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

Issued by the Chief Inspector

Name of designated centre:	Mount Carmel Community Hospital (Short Stay Beds)
Name of provider:	Health Service Executive
Address of centre:	Braemor Park, Churchtown, Dublin 14
Type of inspection:	Short Notice Announced
Date of inspection:	12 November 2020
Centre ID:	OSV-0005337
Fieldwork ID:	MON-0031104

About the designated centre

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

The centre, located in South Dublin, is owned by the Health Service Executive (HSE) and operated by Mowlam Healthcare on their behalf. It offers 105 short stay beds to men and women over 18, with a focus of caring for those over 65. The aim of the service is to facilitate the discharge of medically stable patients from hospitals in the Dublin area to the centre with a care programme to enable them to return home, or where appropriate move on to long-term residential care. It is staffed with a multidisciplinary team including nurses, healthcare assistants, a general practitioner (GP), physiotherapist and occupational therapist. The service is provided on the ground, first, second and third floor of a large premises. It is divided in five units that are all staffed independently. Units had a range of single and multi-occupancy bedrooms. The building is easily accessible and provides parking for a number of vehicles. It is also close to local bus routes.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	77

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 12 November 2020	09:30hrs to 18:30hrs	Sarah Carter	Lead
Thursday 12 November 2020	09:30hrs to 18:30hrs	Siobhan Nunn	Support

What residents told us and what inspectors observed

Residents who spoke with inspectors expressed mixed views about the care they received in the designated centre.

Some residents said that were very happy, and that staff could not have been more helpful. Other residents expressed anxiety about their care and plans for their future. When asked, two residents said that they did not know who to talk to about their concerns and said that they did not know the staff. One resident described staff members as being well trained to perform care tasks but at times found them to be impersonal in their approach. Another resident told inspectors that staff were under pressure, but that they always responded to them when they used the call bell.

Inspectors observed staff interacting with residents in a respectful and kind manner. Staff who spoke with inspectors were knowledgeable about resident's needs.

Inspectors also made the following observations about the centres premises:

- There were signs of wear and tear on paintwork throughout the centre.
- A leak in a section of the roof remained since the last inspection and the damage it caused to paintwork and surfaces was unsightly.
- Parts of the exterior of the building also showed signs of wear and tear its age, and the car park surfaces were in poor condition.

Despite being a registered designated centre for older persons (DCOP), inspectors observed a culture more akin to acute care than a designated centre for older persons. Staff referred to residents as "patients", referred to ward rounds and described the different areas in the designated centre as wards. A significant number of residents were in bed throughout the day of the inspection or in their night wear while out of their bedrooms, which further reinforced the culture of acute care observed.

Capacity and capability

Resident's safety and well-being had been compromised by gaps in clinical governance. The Provider was taking steps to improve resident's outcomes by increasing resources.

The registered provider of this service is the Health Service Executive (HSE). There is a dual governance model in place: where the registered provider has contracted out the clinical operations in the centre to a third party; Mowlam Healthcare. The

provider was represented by a senior HSE manager who was available on-site a couple of days every week.

The service offered is mostly short-term, with residents typically being admitted directly from hospital to await long term care placements, to convalesce, or from the community for a variety of reasons. The centre is registered as a designated centre for older people, and is registered to accommodate up to 105 residents, across 4 floors (including the ground floor).

As a result of the isolation care requirements of the COVID-19 pandemic, a lowered occupancy was set by the management team at 93. This reflected a reduction in multi-occupancy bedrooms in the units which the provider had identified as areas of care for residents with a suspected or actual case of COVID-19. On the day of inspection there were 77 residents accommodated in the centre.

As described above, inspectors found a culture of acute care in this designated centre. A decision was made by senior representatives of Public Health in the local HSE area, to classify the service as akin to an acute hospital for the purposes of categorising its COVID-19 response. In addition the average length of stay, up to the date of inspection, was 40 days. Inspectors were informed by key staff throughout the day of inspection that the services Mount Carmel offered was dictated by the referring hospitals. The statement of purpose, which described the services on offer in the centre, listed a variety of referral criteria, but stopped short of describing the service in this way.

The centres last inspection took place in January 2020, which was a follow-up to the centres expansion from a 65 bedded service to a 105 bedded service. Since that inspection took place, the Chief Inspector had received 10 pieces of unsolicited information relating to the centre, 5 of which made allegations of poor care. Inspectors found evidence that indicated the Provider was aware of these concerns, and had investigated all incidents. Some incidents had been investigated by both the Provider and Mowlam Healthcare.

Despite these investigations and subsequent management reports, some care issues had re-occurred. In recent weeks the Provider had taken steps to increase the number of clinical nurse managers appointed, to monitor and improve the care residents received.

The Centre had experienced an outbreak of COVID-19 between April and June 2020. Thirty eight residents contracted COVID-19, and seven residents sadly lost their lives. These residents had been transferred to hospitals, where they passed away.

The governance systems in place in the centre was identified as requiring improvements in a number of areas including incident analysis, admission processes, resources, complaints management, staff training, staff supervision and some policies and procedures required review.

Reports seen by the inspector’s indicated that in some cases both the Provider and Mowlam Healthcare had reviewed the same clinical incidents. However theses investigations had not resulted in improvements for residents. For example;

pressure care issues had continued in the centre. In information notified to the Chief Inspector, it appeared approximately half of the pressure care issues identified had developed in the centre.

An investigation report seen by inspectors, suggested that the pressure care needs of a recently admitted resident exceeded the capacity of the centre and the resident was transferred back to the hospital, they had been discharged from. The admission process resulted in a poor outcome for the resident, but this process is defined as an option available to the Provider in the Centres' statement of purpose. In a month prior to the inspection, 8 of 88 residents had returned to the hospital that they had been referred from. Improvements were required to ensure that the care needs of all residents could reasonably be met in the centre, minimising disruption to the residents and their discharge plans.

Inspectors identified deficits in staff resources due to a significant attrition rate amongst clinical staff. In the year to date, 23% staff nurses had left, and 63% health care assistants (HCA), had left their positions. Risks relating to the challenges of inducting, supporting and communicating with new staff of various skill levels and backgrounds, had been included in the risk register. It was not evident in governance documents reviewed if staffing attrition was being addressed by the Registered Provider in an effective way.

In addition to the turnover of staff, it became evident on inspection that all residents did not have equal access to specialist supports. For example residents who had been discharged from a specific hospital had a social worker allocated to their care. Residents from other hospitals did not. The centres statement of purpose states clearly that a referral to a social worker will be made if social services are required. This disparity in specialists available to residents could impact on the speed and success of their discharge.

A small number of residents were living in the centre for longer than 300 days and the provider needed to take action to ensure the care being delivered and the capacity and competency of their staff group could meet their needs, including planning clear, effective and timely discharges. The length of stay of residents was clearly documented as being discussed at governance meetings, however these residents remained in the centre.

The centres statement of purpose encouraged residents to enjoy the quiet areas on the ''wards'' or the grounds. While the provider had improved the decoration of some of these areas, inspectors found ongoing signs of wear and tear, which meant they were not welcoming spaces for residents. This aspect of the physical environment will also be discussed in the next section of the report.

Complaints records were maintained in hard copy when received in that form, and digitally if received by email or online. On the day of inspection, the inspector reviewed the complaints records given, and correlated the information against unsolicited information received by the Chief Inspector. Some records were incomplete, and following an interview with the person in charge additional information was given to indicate some complaints had been closed. Inspectors also

found that some allegations of abuse were dealt with incorrectly as complaints and not through the safeguarding policy.The complaints officers work was overseen by a member of the management team, but this structure had failed to identify that allegations of abuse and safeguarding issues were embedded within some complaints.

Overall staff training in the various aspects of infection prevention and control was at a high level of completion. Likewise a very large number of staff had completed safeguarding training. Improvements were required in the training of designated safeguarding officers, in line with National guidelines and policy.

Despite the high rate of staff training in safeguarding, incidents which included allegations of abuse were not picked up by staff or management. This meant there was a failure to respond in a timely manner to ensure all residents were safeguarded.

Due to the roster patterns, all staff had supervision in their roles. However due to the staff attrition rate as discussed above, the completion of staff induction was often compromised. As discussed in the first section of the report, feedback from residents indicated that they sometimes felt there was an impersonal approach to their care. The provider was taking steps to improve this issue, as staff supervision had recently improved with the appointment of supernumerary clinical nurse managers. These managers were tasked with monitoring and improving residents care.

The provider had delegated the development of policies to the third party service provider. A sample of policies reviewed were not in line with national policies that the Provider would have in place in designated centres for older persons across the country. The policies reviewed by inspectors did not reference national policies in their reference list. The incident analysis policy did not provide sufficient assurance that clinical incidents were investigated to a consistent standard, with lessons learned implemented and feedback given to to staff to improve care. This meant that clinical incidents recurred.

When feedback was given to the registered provider’s representative and the person in charge, they reported that many of the issues identified by inspectors had been identified by the governance team. An analysis report was seen that had been completed in June 2020 that identified many of the issues the inspectors found.

Despite the gaps in governance identified above, the Provider was ensuring that residents care and safety was enhanced by:

- Ensuring sufficient numbers of clinical staff were rostered in the centre, and the roster reflected the layout of the centre. Each unit had a staff nurse in charge at night time, and the centre was overseen by a supernumerary senior staff nurse. In addition supernumerary clinical nurse managers (CNMs) had been recently appointed, specifically to improve the quality and safety of care of the different units.
- Infection prevention and control measures were robust. This work was reviewed by the governance team. There was an outbreak control team

established, which met regularly. A manger had been identified to lead the response to COVID-19. A specific nurse had been identified as a lead in infection prevention and control, however the post was vacant on inspection.
- A detailed COVID-19 contingency plan was in place to manage future outbreaks safely in the centre. It had been tested, and the Provider had been able to, manage a small number of residents with COVID-19 without it spreading to other residents or staff.

Regulation 15: Staffing

There was sufficient staff on duty and on the roster to meet residents needs, and which reflected the layout of the centre.

Supernumerary Clinical Nurse Mangers had been appointed in the weeks prior to inspection, and this role was identified by the governance team to monitor and improve residents care.

The issues identified with unequal access to specialist staff and staffing attrition are dealt with under regulation 23 below.

Judgment: Compliant

Regulation 16: Training and staff development

A very high number of staff had completed full training in infection prevention and control and safeguarding of vulnerable adults.

There were two designated safeguarding officers in the management team, however they required up-to-date training in best practices in the area.

The effective supervision of staff and induction of staff was complicated by high level of staffing attrition (This will be included in the judgment under regulation 23.).

Supernumerary Clinical Nurse Managers had been recently appointed to ensure adequate supervision and promote the monitoring and improvement of resident care, however at the time of inspection these positions were new and it was not possible to assess their impact on services to date.

Judgment: Substantially compliant

Regulation 23: Governance and management

The centres statement of purpose lists out both referral and exclusion criteria for the centre. In practice the acuity of the service provided was evolving. The statement of purpose requires refinement to identify the level of acute care it can provide. The centres statement of purpose also lists the staffing quota in the centre, and does not define how residents can access social workers to support their discharge plans. The provider was not providing sufficient and equal access to all residents to social workers to ensure all their needs were met. Some residents retained involvement of social workers from their discharging hospital, to assist their discharge plans, others did not.

The governance structure required review to ensure the roles and responsibilities of managers in incident analysis, risk management and quality improvement were clear, regardless of whether they were employed by the Provider or Mowlam Healthcare. Incidents were investigated by both the Provider and Mowlam Healthcare, but neither had led to tangible long term improvements in residents care by the time inspection took place. Despite recording and investigating, incidents of poor care had re-occurred in the months preceding the inspection.

Governance systems included gathering a full range of key performance data and reviewing it. However the oversight of key areas needed improvement, for example in complaint management, to ensure that the management of safeguarding concerns followed the centres own policy; the management of staffing attrition and the implementation of effective quality improvement plans. As incidents relating to safeguarding residents had not been identified correctly, the Chief Inspector had not been notified within the required time frame.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints records were maintained electronically or in hard copy and were maintained separately from the resident care plans and files. On the day of inspection some complaints records seen did not indicate that complaints investigations had been concluded.

There were significant numbers of complaints were received in the centre over the year previous to inspection. Evidence was seen that several persons who raised complaints, had referred themselves onto the Centre's complaints appeals process, as they were dissatisfied by the initial complaints investigations outcome.

An internal report completed in June 2020 which reviewed the response to COVID-19, prepared by Mowlam Healthcare, had identified gaps in complaints management and the oversight of complaints in the centre. The person in charge was the

designated complaints person, with oversight of the complaints process by a manager. As discussed earlier in the report this oversight mechanism, had failed to identify that some complaints raised contained allegations of abuse, and were incorrectly processed under the complaints policy and not the safeguarding policy, which had a direct impact on residents care and safety.

Judgment: Not compliant

Quality and safety

Improvements were required in the provision of high quality care and to promote the safety of all residents at all times.

Safeguarding policies and procedures were in place and staff who spoke with inspectors were aware of their responsibilities to report safeguarding concerns. However, documentary evidence viewed by inspectors showed that the policy was not being followed. One safeguarding record showed that the outcome of the preliminary screening was not documented and staff did not know if the policy applied to the centre, therefore causing delay in responding to the concern identified. Safeguarding plans did not provide details of the how residents were to be protected in the future from the specific concerns identified. On the day of inspection managers acknowledged to inspectors that they required further training in Safeguarding.

Two GP's employed by the designated centre provided medical care to residents. Residents had access to allied health and specialist medical professionals when their assessed medical needs indicated that these services were required. Medical and allied health intervention and advice was recorded in daily records and incorporated into care plans. However as discussed above access to specialist social workers was defined by what hospital the residents had been discharged from. As stated above in regulation 23, the centres statement of purpose implies that residents should have access to social workers, however this was not the case for all residents who may need that level support and advocacy.

Arrangements were in place for the comprehensive assessment of residents needs to be completed prior to residents being admitted. Care plans were developed on admission which included detailed guidance for staff on how residents assessed needs were to be met, including residents preferences. Inspectors reviewed a number of electronic resident records and found that care plans were reviewed regularly and were updated as resident's needs changed. Despite this, a small number of residents returned to the hospitals from which they were discharged. That outcome is undesirable for residents, and ongoing oversight was required to ensure the care and skill mix available can meet the needs of all residents admitted.

Inspectors observed staff knocking on residents doors prior to entering and speaking to them with respect. Every effort was made by staff to ensure that

residents kept in contact with their families and friends, using phone and video calls. Activities which ensured that social distancing was maintained, were available to residents. These included access to religious services and films in residents rooms, jigsaws were available, and access to library books was facilitated by staff. Easy access to advocacy services was ensured by the allocation of a manager to assist residents and make referrals.

The centre premises showed signs of wear and tear. Following the centres last inspection, the registered provider had taken steps to improve some areas in the centre. However the inspectors noted a leaking roof (previously identified on inspection) remained in the same state. There was also signs of wear and tear on paintwork on walls and skirting boards in several areas. This was visually unappealing, and decreased any atmosphere of homeliness and comfort to residents, and the water ingress was a potential trip and slip hazard on a busy thoroughfare.

The management of risk in the centre was guided by a policy. While this policy addressed the key risks as required in the regulation, it did not reflect all practices in the centre. For example allegations of a safeguarding nature were defined as incidents within this policy, but safeguarding allegations were not being consistently identified as incidents. On review the incident management policy reviewed on the day of inspection did nt reference dealing with incidents involving residents and how the learning from incidents was managed.

There was clear suite of infection control policies in place, which had been developed to guide staff to manage COVID-19. There was an identified role within the governance structure, however this role had recently become vacant. A senior manager was also identified as the lead person for the COVID-19 response. Staff had high levels of training in infection prevention and control. Inspectors observed staff engaging in appropriate and correct hand hygiene, whilst donning and doffing of personal protective equipment. A comprehensive line listing was maintained for both staff and residents, recording any testing and results received for COVID-19. The sluice and store rooms reviewed were noted to be organised and clean.

Some upholstery of seating required replacement and remnants of sticky-tape was seen on walls and on furniture in communal areas of the centre. These present infection control risks as they do not allow for the easy cleaning of surfaces.

Regulation 17: Premises

Areas of the premises were found to not be in a good state of repair:

Internally:

- There was wear and tear evident on paintwork throughout the building. This included indentations in the walls where chairs and beds had rubbed against them, and scuffed and marked skirting boards.

- A glass roof on an corridor adjoining units was leaking. This had been identified as an issue by the Provider several years previously.

Externally:

- Large sections of the car park required resurfacing.
- The outside facade of the building looked dilapidated.

Both of these findings contributed to increased risk to residents, from a lack of comfortable and appealing spaces to spend time and relax, a risk of a slip or trip hazard from water ingress or uneven surfaces.

Judgment: Not compliant

Regulation 26: Risk management

The risk management policy in the centre required improvement. The policy referenced that the registered provider was responsible for the risk management process. However the policy was not drafted by the registered provider, it was prepared and published by Mowlam Healthcare.

This policy referenced that safeguarding issues are logged as incidents. The incident management policy seen on the day of inspection did not describe a clear pathway to managing safeguarding incidents.

Improvements in the incident management policy and procedures were required to ensure all clinical incidents were consistently investigated, and the lessons learned from each incident were embedded into improvements in residents care.

Judgment: Substantially compliant

Regulation 27: Infection control

The premises was clean, tidy and well-equipped with hand washing stations, antibacterial gel dispensers, information posters to assist and remind personnel to abide by social distance practices.

There were good systems in place to ensure appropriate Personal Protective Equipment (PPE) was accessible and available and staff used it in line with current guidance. Inspectors observed good hand hygiene practices on the day of the inspection and staff were using PPE appropriately. Staff were knowledgeable and confident when they described to inspectors the cleaning arrangements and the

infection control procedures in place.

Overall, there were robust cleaning processes in place. Cleaning schedules and signing sheets were completed. Inspectors observed staff decontaminating equipment between use and adhering to infection control guidelines. There were safe laundry and waste management arrangements in place.

Staff temperatures were recorded twice daily and staff were aware of the local policy to report to their line manager if they became ill. There was a staff uniform policy and all staff changed their clothes on coming on and off shift.

Hand sanitizers were placed strategically to ensure staff were accessing and using them regularly in line with current best practice guidance. There were systems in place to ensure staff minimise movements around the centre and rosters showed that staff worked in one designated unit and did not transfer across to other units in the building.

The provider had prepared a clear COVID-19 contingency plan, and there was oversight of infection prevention and control by the senior management team.

Torn upholstery on some seating and the use of sticky tape on walls presented infection prevention and control risks as their surfaces were not easily cleaned. These were brought to the attention of staff on the day.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors viewed ten percent of residents records focusing on residents who required pressure care, those who displayed responsive behaviours and new admissions. Comprehensive pre-admission assessments had been completed for all residents, which identified resident's needs prior to admission. There was evidence that care plans were developed within 48 hours of admission.

A number of clinical tools were used to assess different aspects of residents needs including, skin integrity, nutrition, mobility, and responsive behaviours. There was evidence that care plans were reviewed regularly and that they reflected assessed need.

Staff who spoke with inspectors were knowledgeable about caring for residents with pressure care needs. They reported that they had recently completed pressure care training. Clinical nurse managers allocated throughout the designated centre reported to inspectors that they monitored resident's well-being which included skin care. They were knowledgeable about residents care needs when speaking to inspectors. Resident's assessments, care plans and daily records were up to date.

Judgment: Compliant

Regulation 6: Health care

The designated Centre had two resident GP's who were available to meet resident's medical needs. Staff described and inspectors observed the system that was in place to ensure that residents were assessed promptly by the GP when the need was identified.

Inspectors viewed evidence in resident's records that advice from health care professionals, including tissue viability nurses, was recorded and being followed.

Residents had access to allied health professionals to meet their needs. Inspectors spoke to occupational therapy staff and observed them providing equipment to residents which enabled them to maximise their independence.

Judgment: Compliant

Regulation 8: Protection

A review of safeguarding documentation was completed on a sample of three records. Inspectors found that there were a number of gaps in the response to allegations of abuse on all records. These included, abuse not being recognised, and confusion about the reporting responsibilities outlined in the centre's safeguarding policy. Robust safeguarding decision making was not documented in records. Safeguarding plans were generic and did not provide details of the unique safeguarding measures to be put in place for each resident following the completion of safeguarding investigations.

Two members of the management team told inspectors that they needed training in how to respond to and document allegations of abuse. Both managers were identified as designated officers. One had received designated officer training but acknowledged that they needed a refresher and the second manager had not attended the training.

Staff had attended safeguarding training and those who spoke to inspectors were aware of the procedures to follow if they had concerns about the abuse of a resident. A policy was in place for the management of residents finances. At the time of the inspection the centre was not acting as financial agent for any resident.

Judgment: Not compliant

Regulation 9: Residents' rights

The variety of activities available to residents had changed due to the infection prevention and control measures implemented as a result of COVID -19. The designated centre employed three activities coordinators to provide residents with facilities for occupation and recreation.

Inspectors observed activities' lists which were displayed clearly on notice boards in each unit. They included films which were shown on a designated television channel on residents televisions every day at 2pm, chair exercises and jigsaws. A hard copy of a list of activities for each resident was maintained on units. These activities cards were updated regularly by activities staff. Residents were assisted to access books from the library and although the oratory was closed Mass was available every day on the television.

Advocacy services were available to residents and a manager within the centre was identified to refer residents to advocacy and assist residents to access these services.

Activities coordinators organised video calls for residents to ensure that they remained in contact with friends and family. Inspectors viewed an information booklet which was available to residents in their room. This included details of the services available in the centre and the complaints procedure.

Inspectors reviewed records of resident's satisfaction surveys which were completed with residents during their stay. Relevant feedback was provided to staff immediately and the information was collated on a quarterly basis for distribution to stakeholders.

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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mount Carmel Community Hospital (Short Stay Beds) OSV-0005337

Inspection ID: MON-0031104

Date of inspection: 13/11/2020

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	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• Staff Training Needs Analysis: A review of all staff training will be undertaken and completed by 28/02/2021. Following this review, management will develop a targeted staff training and development plan which will address any updated training needs with further staff training scheduled as required.

• The introduction of the supernumerary CNMs has resulted in improved oversight, supervision and mentorship on each ward. They provide daily support and guidance to all staff on each ward, ensuring that staff are appropriately deployed and allocated to undertake duties suitable to their roles and qualifications. The CNMs evaluate the induction and performance of each staff member and can then target specific training and education to address individual staff development areas. This will form part of the clinical supervision and reflective practice cycle that will contribute to the overall performance appraisal of each staff member.

• The current designated safeguarding officers have received training and education in Safeguarding & Safety. The staff training and development plan will include the provision of enhanced Safeguarding and Safety training for the current safeguarding officers to ensure that they remain up to date regarding their safeguarding knowledge, awareness and current best practices in this area. The level of training provided will specifically address the role of the designated officers and provide assurances that all suspicions or allegations of abuse will be dealt with appropriately and thoroughly, including: reporting and responding to suspicions or allegations of abuse; investigation, resolution and notifications to the Authority; appropriate and timely escalation to senior management and to the Community Safeguarding Officer and/or other external agencies such as An Garda Siochana, as required.

• In addition, as part of the staff training and development plan, the Service Provider will determine whether additional designated officers are required and identify which suitably experienced staff can undertake this training, as this would facilitate the provision of additional safeguarding resources within the Community Hospital.

• Clinical oversight is provided by a designated senior nursing manager who carries out

regular site visits to monitor standards and practice. These are usually unannounced visits which facilitate effective evaluation in real time.	
Regulation 23: Governance and management	Not Compliant

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

• The Statement of Purpose: Since the inspection, the Statement of Purpose has been further reviewed and updated to identify the clinical care criteria of admissions to the Community Hospital.

• There is a Standard Operating Procedure for Mount Carmel Community Hospital, which describes the service provided in the Community Hospital, including: referral, admission and discharge procedures; patient referral suitability criteria; and exclusion criteria, which outlines the patient categories that are unsuitable for referral to the Community Hospital. This document describes the general categories and acuity of patients that can be safely managed in the facility.

• The number of assessments/discharges/delays in discharges and reasons for admissions not meeting admission criteria are also discussed weekly with the HSE Service Manager.

• Social Care Needs: The Mount Carmel Community Hospital Standard Operating Procedure also describes the social care supports structure, which uses the HSE Common Summary Assessment Report (CSAR). This assessment is used as appropriate for patients who may require social care advice to support their discharge plans. All patients' social care and support needs will be reviewed and any patient requiring social care supports will be reviewed using the HSE CSARs and a referral will be made to a Social Worker if indicated.

• The Statement of Purpose has been updated to reflect that a designated Social Worker from Tallaght University Hospital (TUH) has been seconded by TUH to spend 2 days per week in Mount Carmel Community Hospital to ensure that the social care discharge plans of the patients referred from TUH are implemented appropriately. TUH patients account for a significant number of the referrals to Mount Carmel Community Hospital and admissions from Tallaght Hospital are made on the basis that there is social work support available where these patients have additional social care needs to support their discharge plan.

• Designated Staff: The Patient Flow Manager will oversee all admissions and in conjunction with the nursing management team, will ensure that patient transfers and discharges are clinically and medically safe, determined on the basis of clear criteria, and compliant with the contract of care.

• Incident Management Oversight: The Service Provider will ensure that there is a coordinated management response to all incidents and adverse events in the community hospital. The PIC if appropriate, will investigate any significant incidents with the support of the regional Healthcare Manager (HCM) in the first instance.

• For serious adverse events or incidents, a joint senior management review will be

undertaken, involving members of the Service Provider senior management team, including the PIC, regional HCM, Provider Representative and Director of Care Services. This group will coordinate the collective incident management response and assign responsibilities and timelines for further actions, as required.
• All Serious Incidents will be reported to HSE Management and discussed in detail at monthly Governance Meetings.
• The Service Provider will ensure that this group will review progress in the implementation of the action plans until they have been completed or improvements established.
• This incident management escalation process will be subject to frequent review by Service Provider senior management team to ensure that it is suitable and effective and is managed in line with the HSE Serious incident framework.
• Staff retention is a high priority for the Service Provider. In the latter half of 2019, the recruitment programme was primarily focused on providing additional staff in line with the increase of beds from 65 to 105. The current Covid-19 pandemic has had an impact on staff attrition, with several staff citing anxiety around Covid-19 as a personal reason for leaving in exit interviews.
• All staff have received enhanced education and support so that they feel confident and competent to meet the additional challenges of this unprecedented situation and we will implement additional supportive measures as part of an overall staff retention strategy, including:
• Reflective Practice Framework: A new reflective practice framework will be implemented as part of the enhanced performance appraisal of all staff involved in caring for patients in the community hospital. This framework is applicable to all levels of the clinical care provision, including complaints management, the management of safeguarding concerns, the management of staffing attrition and the implementation of effective (SMART) quality improvement plans.
• All nursing staff and managers involved in patient care will participate in the reflective practice process. This assurance process is designed to review and set care priorities/objectives, discuss individual patient's clinical needs/incidents in depth, change or modify practice and identify any staff training needs. The ultimate aim will be to ensure accountable professional standards and improved patients' care outcomes.
• A review of serious incidents/complaints will continue to take place quarterly through the HSE/Service Provider Governance structure with a focus on learning/implementation of recommendations and putting in place an action plan to ensure that recommendations and learning outcomes are fully implemented.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Complaints Management: The Service Provider Complaints policy is written in accordance with the HSE Policy "Your Service, Your Say". The Complaints Procedure is displayed prominently in the community hospital and the Service Provider will ensure that

all patients and their representatives are aware of how to make a complaint. The Service Provider will acknowledge all complaints promptly, investigate them thoroughly and respond to the complainant as soon as possible within a designated timeframe. The Service Provider will ensure that the complainant is aware of the procedure and named person to appeal to if they remain dissatisfied with the original response.
• All complaints received are logged onto the electronic care record, but all records associated with the complaint are stored separately to the patient's care records. This arrangement facilitates real-time complaints monitoring and reviews, which are regularly undertaken by the PIC.
• The PIC is supported and overseen in the management of complaints by the Service Providers regional Healthcare Manager, who will ensure that the Complaints records are comprehensively completed, including an indication of the outcome, complainant's satisfaction and lessons learned, and this will provide assurance of suitable complaints management and oversight.
• The reference to gaps in complaints records in the internal report of June 2020 have been resolved and the PIC has confirmed that the specific records referenced in the report have been addressed to the satisfaction of the complainant.
• Any complaint that could conceivably have been considered as potential abuse will be further reviewed to ensure suitable assurances are available and any further safeguarding actions, including retrospective notification or improvements required, will be implemented.
• The Service Provider will provide additional complaints oversight by including a review of complaints in the staff reflective practice meetings.
• All complaints are discussed and reviewed at the monthly governance meetings. This structure will ensure full implementation of the hospitals' complaints management process.
• A review of serious incidents/complaints will take place quarterly through the HSE/Service Provider Governance structure with a focus on the learning/implementation of recommendations and having in place an action plan to ensure recommendations and learning are fully implemented.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The HSE in conjunction with HSE Estates will address as priority the areas of wear and tear and repainting work that is required throughout the building. A painting programme is now in place to address minor painting and refurbishment
• Leaking Glass Roof: The HSE is currently working with HSE Estates in relation to the repair works for the leaking glass roof on the corridor adjoining the units. A contractor has been secured and is scheduled to be on site by 31st March 2021. The works will take approximately 3 weeks to complete.
• Car Park Resurfacing: The car park has been temporarily closed with staff utilising the car park on the left hand side of the building. A meeting has taken place with HSE Estates and quotes will be received and funding sought under Minor Capital expenditure

to facilitate the re-surfacing of the car park

Ongoing capital works at Mount Carmel Hospital – it is planned a capital development plan will be undertaken in conjunction with HSE Estates regarding the ongoing requirements associated with the building and the future development of services on the campus.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
• Incident Management Policy: The Service Provider has reviewed the Incident and Accident policy and this is written in accordance with the HSE Incident Management policy. The policy is hospital specific, contextually correct and fit for purpose to guide staff in effectively managing incidents and ensuring optimal patient outcomes.
• Incident Management Process: The Clinical Nurse Manager (CNM) on each ward is now the designated accountable staff member for the management and monitoring of risk in their clinical area, including fire safety, any incidents, accidents, near misses and complaints occurring on each ward.
• The PIC, with support from her management team, including the Assistant Directors of Nursing, will provide management support and oversight of this process.
• The Service Provider will ensure that all incidents are consistently investigated, and the lessons learned from each incident are embedded into improvements in patient care provision.
• The Service Provider will ensure that all allegations and suspicions of abuse are logged as incidents, in accordance with our policy. In addition, all Safeguarding records will be documented in accordance with the HSE Safeguarding policy and the Safeguarding Officer's requirements. All suspicions and allegations of abuse will be consistently investigated, and the lessons learned from each will be embedded into improvements in patient care provision.
• Hospital Health & Safety Committee: This incident management process is now supported by the Health & Safety lead for each ward (the CNM) and all management staff who attend the hospital Health & Safety committee meetings. The role of this committee is to ensure a proactive and responsive incident management process including the identification, assessment, management and ongoing review of hazards, risks and incidents at individual ward and hospital-wide levels.
• An additional KPI will be included on the monthly Governance Meeting with the HSE and the Service Provider which will be monitored on an ongoing basis. April 2021

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Furniture repair or replacement schedule: Following a review of the seating furniture upholstery in the hospital; a seating furniture repair or replacement schedule will be completed in consultation with the Registered Provider to repair or replace seating upholstery, as required. This schedule will be completed by 31/03/2021.
• The use of sticky tape has been discontinued. The Service Provider will monitor each ward to ensure that effective cleaning procedures are implemented in accordance with infection prevention and control requirements.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Safeguarding Management: All incidents are logged on the electronic care recording system. This arrangement facilitates real-time safeguarding monitoring and reviews, which are completed regularly by the PIC, who will ensure that the records are comprehensively completed and contain evidence of robust safeguarding decision-making and individualised safeguarding plans if required, in accordance with the safeguarding policy.
• The PIC will ensure that all appropriate notifications are made to the Authority.
• Additional oversight will be provided by including Safeguarding & Safety as part of the individual staff reflective practice meetings. This will encompass a review of the relevant safeguarding records including incident reports, complaints, and patients' care plans. The schedule of reflective practice meetings has been established and regular meetings have already been commenced with individual staff members.
• Staff Safeguarding Policy Awareness: A review of staff knowledge and awareness of the hospital safeguarding policy will be completed by 31/03/2021 to ensure that all staff are aware of their roles and responsibilities under this policy.
• Designated Officers Training: As part of this review, the two designated officers will be provided with updated safeguarding training by 31/03/2021 that will specifically address their role as designated officers and provide assurances that all suspicions and/or allegations of abuse will be dealt with appropriately and thoroughly, as outlined under Regulation 16.
• Safeguarding Governance: Any incident or complaint that could conceivably have been considered as potential abuse will be further reviewed to ensure suitable safeguarding assurances are provided and any further remedial actions including retrospective notification or required improvements will be implemented.
• A KPI on Safeguarding & Safety as part of the Monthly HSE/Service Provider Governance Meetings is being put in place to put a closer focus on this area, commencing in the April 2021 meeting, and this will further enhance the quality of reporting, monitoring and decision-making in relation to safeguarding incidents.

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	31/03/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/03/2021
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	30/04/2021
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	Not Compliant	Orange	31/03/2021

	the statement of purpose.			
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	31/03/2021
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	31/03/2021
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	31/03/2021
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and	Substantially Compliant	Yellow	31/03/2021

	learning from serious incidents or adverse events involving residents.			
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.	Substantially Compliant	Yellow	28/02/2021
Regulation 34(1)(d)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall investigate all complaints promptly.	Substantially Compliant	Yellow	31/03/2021
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint,	Substantially Compliant	Yellow	31/03/2021

	the outcome of the complaint and whether or not the resident was satisfied.			
Regulation 34(1)(h)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall put in place any measures required for improvement in response to a complaint.	Not Compliant	Orange	31/03/2021
Regulation 34(3)(a)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to.	Substantially Compliant	Yellow	28/02/2021
Regulation 34(3)(b)	The registered provider shall nominate a person, other than the person nominated in paragraph (1)(c), to be available in a designated centre to ensure that the person nominated under paragraph (1)(c) maintains the records specified under in paragraph (1)(f).	Substantially Compliant	Yellow	28/02/2021

Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	28/02/2021
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	31/03/2021
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	31/03/2021