noted in the provider's failure to ensure that there were adequate precautions in place to prevent and reduce the risk of the transmission of infection.

Additionally, between July 2020 and December 2020, the provider had operated an additional isolation unit in a number of rooms located on the same floor of the building the designated centre is located. However, the provider failed to ensure that these had been registered in accordance with the Health Act 2007 (as amended).

As previously mentioned while the observable staff interactions with residents indicated that they were being well supported on the day of inspection, a number of critical factors which directly impact on the overall safety of residents and the quality of the service, indicate there were significant failings in the provider's overall governance and oversight of this designated centre. As a consequence the provider was required to take immediate action to put in place adequate fire protection arrangements, and to submit a time-bound urgent compliance plan to the Chief Inspector.

Capacity and capability

The provider had failed to ensure that their own governance and oversight arrangements, set out in the organisation's policy and procedural documents were being followed at all times. This meant that while issues and actions were being identified by the provider, actions; which would ultimately resolve and improve the overall safety of the service, were either not being taken in accordance with the provider's own time frames or had not been adequately developed and monitored for completion.

For example, a previous inspection of this service was completed in July 2020. During that inspection, concerns and failings were found in relation to the overall effectiveness of the provider's fire safety arrangements. It was also noted that the provider had previously identified these and was working towards making the necessary improvements. In their compliance plan response to that inspection report, the provider submitted that all the necessary fire upgrade works would be completed by 23/04/2021.

During this inspection, the inspector found that while some of the fire safety improvements works had been completed such as the replacement of some fire doors, there remained significant concerns with the overall fire safety arrangements in the service. Examples included, damaged or poorly fitting fire doors throughout the centre, automatic door closures failing to close fire doors fully when activated and a door which opened up onto an evacuation route, being held open with a door wedge.

Additionally, In their policy and procedures, the provider has guidance and documents in place for staff to complete both daily and quarterly fire safety check lists. These documents set out very clearly that the staff responsible for completing these check lists should initial each item checked, and where defects were found that these should be escalated and where necessary actions taken to address these issues in order of priority, based on the organisations risk assessment of the issue.

The inspector reviewed a number of these documents, and found that the procedure for completing these was not being followed and there were gaps in the completeness of these checks. This meant basic daily checks were not being completed and the provider could not be assured that the service was being adequately reviewed for fire safety, on a daily basis, as required by their own procedures. The inspector noted, in reviewing these documents, that staff were using a range of symbols on the documents rather than their initials, which was inconsistent with the providers' guidance. For example, staff were using a variety of ticks, crosses and dashes. This could ultimately lead to confusion in the interpretation of the daily check in terms of the meaning of each symbol. Additionally, there was no evidence that these documents were subject to review, where there were gaps in the completeness of the documents, and no evidence that improvements were being made to the overall quality of the completion of these

records, as the same practice was noted in both the July and August daily check register. Of particular concern was the fact that the daily checks were failing to identify the issues noted during the inspections with no evidence that the continued issues with the fire doors being reported.

Other documentation in relation to fire safety, including pre-planning assessments, hazard risk assessment and fire safety risk assessments while present in the unit were not being kept up-to-date and as a result had misleading information. For example, the pre-planning assessment for the local fire service had not been updated since November 2013. This had key information about the location and number of critical fire safety measures, however; there was also conflicting information noted in that document. For example, on one page of the document it stated there were 11 fire hoses located in the centre. Later in an appendix to the document it stated that these hoses had not been serviced since 2009 and were no longer in use. In other parts of the document, the location and number of both portable and cylinder oxygen tanks were incorrect.

The provider had also failed to ensure that they were operating the centre in compliance with the Health Act (2007) and the regulations made there under by opening and operating an area of the building as an isolation unit and failing to make an application to vary the registration of the designated centre. The centre was in operation between July 2020 and December 2020. The rooms used for this unit were immediately adjacent to the registered footprint of the designated centre. Residents who lived in the centre, who were returning from hospital, were required to isolate in this unit for periods of 14 days, in order to comply with public health advice in the management and prevention of outbreaks of COVID-19 during the period the centre was in operation. The decision and ultimately the non-adherence to the Health Act 2007 (as amended) and the regulations made there under, highlights a significant failure by the provider to ensure that the service was well operated and had governance arrangements in place to ensure the overall quality and safety of the service.

Registration Regulation 8 (1)

The provider had failed to ensure that they made an application to vary the registration of this designated centre to include the isolation unit that was operated between July 2020 and December 2020.

Judgment: Not compliant

Regulation 23: Governance and management

The provider has failed to ensure that there were governance and management

systems and processes in place in the centre to consistently and effectively monitor the service. For example, these systems were not being implemented in accordance with the providers own policies and procedures, and where they were, they were failing to adequately identify critical issues which would highlight areas where the service was not safe and was creating a potential risk of harm to residents and staff. For example, the poor quality of environments and maintenance in the overall premises, the failure to monitor fire safety measures and the evidence of poor infection control and cleaning procedures.

Judgment: Not compliant

Quality and safety

Overall the inspector found that there was a fundamental and persistent failure by the provider to ensure the designated centre was achieving the basic quality and safety standards required by the regulations in relation to fire safety and protection against infection. This meant there was a significant risk to the safety of the residents in the event of a fire or an outbreak of infection. As discussed while the provider had self-identified some of these factors, they had failed to adequately ensure that action had been taken to improve the overall quality and safety of the service, in a timely manner, and to ensure that there was good adherence to their own policies and procedures and national guidelines and standards, in relation to fire safety and infection prevention and control.

During the inspection, the inspector reviewed the provider's arrangements for the containment of fire, and ultimately the safe evacuation of residents from the premises. In this centre, and due to the needs of the residents, the provider had put in place arrangements for the horizontal evacuation of residents to designated safe zones, away from the fire, until a full evacuation could be facilitated with support from the local fire service. Essentially, this meant that there were a number of zones or compartments in the designated centre, that had fire doors at each end that would, if working correctly, reduce and delay the spread of fire and smoke throughout the centre. In addition, and due to the layout of the centre, many of the residents' living and communal spaces opened directly onto corridors, and the provider had put arrangements in place to have fire doors fitted to their bedrooms as a secondary measure.

The inspector, accompanied by a member of the provider's maintenance team, reviewed 37 of the doors located throughout the designated centre. The majority of these doors opened directly into a resident's room or were located along the main evacuation corridors in the centre. Of these 37 doors, defects were noted in 33; ranging from the absence of automatic door closures, which would operate in the event of a fire, to poorly fitting doors which would not close in the event of a fire.

Many of these doors were located at the critical stop points of the four fire

compartments in the designated centre, which meant that the compartment would not act as a safeguard in the event of a fire. In one area the fire doors located either side of a stairwell, designated as a fire escape for the whole building were not shutting correctly. This meant that the provider could not be assured that fire could be adequately contained in the unit.

On the corridor where one of the stairwell doors were located, the inspector found that there were three rooms used by residents, each where there was either no total cold smoke or intumescent strip around the door, no automatic closing mechanism and where each of the doors could not be closed properly. This meant that this area would provide little or no protection to residents in the event of a fire, and was not able to adequately provide a safe compartment between a potential fire or the rest of the building.

There were many other examples where fire safety precautions were not adequately implemented including the inspector noting the use of a door wedge to hold open a door to one room and a hook and eye to hold open a fire door in another area. In one instance the inspector noted that the fire closure mechanism to the door of the dry laundry store had been decoupled and meant that the door was now permanently opened. This room was adjacent to the laundry facility on the floor which housed two washing machines and a tumble drier, again the door to this facility was left open.

Both of these rooms opened directly onto another safe compartment in the centre where resident's bedrooms were located. In the event of a fire in either of these rooms the practice of leaving these doors open, and the failure to have suitable safeguards in place such as automatic door releases and closing mechanisms, would mean fire and smoke could quickly spread within the centre. Of note again, on this corridor, the automatic door closures and seals to residents bedrooms were not closing fully when activated, meaning that in the event of fire smoke or fire could easily breach the fire door.

Due to the significant risk posed to residents the provider was issued with an immediate action to ensure that the fire safety arrangements in the centre could adequately contain fire or smoke and that residents were provided with a safe and adequate means of escape. Further findings in relation to fire safety measures are detailed later on in this report.

As previously mentioned, at the beginning of this inspection the inspector completed a walk around of this designated centre. During this walk around the inspector reviewed the overall quality of the provider's premises and how this was supporting good infection prevention and control practices. The inspector noted there was adequate supply of hand sanitser, hand washing facilities and soap for staff and resident use and there was ready access to face masks for staff to wear, when indicated. Staff were observed to be adhering to standard hand-washing and public health guidance in the appropriate use of face coverings.

The inspector reviewed the overall quality of bathing and washing facilities and kitchen areas. In each bathroom, the inspector noted the arrangements for cleaning,

and as a result good infection control, were inadequate. For example, a wooden toilet seat was fitted to one toilet and the paint had deteriorated on this leaving exposed wood. This meant that the toilet seat could not be effectively cleaned and would provide a place for bacteria to colonise. Each of the residents used different equipment for bathing, however; each bathroom had shower beds and hoists in-situ.

The inspector observed a number of residents were being supported to bathe throughout the day and reviewed the cleaning arrangements of the bathing equipment between each resident and found that improvements were required to the overall cleaning and maintenance of these facilities. For example, in each bathroom the sealed floor, which curved up to meet the wall covering, had perished and detached from the wall. This created an environment for bacteria to colonise. Many of the walls in the bathrooms had lime scale beginning to accumulate and, in one bathroom, there was a pool of standing water that was not draining which had begun to stain the floor covering.

However, of critical concern was the overall cleanliness of pad within the shower bed in one of the bathrooms. While the bed had recently been used, and washed down after use, the inspector found a significant build up of old soap and hair in the creases and folds of the pad. In one place, this had begun to turn moldy and black. This was a clear indication that these areas were not being subjected to the level of cleaning required between each resident. This meant the cleaning routines were not effective in ensuring that they were safe to use and could not harbour harmful bacteria or substances that could lead to infection if absorbed or ingested.

In another bathroom a toilet had been removed from the room. However the down pipe, connected to the main waste disposal pipe had not been adequately removed or sealed. Instead a black bin liner had been placed over the aperture. Again, this meant there was open access to a waste pipe in one of the bathrooms, and while the room was not actively in use, the door to the room remained unlocked and accessible. In another example, a commode chair, which had recently been used by a resident, had been returned to a clean bathroom. However, the inspector noted that this had not been cleaned correctly and there was evidence of talcum powder from the previous resident left as a residue on the lap belt of the commode.

In this centre, the majority of residents use hoists to support transfer. Residents may use either electric ceiling mounted hoists, or mobile hoists. The inspector requested the person in charge to provide evidence that the mobile hoists were being cleaned between each use. However, the person in charge confirmed that this measure, which would support the prevention of the transmission of infection, was not in place on the day of the inspection. The person in charge did however implement this process prior to the end of the inspection. However, it was concerning to note the absence of regular cleaning of high risk or high use areas, as recommended in the public health infection control guidelines for the management and prevention of COVID-19.

There were two kitchen areas located in the designated centre and the inspector again noted failures in the overall quality of these facilities which meant the provider could not ensure effective infection control measures and hygiene standards could

be maintained. For example, there was lime scale evident on the kitchen surfaces around the kitchen sinks and in some cases the sealant around the sink was missing or deteriorated. Both of these areas provide a location for harmful bacteria to colonise. In both kitchens, the inspector noted that there were missing doors to kitchen cupboards and damage to the work surfaces. Again both of these issued prevented effective cleaning routines and could result in the colonisation of harmful bacteria. The inspector noted that the seal to the fridge door in the residents' kitchen was damaged and that in both kitchens the plastic heat proof back splash, had warped and was coming away from the walls, or had been drilled and filled. Each of these issues meant that the provider could not ensure that the surfaces were being kept sanitised and free from colonisation due to the deterioration in the surface coverings, fixtures and fittings.

Regulation 17: Premises

The premises was in a poor state of repair with critical areas showing a high level of defects or damage. Areas such as kitchen surfaces and floor coverings which had deteriorated, meant the provider could not demonstrate they were maintaining the premises in accordance with regulations.

Judgment: Not compliant

Regulation 27: Protection against infection

There were significant infection control risks posed to residents due to poor levels of cleaning and maintenance in both the bathrooms and the kitchen areas of the designated centre. This risk was greatly increased due to the overall vulnerability of the people who lived in the service and their reliance on equipment that was not being adequately cleaned or maintained. In another example, the wipe clean surfaces of a number of easy chairs in a number of different rooms had deteriorated, which meant they could not be cleaned effectively and there was evidence of staining on another chair in another room. While these chairs may not have been used by residents, they may be in regular use by staff and visitors and could provide an opportunity for bacteria or other infections to colonise and to potentially be transferred to residents.

Judgment: Not compliant

Regulation 28: Fire precautions

There were significant failings in the oversight of fire safety measures in the centre, coupled with the poorly fitting doors which could not close properly or seal. This meant there were significant risks to the safety of the residents in the event of a fire in the centre or the building in which the centre was located. As a result an immediate action was issued to the provider requiring them to make improvements to the fire safety measures in the centre. In terms of other issues which impact on fire safety, the inspector also noted:

- Residents' personal evacuation plans were generic and not sufficiently detailed to guide staff on the correct procedure to follow for each resident's individual evacuation. In addition, all residents were being directed to the same safe location and the personal evacuation plans did not include the scenarios required to direct residents to safe compartments or stay in there rooms depending or where the fire was located.
- The provider's fire safety feedback report had not been reviewed since 23/04/2020 and had not been updated to show how actions that should have been completed within three months from the last review, or 12 months since the last review had been progressed. One of these relating to fire doors remained as a high priority on this plan for completion
- The fire risk assessment was last reviewed on the 18/01/2021. However, while this contained the current mitigating actions, it did not include the additional risks identified in the provider's fire safety feedback form, or the controls in place to manage these. In addition, this assessment did not identify any of the issues with the failure of the fire doors or practices in keeping fire doors without automatic door closures held open, noted throughout this inspection.
- The fire hazards assessment did not accurately detail the location of all portable and cylinder oxygen in the centre
- The fire evacuation procedure did not accurately describe who was responsible during the day for calling the fire brigade. The night time guidance identified the need to alert the Fire Brigade as number five on the sequential list of six items to be completed in the event of a fire alarm sounding. Which could result in a delay in alerting the fire brigade to the presence of a fire.
- A fire drill completed in December 2020 identified there was confusion in understanding the location of a fire, based on the reading given by the fire panel. Training on reading the fire panel was due to be given to staff with a follow up drill to be scheduled for the following month. The follow up drill was not completed
- A further fire drill, completed in June 2021, found that staff were unable to accurately determine the location of a potential fire using the fire panel and training was to be provided in reading the panel, despite this being identified as an issue during a previous fire drill.
- Quarterly fire safety checks had identified a number of issues relating to fire safety and the need for training; however, there was no evidence that these actions had been taken forward and addressed or recorded in the supporting action plans to these checks.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 8 (1)	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Baldoyle Residential Services OSV-0002340

Inspection ID: MON-0025859

Date of inspection: 26/08/2021

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 Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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
Registration Regulation 8 (1)	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 8 (1): • The provider acknowledges that an isolation room was used for a number of residents who were returning to the centre from acute settings and were unable to self isolate – this is no longer in use. • Residents if required to isolate will be supported to do so within the footprint of the designated centre with all neccessary precautions in place. • A full review of all of the rooms and their use has been completed; • The SOP is under review to consider any changes that may be required. • An application to vary will be submitted to reflect changes in the use of rooms and to extend the designated centre to include additional corridor and storage space. The updated SOP will be submitted as part of the application to vary.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A Service Improvement Team has been established by the CEO and chaired by the Director of Operations. The service improvement team have agreed Terms of Reference, and a comprehensive work plan to address the non-compliances with regulations The Service Improvement Team meet weekly and have an agreed agenda and actions to be completed. • The CEO communicated concerns to St Michael's House Board of Directors and an emergency Board meeting was held to discuss the concerns in the designated centre. • A passive fire protection survey and audit of the center commenced in July and was	

completed on 4.08.21
• Schedule of works and cost plan developed so a phased approach can be implemented. Final report and Cost plan received on 01.09.21. This was revised to include further works and received 17.09.21
• Fire survey report, escalated to Chief Officer CHO9
• Immediate remedial fire safety works were carried out in the centre to address priority areas to include;
• All fire doors have been fitted with automatic closures.
• Independent fire engineer appointed to project manage all fire upgrade works 9/9/2021,.
• The fire evacuation procedure for the centre has been updated to include who was responsible during the day and night time for calling the fire brigade to prevent a delay in same.
• Fire Evacuation plan and fire warden plan has been reviewed with SMH Fire Officer
• Fire Training has been completed by all staff
• Additional bed evacuation and simulated fire drills, supervised by the SMH fire officer were completed on 14th/ 15th Sept and will continue on 21st and 22nd Sept 2021. Feedback from previous fire drills was incorporated into the bed evacuation training.
• Additional specific fire training for the designated centre has been developed that includes reading the fire alarm panel and use of walkie talkies and the overall evacuation plan for the designated centre. All staff will complete this by 30th Sept.
• Enhanced fire evacuation training arrangements are in place for relief and agency staff to ensure familiarity with updated fire evacuation arrangements.
• Daily fire check lists are in place and are completed in line with policy and procedure. Updated review process is in place to ensure these are completed accurately. If there are any actions required these will be escalated to PIC/ CNM1/ PPIM for immediate follow up.
• A review of locations for the storage of oxygen cylinders has been completed all are securely stored upright in appropriate trolleys.
• Immediate remedial works to address IPC concerns were completed and a full IPC audit conducted by SMH Infection Prevention & Control Nurse. Actions from this audit are being implemented.
• A Full 32 regulation Audit has commenced and will be fully completed currently 30/9/21.
• The PPIM/ PIC are auditing reports relating to designated centre to include previous HIQA compliance plans/ 6 monthly audits/ annual reviews etc

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Damaged kitchen surfices have been repaired or replaced
• Damaged kitchen cupboard doors have been replaced
• The fridge has been replaced
• The plastic heat proof back splash has been repaced with tiles.

• All cleaning routines have been revewed and a comprehensive system of checklists for confirming cleaning routines re-estbalished
• Procurement procedures are underway to complete the redecoration of the center. This will be completed after the programme of remedial fire works.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• Immediate remedial works to address IPC concerns were completed and a full audit was conducted by SMH Infection Prevention & Control Nurse on the 1/9/21 and a second audit will be completed when all remedial works have been completed.
• All actions from the IPC audit are being implemented.
• All cleaning routines have been reviewed and a comprehensive system of checklists for confirming cleaning routines re-estbalished
• Flooring in one bathroom has been replaced, the flooring in the second bathroom will be replaced week commencing 20th Sept.
• Toilet seat in bathroom has been replaced
• Enhanced cleaning checklists are in place to evidence cleaning arrangements for bathing equipment after use.
• Lime scale has been removed from bathroom wall
• Down pipe in bathroom has been sealed.
• Fridge has been replaced.
Staff have completed refresher Covid 19 training.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A fire detection system is in place.
• Emergency lighting is in place. Generator is in place to provide backup power supply.
• A passive fire protection survey and audit of the center commenced in July and was completed on 4.08.21
• A schedule of works and cost plan has been developed so a phased approach can be implemented. Final report and cost plan received on 01.09.21 This was revised to include further works and received 17.09.21

• Fire survey report and findings was escalated to Chief Officer CHO9
• Immediate remedial work was completed to ensure that all fire doors close

- All fire doors have been fitted with automatic closures
- Fire engineer has been appointed to project manage fire upgrade works 9/9/2021. He completed a fire risk assessment and this report was received on the 17/9/21. The fire engineer has identified scope of works to be completed and the timeframe for these works to be carried out. The works identified will be completed as one activity and as Provider we are committed to the timeframes highlighted in the risk assessment. Work will be completed by 28/2/22 with high risk areas completed by 20/12/21.
- Fire safety risk assessment / feedback report has been updated to include the recommendations of the passive fire protection survey August 2021.
- The fire hazards assessment has been updated to include the location of all portable and cylinder oxygen in the centre
- The fire evacuation procedure for the centre has been updated to include who was responsible during the day and night time for calling the fire brigade to prevent a delay in same.
- Fire evacuation plan and fire warden plan has been reviewed with SMH Fire Officer
- Fire training has been completed by all staff
- Additional bed evacuation and simulated fire drills, supervised by the SMH fire officer were completed on 14th/ 15th Sept and will continue on 21st and 22nd Sept 2021. Feedback from previous fire drills was incorporated into the bed evacuation training.
- Additional specific fire training for the designated centre has been developed that includes reading the fire alarm panel and use of walkie talkies and the overall evacuation plan for the designated centre. All staff will complete this by 30th Sept.
- Enhanced fire evacuation training arrangements are in place for relief and agency staff to ensure familiarity with updated fire evacuation arrangements.
- Enhanced staffing is in place during night time hours to support safe evacuation until remedial works are completed.
- Personal Emergency Evacuation Plans (PEEPs) have been reviewed for all residents with details for the evacuation procedure as it applies to each individual.
- Daily fire check lists are in place and are completed in line with policy and procedure. Updated review process is in place to ensure these are completed accurately. If there are any actions required will be escalated to PIC/ CNM1/ PPIM for immediate follow up.

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
Registration Regulation 8(1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Not Compliant	Red	17/09/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Red	17/09/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the	Not Compliant	Red	17/09/2021

	designated centre are clean and suitably decorated.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Red	17/09/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Red	17/09/2021
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	02/09/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting,	Not Compliant	Red	02/09/2021

	containing and extinguishing fires.			