Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Raheen Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Tuamgraney, Scariff, Clare
Type of inspection:	Unannounced
Date of inspection:	06 September 2021
Centre ID:	OSV-0000611
Fieldwork ID:	MON-0033332

About the designated centre

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

Raheen Community Hospital iIs situated in an idyllic rural setting in Raheen Woods, three miles from Scariff. It is registered to accommodate 25 residents. It is a two-storey building and the bedroom accommodation comprises of eight single rooms, one twin room, two palliative rooms, three three-bedded units and one four-bedded unit, all with en-suite facilities. Communal areas comprise of sun room/ conservatory, relaxation garden room, sitting room, church, dining room, family room, kitchen and St Teresa's Garden. Raheen Community Hospital provides 24-hour nursing care to both male and female residents aged 18 or over requiring long-term, short-term, respite and palliative care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21

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
Monday 6 September 2021	10:00hrs to 17:30hrs	Sean Ryan	Lead
Monday 6 September 2021	10:00hrs to 17:30hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

Residents living in Raheen Community Hospital told inspectors that this was a nice place to live, they received good care and the staff were very kind and supportive. Through observations and interactions with the residents and staff, inspectors were assured that residents received good quality health and social care from a team of dedicated staff who knew the residents well and supported them to have a good quality of life.

This was an unannounced risk inspection by inspectors of social care services during the COVID-19 pandemic.

Following an opening meeting, inspectors completed a walk around the centre with the person in charge. The inspectors spoke with eight residents during the inspection and a common theme throughout the conversations with residents was that the centre was clean, the food was "beautiful" and that throughout the restrictions residents continued to enjoy social and recreational activities, including outings to areas of local historic and scenic interest. One resident told inspectors that staff had supported him so well that he felt his health had improved and confidence had returned. Residents were complimentary of the management and staff efforts to keep them safe from COVID-19 and residents told inspectors that no resident in the centre had tested positive for the virus. Residents said that they were kept informed about changes in the centre. Residents spoke of the fear they had experienced as a result of the pandemic and the challenges they faced when restrictions were in place. The vaccination programme had given some residents confidence that they were protected and they felt that this was important as families began to visit again. While visits were facilitated in the centre, further improvement was required as the visiting remained somewhat restricted. The residents and their families wished for further review of visiting arrangements and this was evidenced in resident and family feedback surveys in addition to conversations inspectors had with residents.

Residents were observed to be relaxing in their bedrooms and dayrooms, freely walking through the corridors, chatting with one another and listening to morning mass. Residents confirmed to inspectors that they could choose to get up early in the morning or spend time relaxing in bed if they wished. Their choice of where and when to have their breakfast was respected. The morning time had a relaxed and unhurried atmosphere. Residents were observed to have their individual style and appearance respected and staff supported them to maintain this. Residents and staff knew each other well which added to the observed comfort residents felt with the staff. Residents confirmed that they would not hesitate in raising a concern or complaint with a member of staff and that any issues would be promptly resolved.

Overall, inspectors found that the premises was bright, spacious and well laid out to meet the needs of the residents. The corridors were easily navigated through the placement of directional signage. There were some areas of the premises that

required some maintenance and repair due to wear and tear along door frames and skirting. There was ample indoor private and communal space with bright and comfortable furnishings which were well maintained. The residents had unrestricted access to outdoor space and could enjoy well-maintained gardens that were furnished appropriately and decorated with flower beds, water features and had a pleasant view of the surrounding landscape. On the day of inspection, the centre was undergoing planned building works to enhance the facilities for the residents. The appropriate risk assessments, including noise reduction measures, were in place to ensure the residents were not impacted by these building works.

The corridor walls were decorated with various pieces of artwork by residents that evidenced the variety of past activities that had taken place. Residents confirmed that activities were provided seven days per week and there was "always something enjoyable" occurring in the centre. The activities schedule was prominently displayed in the centre. Further improvement was required to ensure that the activities on offer to residents were aligned with the schedule on display. A visitor's room contained a desktop computer for the residents to use as they wished. Inspectors observed a resident using the Internet to take guitar lessons. Residents had access to radio and newspapers, and mass was held twice per week in the centre's chapel. Residents had the option of attending the mass or watching it on live stream from the chapel.

Some residents were observed relaxing in the sitting room in addition to several small communal spaces and staff were present to provide supervision and support. Inspectors observed the residents' dining experience and the atmosphere was relaxed. The dining room was large and bright and the residents were provided with a choice at mealtimes. Staff were available to assist the residents and staff were observed providing assistance that was respectful, discreet and unhurried. Some residents chose to have their meals in their bedroom and staff were also available to provide assistance and support there. Residents in the dayroom confirmed to inspectors that they were provided with snacks, teas and juices throughout the day and at their request. Residents who chose to remain in their bedrooms confirmed that this choice was also offered to them, adding that staff would often sit with them and chat while having a cup of tea.

Residents' bedrooms were personalised with items of significance such as family photos and ornaments. Bedrooms provided adequate space to undertake activities in private, in both single and multi-occupancy bedrooms. Residents had access to televisions in all bedrooms. The person in charge assured inspectors that a review of the placement and access to television for residents in multi-occupancy bedrooms would be undertaken to ensure all residents could view the television comfortably. Bedrooms were clean and bright and provided adequate storage for each resident's personal belongings and clothing. Some bedrooms were furnished with comfortable reclining chairs that residents were observed enjoying while watching TV. The person in charge informed inspectors that all bedrooms now contained en-suite facilities for residents. Call-bells were placed in all areas occupied by residents, and they were observed to be answered in a timely manner and staff were readily available to assist residents. Where possible, social distancing was maintained and residents were aware of the rationale for this requirement. There was appropriate

signage in all areas of the centre for residents and staff to prompt hand hygiene.

The following sections of this report detail the capacity and management of the centre and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

Inspectors were satisfied that the residential service was sufficiently resourced and had a clearly defined governance structure and a responsive management team that was accountable for the delivery of safe and effective care to residents. However, the registered provider was found to be in breach of condition one of its registration as it had failed to inform the Chief Inspector that an unregistered adjacent building was being used for storage and was also in use by residents. While there were systems in place to monitor and improve the quality of the service provided to residents, inspectors found that these systems required further oversight and development as described under Regulation 23: Governance and Management.

The Health Service Executive is the registered provider of the designated centre. There was a clearly defined management structure with clear lines of authority and accountability. The management team consisted of a general manager, a manager of older person services and the person in charge.

The person in charge had good clinical oversight of the service provided and information was communicated on a daily and weekly basis from the clinical team in terms of residents who were at risk of malnutrition, incidents, wound care and residents that required medical review. Inspectors reviewed the minutes of weekly governance meetings that were held via teleconference and items on the agenda included risk, COVID-19 updates and there was also evidence of shared learning between centres. The centre's clinical team held regular meetings that discussed clinical care, risk management, COVID-19, staffing, training and results of audits. Some improvement was required to ensure that where actions are identified, the documentation supports the delegation of specific actions, time frames for completion and if they have been completed. There was a comprehensive audit schedule in place that assessed all aspects of the service provided, but this required further development.

On the day of inspection, there were 21 residents accommodated in the centre in both single and multi-occupancy bedrooms. The person in charge was supported by a clinical nurse manager with clinical oversight and supervision of the care provided to residents by a team of nurses and multi-task attendants. Inspectors reviewed the staffing rosters which evidenced that there was an appropriate number of skilled staff on duty at all times to meet the assessed needs of the residents. Night time staffing levels consisted of two registered nurses and one multi-task attendant. The person in charge confirmed that where new staff are employed, the rosters are amended to ensure there is an experienced member of staff on duty to oversee and

guide the care provided.

Records requested by inspectors were well maintained, stored safely and easily retrieved. A review of the directory of residents found that information regarding each resident in the centre was maintained as required by the regulation. Inspectors reviewed a sample of staff records and all files contained the information as required by the regulation with the exception of one file that, on review, did not contain an employment history. Inspectors were assured that this document would be returned to the staff file immediately.

A review of the training records evidenced that all staff had up-to-date mandatory training in safeguarding, fire safety, manual handling and infection prevention and control (IPC). Staff were knowledgeable regarding the safeguarding of vulnerable adults and described the centre's procedure should a concern arise regarding the care and welfare of a resident. Staff knew what to do in the event of the fire alarm activating and guided the inspector to the fire panel and referenced the residents' personal evacuation plans. Staff demonstrated good knowledge of IPC procedures and the protocol to initiate should a resident or staff be suspected or confirmed with COVID-19. Staff were observed engaging with residents in a person-centred and caring manner. However, inspectors observed that not all staff had received training specific to dementia awareness and this was brought to the attention of the management team in the context of the number of residents with a diagnosis of dementia in the centre and that further training and development for staff would enhance the care provided.

The complaints procedure was displayed prominently in the centre and residents and staff were aware of this procedure. The centre maintained a complaints log and inspectors reviewed one complaint that had been managed and closed. Inspectors found that further development was required in the documentation of complaints. For example, a complaint had not recorded the complainant's satisfaction with the actions taken and outcome of the complaint and there was no evidence of learning from the complaint or disseminating this learning among staff. Further analysis of feedback to improve the service is required to ensure that all information consistent with a complaint is progressed through the complaints procedure.

The centre had an in date risk management policy that contained the risks required by regulation. While all incidents and accidents were logged, there was limited documentation to sufficiently demonstrate learning from incidents and accidents so that risk may be reduced and recurrence of an incident may be prevented. Additionally, further oversight and screening of incidents is required to ensure specific incidents, such as serious injuries sustained by residents, are notified to the Chief Inspector as required by regulation.

Regulation 15: Staffing

There was an appropriate number and skill-mix of staff on duty to meet the needs

of the residents.

Rosters evidenced that nursing staff were on duty at all times and were responsible for supervising and coordinating the care provided to residents.

Staffing was supported with the use of regular agency staff who knew the residents well and this had a positive impact on the continuity of care provided to residents.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors reviewed the training records of staff and all staff had completed mandatory training in safeguarding of vulnerable people, fire safety, manual handling and infection, prevention and control. Staff demonstrated knowledge in both theory and practical application of their training.

Staff were appropriately supported and supervised to carry out their duties. The person in charge detailed the induction procedure for new staff joining the centre and confirmed that a experienced member of staff is on duty to support new staff at all times.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was made available for inspectors to review. The directory was found to contain all the information as required by the regulation.

Judgment: Compliant

Regulation 21: Records

There were good systems of record-keeping and file-management to ensure records were appropriately secured and maintained.

All records requested on the day of inspection were made available for review.

The management team ensured that safe and effective recruitment practices were in place and all staff had a valid An Garda Síochána (police) vetting disclosure on

file.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had breached condition one of their registration which is a breach of the Health Act 2007 (as amended). The centre was using the facilities of an unregistered adjacent daycare centre for the provision of activities, storage and to facilitate visits while planned building works were underway. The registered provider had not made an application to the Chief Inspector for the variation of a condition applied to the registration of the designated centre.

Inspectors identified that further attention was required to ensure the systems in place to monitor and assess the quality of the service were robust. For example:

- Clinical audits were a gathering of statistical information and did not provide evidence of the specific areas that required quality improvement or details of the action taken to address the issues identified.
- Where issues were identified, the records were not updated to reflect if the issue had been resolved or if it persisted.
- Feedback from residents and relative surveys were not screened for opportunities for quality improvement.
- Incidents and accidents were not analysed or trended and in some cases there was no follow up or learning from the incident.

The systems in place to ensure the service provided is safe, appropriate, consistent and effectively monitored required strengthening. Although a risk register was maintained in the centre, it did not include all risks as observed by inspectors on the day, to ensure appropriate controls were put in place. For example, the provider had not identified:

- the risk associated with the storage of oxygen cylinders in the corridors
- risk associated with mains oxygen supply in the context of ongoing building works.
- the risk associated with reduced storage facilities as a result of the building works
- the risk associated with installing a washing machine and dryer in the sluice room.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge was aware of the requirement to submit statutory notifications to the Chief Inspector. However, the Chief Inspector had not been notified of a serious injury arising from a fall.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Further improvement was required in the management of complaints. Inspectors reviewed the complaints log and observed one complaint had been closed in 2021.

The complaints did not detail the following:

- the complainant's satisfaction with the outcome of the complaint.
- there was no evidence of learning from complaints in terms of quality improvement.

Inspectors reviewed the feedback from resident and relative surveys and emails from relatives. Some feedback contained information that was consistent with a complaint and this had not been reviewed or progressed in line with the centre's complaints policy and procedure.

Judgment: Substantially compliant

Quality and safety

Inspectors were satisfied that residents received good quality care and they were supported to enjoy a good quality of life. As previously stated, the systems in place to monitor and analyse information about the service required strengthening to promote ongoing quality improvement in the service. Under this section, these systems refer to the monitoring of:

- Assessments and care plans
- Premises
- Infection control
- Fire precautions.

All residents had a comprehensive nursing assessment completed on admission to the centre. Risk assessments such as malnutrition screening, falls, skin integrity and dependency needs were assessed quarterly. Care plans were developed from assessment findings and updated when any changes occurred. Care plans provided guidance in the provision of health and social care and, for example, detailed how

staff will support the residents to complete a particular activity on a daily basis. Inspectors reviewed a sample of care plans and found them to be detailed and person centred. Residents with specific care needs, such as those with diabetes, specific continence care needs and residents with responsive behaviour (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), had focused plans of care to guide staff in meeting their specific care needs. Some improvement was required to ensure that recommendations from allied healthcare professionals were updated into the resident care plans. Residents had detailed end-of-life care plans in place that contained residents' individual wishes and actions to be taken when their end-of-life journey began.

Residents had unrestricted access to allied healthcare professionals through a blend of remote and face-to-face consultation. A review of residents' medical records evidenced frequent medical reviews and all residents admitted to the centre were reviewed by a medical officer. There was a system of referral in place for residents who required further expertise such as dietitian review and tissue viability expertise.

There was an ongoing initiative to promote a restraint-free environment in the centre in line with the national policy and there were no bedrails used in the centre. Alternatives to restraint were promoted such as low beds, mats and sensor alarms. The use of 'as required' psychotropic medication was minimal. An ABC (antecedent, behavior, consequence) chart was maintained for residents who required this. This is an observational tool used to inform positive behaviour support plans. While inspectors observed good practice in relation to the care of residents with responsive behaviour, records of care provided were not sufficiently detailed to capture the good practice observed.

Inspectors found that the premises was clean and well laid out to meet the needs of residents. Residents had access to ample indoor communal and private space and unrestricted access to the gardens around the building. Bedrooms and en-suite facilities contained adequate mobility aids and grab-rails to support residents to undertake activities safely. Some areas of the centre required minor repairs where paint had chipped from walls. However, the building works had impacted the centre's available storage facilities. Further findings regarding the premises are discussed under Regulation 17: Premises.

Residents' lives had been significantly impacted by the COVID-19 pandemic and restrictions. Throughout the pandemic, the centre had not had an outbreak of COVID-19. No resident had tested positive for the virus and where there were suspect or confirmed cases among staff, this was managed in line with national guidelines and public health support. The management team had implemented measures to reduce the risk of the virus entering the centre. This included:

- Symptom and temperature checking for residents, staff and visitors.
- Appropriate signage in place to prompt frequent hand hygiene and social distancing.
- Trained staff to carry out swabbing for COVID-19 if necessary.
- Detailed COVID-19 preparedness plan.

- Ongoing training and supervision of staff regarding infection, prevention and control.
- Equipment used by residents was clean.

Inspectors observed good practice regarding the use of personal protective equipment (PPE) that was in line with national guidelines and staff provided clear information regarding their contingency arrangements in the event of an outbreak. A colour-coded mop system was in use and the cleaning procedure was consistent with national guidelines. Staff were clear on cleaning procedures to minimise the risk of cross infection. Notwithstanding the positive infection control measures, further monitoring and oversight of IPC systems are required to ensure they comply with national guidelines.

A review of the fire register found that all precautions in respect of fire safety were adhered to. Daily checks of the fire panel and means of escape were completed. Quarterly and annual servicing certificates for maintenance of fire equipment were available for review. There was evidence of fire drills taking place and staff demonstrated adequate knowledge regarding progressive horizontal evacuation procedures. However, further assurances were required regarding the safe evacuation of residents when means of escape may be obstructed due to external building works.

The centre had a risk management policy that was within the required time frame for review. The improvements required with systems of risk identification are described under Regulation 23: Governance and Management in this report.

Residents were supported to exercise choice and could contribute to the running of the service. Feedback was sought through surveys and conversations with residents and their relatives. Residents confirmed that staff and management kept them informed of changes occurring in the centre. Residents were engaged in meaningful activities and were supported to be part of their local community. Residents had access to newspapers, radio and television all of which kept residents up to date with current affairs. Mass was held on-site in the centre's chapel that was accessible to residents.

Regulation 11: Visits

While visiting had recommenced in the centre and was managed through a booking system, visiting was restricted to a designated area and was not facilitated in line with the current Health Protection Surveillance Centre (HPSC) guidelines.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Residents were provided with appropriate storage in their bedrooms for personal possessions and were encouraged to personalise their private space with items of significance such as photos and ornaments.

As a temporary measure to facilitate building works, residents' clothing was laundered off-site. The laundry system in place minimised the risk of items of clothing becoming damaged or misplaced. Residents were satisfied with the service provided.

Judgment: Compliant

Regulation 13: End of life

A holistic approach to end-of-life care was promoted in the centre that incorporated the physical, emotional, psychological and spiritual needs of the residents and their significant others.

Advanced care plans were in place for all residents and it was evident that residents and their families were consulted about their wishes and this was incorporated into a person-centred care plan.

The centre had designated palliative care bedrooms to provide residents and their families with privacy during their end-of-life journey.

Where necessary, palliative care support and intervention was provided.

Judgment: Compliant

Regulation 17: Premises

The premises was undergoing planned building works that were progressing on a phased basis. Although improvements in the premises were noted during this inspection, further oversight of the appropriate use of the premises facilities and storage was required:

- There was inappropriate storage of items in a bathroom where a bath was currently out of order. A time frame for repair of the bath in the centre was not available at the time of inspection.
- A washing machine and dryer had been installed in a sluice room for laundering housekeeping cloths and mop heads. This presented a risk of cross contamination.
- A housekeeping trolley was stored in a sluice room.

- Ventilation was poor in the sluice rooms.

Some areas of the premises required maintenance and repair. For example:

- There were exposed copper pipes providing water to the sluicing facilities had evidence of corrosion that compromised effective cleaning.
- A en-suite shower had persisted to cause issues and was out of order.
- Areas of the centre showed signs of general wear and tear such as door frames.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Inspectors observed the dining experience for residents and it was found to be a social engagement with a relaxed and pleasant atmosphere.

Residents were provided with a choice of meal daily and residents said they were satisfied with the meals provided.

Where residents were prescribed a specific dietary requirement, such as modified texture diet or fluids, this was communicated to the catering staff. In addition, residents' individual likes and dislikes in terms of food preferences were also considered.

Residents had access to snacks and fluids throughout the day and staff were available to assist resident sensitively and discreetly.

Judgment: Compliant

Regulation 26: Risk management

The centre had a risk management policy that was within the required time frame for review. The policy contained the specific risks and controls in place to mitigate the risk as required by the regulation.

A risk register was maintained that detailed identified risk specific to the centre and the controls in place to mitigate the risk.

Judgment: Compliant

Regulation 27: Infection control

Inspectors observed the following infection, prevention and control risks:

- A review of hand hygiene facilities, specifically the location of alcohol hand sanitisers, was required near high-risk areas such as the sluicing facilities and designated isolation area.
- A hand hygiene sink was out of order in one multi-occupancy bedroom and this increased the distance to travel to perform hand hygiene.

The centre had a COVID-19 contingency plan that was updated by the person in charge. The contingency plan required review to include reference to the up-to-date guidelines published by the Health Protection Surveillance Centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

A review of the fire safety strategy was required to ensure that staff were confident in their knowledge of the evacuation procedure in the context of ongoing building works that may affect means of escape.

The residents' personal evacuation plans formed part of the fire safety procedure. Further development of these plans is required, such as the inclusion of the resident's ability to recognise and respond to the fire alarm and the safe placement of residents in terms of the resident's requirement for staff supervision and support after evacuation.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Through observations and conversations with staff and management, inspectors were assured that residents received care in line with their assessed needs and as recommended by allied healthcare professionals. However, the documentation to record individual care needs and provide guidance to staff required improvement. For example:

- The diet described in a resident's nutritional care plan was not consistent with the modified diet prescribed by the speech and language therapist.
- Some recent Malnutrition Universal Screening Tool (MUST) scores had not been updated into the nutrition care plans.

- Care plans did not consistently detail the requirement for blood sugar monitoring for residents with diabetes or the frequency of this monitoring.
- There were gaps in the ABC charts for some residents that exhibited responsive behaviour and this information was not consistently used to develop person-centred care plans to support the resident.

Where there had been a change to a resident's plan of care, this was not always implemented in consultation with the resident or, where appropriate, their relative.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had unrestricted access to their general practitioner (GP) and there was a system of referral in place to allied healthcare professionals (AHP) that included dietetic services, speech and language therapy, physiotherapy, occupational therapy and tissue viability nursing expertise.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Inspectors observed that residents who exhibited responsive behaviors received care that supported their physical, psychological and social care needs**.**

There was no resident requiring the use of bedrails in the centre and alternatives to restrictive practices were in place.

Where 'as required' psychotropic medication was administered, the effects and outcome for the resident following the administration of the medication was recorded.

Judgment: Compliant

Regulation 9: Residents' rights

Residents reported that staff made them feel at home in the centre and that they were treated with dignity and respect. Residents felt supported and could exercise choice in how they spend their day.

Residents expressed their satisfaction with the activities programme and looked

forward to scheduling outings to areas of local interest.

The facilities had improved in the centre which provided residents with adequate space to undertake personal activities in private or spend time in communal day rooms if they wished.

Residents were provided with daily newspapers and could watch television in either the communal dayrooms or in their bedrooms. Residents detailed how they maintained contact with their friends and families during restrictions, such as telephone and video calls, and they were satisfied that Mass had continued in the centre twice a week in the chapel.

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	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Raheen Community Hospital OSV-0000611

Inspection ID: MON-0033332

Date of inspection: 06/09/2021

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Resumption of the Day Centre services is under review and a start date for commencement of services has yet to be decided. In the interim period, an application to the Chief Inspector, to use available facilities to adjacent Daycare Centre by the designated center, for the variation of a condition applied to the registration of the Centre will be submitted by 31st October 2021.

The designated center has existing quality systems in place. Incident and accidents for 2021 have been analyzed and learning highlighted to staff at afternoon handover meetings.

All staff received risk and safety training and falls training during July/August 2021. A culture of learning that supports training and development of staff is promoted, which supports the ongoing enhancement of quality and safety.

Quarterly analysed incident reports from the Quality Risk & Safety Department are submitted to the Person in Charge. These are shared with staff, the most recent available report was shared with staff in June 2021. In addition to files currently stored at nurses' station, a copy of the Quarterly Analysis of Reported Incidents report will now also be filed and will be available within the Incident Report File.

Feedback given by residents at their monthly residents meetings are always actioned following the resident meeting, to ensure resident well-being and promote quality improvement.

Feedback from residents and relative surveys have been explored to identify opportunities for quality improvement. Resident satisfaction survey during COVID-19 was carried out externally to the unit in January 2021 and outcome from this report was actioned. Action from this survey involved arranging a video conference meeting with an

advocacy service on 23/03/21 for residents to further inform and remind them of their role. A virtual family forum was conducted in February 2021 with relatives, feedback received was very positive. A further resident satisfaction survey was carried out on 20th July 2021, reviewed and the two required actions were actioned on the same day.

On the morning of the inspection, one oxygen cylinder was required urgently for a resident and had not being returned from the corridor following the event to the designated storage area. The oxygen cylinders were immediately returned to the designated storage area and staff reminded of correct storage as per procedure.

The mains oxygen supply was relocated to the new compound in June 2021 and has been managed appropriately by the construction onsite manager. This mains oxygen supply to the building has been fully commissioned and records are available on site.

Controls put in place at the start of construction to address risks associated with reduced storage facilities due to the new building works included the installation of four temporary porta cabins to support storage; however, additional temporary storage was required on site. A "not in use" bathroom area was used for storing some clean items as a temporary measure due to the new build.

Weekly project meetings in relation to the building works have taken place since commencement of the building works. The project group includes senior management, IPC advisor, risk advisor, health and safety advisor and maintenance to address issues arising from the building works and to ensure resident and staff safety. IPC, risk and health and safety advisors attend the designated centre on a regular basis to advice.

The washing machine and dryer were installed at the start of COVID-19 as alternative emergency backup in the event of a possible COVID-19 Outbreak as this is a COVID-19 isolation area. This was to support the decontamination of cloths and mops used in this area and prevent the movement of these supplies to the Non-COVID area within the designated centre. The washing machine and dryer in the sluice area have now been relocated to an alternative area.

Monitoring systems are in place and reviewed to ensure clear oversight of all areas and actions identified for improvement. Progress on actions are monitored and tracked to ensure they are progressed.

Actions to be Completed:
• A review of the Clinical Audit process will be completed in conjunction with QPS advisors. Records will be updated to reflect resolution, or otherwise, of any issues identified and all issues closed out. Oversight and screening of Clinical Audits, actions taken to address issues identified is the responsibility of Clinical Nurse Managers and Senior Nurses. Clinical audits will be monitored on a monthly basis by the Person in Charge to ensure follow up of audit actions and outcomes are achieved.
• Resident surveys will continue to be reviewed to further identify any opportunities for quality improvement. Additional templates will be developed to track and trend survey outcomes.
• The designated center's risk register in relation to the building works has been developed in conjunction with IPC, risk and health and safety advisors to ensure that all

safety risks have been identified, assessed and managed and to provide assurance that all measures are in place to ensure safety are being actioned. This is monitored via on site visits from Health & Safety, Risk and IPC advsiors and weekly project meetings.
Actions to be completed:
• 31st October 2021

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All incidents are reported on The National Incident Report Form and reported to the line manager. The reporting process has been and will be revisited with all staff. Staff are informed to ensure all incidents requiring medical or hospital treatment are reported to line manager and NF03 submitted. This is on the agenda for staff meetings.

Notifiable events are discussed at team meetings to ensure learning for all on matters requiring notification.

Any adverse event requiring medical review will be in line with regulations.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Written complaints received under the complaint policy, "Your Service Your Say" are handled in confidence and without prejudice, are filed in the Complaints folder and progressed in line with the designated center's complaints policy and procedure. Under the policy and where possible, complaints are resolved as close to the point of contact. Any learning from complaints are shared with all staff.

The complaints procedure is clearly displayed within the designated centre. Two comment boxes for complaints are available and a complaints folder to record all complaints received is in place.

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
Visiting restrictions have eased in the centre in line with the guidance and recommendations from the Health Protection Surveillance Centre. Visiting is unrestricted within the Centre at a safe designated area to accommodate residents in multi-occupancy rooms. There is a booking system to attend the Centre in place, this is to ensure safety of our Residents who have remained COVID free throughout the pandemic and in the best interest of residents. There is flexibility to accommodate visiting as requested. In addition, any visiting requests at short notice are accommodated. Birthdays and special occasions with family members are facilitated to spend time with their loved one. Families have expressed their satisfaction with this arrangement. Residents go out with family as requested and compassionate visits facilitated as requested as per national guidance.

There is a weekly teleconference held with Public Health Department in relation to public health advice including visiting attended by the Person in Charge.

Action to be completed:
There will be a review of visiting for residents in multi-occupancy rooms in assigned areas.

Date for completion: 31st October 2021

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Currently building works for the new extension are in progress, resulting in the Centre having less space on a temporary basis. The Person in Charge has followed up on the timeframe required for repair of the bath. Ventilation requirement will be reviewed as a priority. The washing machine and dryer have been suitably relocated. All required maintenance work will be completed as a priority by the Maintenance Manager.

A "not in use" bathroom area was used for storing some clean items as a temporary measure due to the new build. Maintenance are currently sourcing a bath part. This may be delayed due to current supply issue.

Actions completed :

• En-Suite Shower works completed, 07/09/21.

Actions to be completed :
• Maintenance of exposed copper pipes to be completed -15/11/2021
• Painting of door frames and skirting - 15/11/2021

• Review of ventilation in the sluice rooms – 15/11/2021

Regulation 27: Infection control	Substantially Compliant

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

Staff have the opportunity to access HSPC guidance and any new information provided and shared within the Staff Covid-19 Folder at nurse's station.

All staff carry personal pocket size alcohol hand based gel at all times.

Actions completed:

• Hand sanitizers mounted outside sluicing facilities and designated isolation area.
• Hand sink in multi occupancy bedroom is in working order.
• Staff have the opportunity to access HSPC guidance as updated.
• Contingency plan has been reviewed to include reference to the up to date guidelines published by the Health Protection Surveillance Centre.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire safety systems in place to provide assurance of fire safety:

• Safety Management Policy
• Fire Safety Register
• Fire Safety Management Procedures, Daily Visual Checks Fire Alarm Panel, fire Exits.
• Weekly testing of Fire Alarm System and Emergency Lighting.
• Local Fire Drills
• Annual Fire Safety training records.
• Current floor plans
• Fire Safety Induction for all new and existing staff including agency.
• Residents personal evacuation plans

Actions to be completed :
• Fire safety strategy review will be carried out to remind staff of the evacuation procedure in the context of ongoing building works

• Further development of residents evacuation plan will incorporate the inclusion of the resident's ability to recognize and respond to the fire alarm and safe placement of residents in terms of supervision requirements after the evacuation will be included in our current template
• Information on the ability of the resident to understand the sound of the fire detection and alarm system going off will be discussed at monthly resident meetings.

Date for completion: 31st October 2021

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
To ensure compliance with Regulation 5 :

Actions completed:
• In relation to a new resident's care plan admitted on the 19/8/21 but not updated with a SALT assessment on the 24/8/21, this was highlighted to all nurses to ensure residents care plans are updated as changes happen. This specific care plan has been reviewed and updated accordingly.
• Staff have been made aware of the requirement to update MUST scores into the nutritional care plans
• Care plans will detail the requirement and frequency for blood sugar monitoring for all diabetic residents.
• All staff have been made aware of gaps in ABC charts and having consistency with same, ensuring person centered care delivered.
• Staff have been reminded that, where there has been a change to a resident's plan of care, this is always implemented in consultation with the resident or, where appropriate, their relative.

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 11(2)(a)(i)	The person in charge shall ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident.	Substantially Compliant	Yellow	31/10/2021
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	15/11/2021
Regulation 17(2)	The registered provider shall,	Substantially Compliant	Yellow	15/11/2021

	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.			
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	31/10/2021
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	15/10/2021
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation	Substantially Compliant	Yellow	31/10/2021

	procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	31/10/2021
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	06/09/2021
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	Substantially Compliant	Yellow	15/10/2021

	person maintains a record of all complaints including details of any investigation into the complaint, 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.	Substantially Compliant	Yellow	15/10/2021
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	15/10/2021