Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	St Joseph's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Mullindrait, Stranorlar, Donegal
Type of inspection:	Unannounced
Date of inspection:	01 May 2025
Centre ID:	OSV-0000625
Fieldwork ID:	MON-0045807

About the designated centre

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

The designated centre provides care and support to meet the needs of both male and female older persons. The philosophy of care is to embrace positive ageing and place the older person at the centre of all decisions in relation to their holistic needs. This approach involves multidisciplinary teamwork with an aim to provide a safe therapeutic environment where privacy, dignity and confidentiality are respected.

It provides twenty-four hour nursing care in three distinct areas, Barnes View (accommodating up to 24 residents requiring long term care), Woodville (dementia care for 19 residents) and Finn View (20 beds for residents needing short term care assessment, rehabilitation, convalescence and respite care).

The centre is situated on the ground level and located on the outskirts of an urban area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	26

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 1 May 2025	09:00hrs to 16:20hrs	Catherine Rose Connolly Gargan	Lead
Thursday 1 May 2025	09:00hrs to 16:20hrs	Gordon Ellis	Support

What residents told us and what inspectors observed

This unannounced inspection was carried out over one day. The inspectors met with residents, staff and members of the centre's local management team and senior managers representing the provider. Overall, residents were content with living in the designated centre and felt that their needs were well met. Residents' feedback to the inspectors was unanimously positive regarding their upgraded living environment, their quality of life and the care they received in the centre. Residents were also very complimentary regarding the staff caring for them.

Following an introductory meeting, the person in charge demonstrated the improvements made since the last inspection in August 2024 in a walk around the centre with the inspectors. This also gave the inspectors an opportunity to meet with residents and staff and observe practices and the residents' day-to-day routines in the centre. The inspectors observed that there were no residents living in the Barnesview unit at the time of this inspection, and cleaning staff were cleaning this unit. The inspectors communicated with a number of residents who said that the completed works to their living environment were a 'top-class job', 'now a beautiful home', 'very comfortable' and 'nowhere better'. Residents told the inspectors that they had 'the best of fun', with staff and that staff ' are always good to me'. Some residents described the staff as being 'good friends' and being 'there when you need them'. These comments reflected the inspectors' observations of staff and resident interactions that were person-centred and caring throughout the day of this inspection.

The inspectors observed that there was a welcoming and relaxed atmosphere in the centre. Residents' choices regarding when they got up in the morning were respected, and a number of residents were eating their breakfast while resting in bed later into the morning, as they wished.

Residents' communal sitting and dining rooms were bright, spacious and well-decorated in a domestic-style that was familiar to the residents. Items of traditional memorabilia, residents' artwork and domestic style furnishings made these communal rooms comfortable and relaxing areas for the residents. The communal rooms in the Finn View and Barnesview units provided residents with views of the surrounding countryside. Residents in the Woodville dementia unit were able to freely access their dining room whenever they wished. The inspectors observed that all areas of the residents' lived environment in the centre had been refurbished to a good standard. A number of the rooms with three beds were reconfigured to twin bedrooms, and rooms with four beds were reduced to bedrooms with three beds. This significantly increased the space available to residents in these bedrooms to meet their needs. The inspectors observed that many of the residents' bedrooms and bed spaces were personalised with their family photographs, soft furnishings and ornaments. Shelves were fitted by the residents' beds and they were using them to display their personal photographs and other items. Each resident had

adequate storage for their clothes and personal possessions. Residents' wardrobes and lockers were located within their bedspace area and were accessible to them.

Overall, residents were supported to enjoy a good quality of life in the centre. Finn View and Woodville units operated independently of each other with designated staff, different social activity schedules and separate outdoor areas. There was a varied schedule of social activities taking place for the residents in each of the two units, and the inspectors observed that the majority of residents were engaged in the various social activities taking place. Residents' social activities in the dementia unit were specifically tailored to meet their individual interests and capacities. Residents who did not wish to participate in the group social activities taking place in the communal sitting rooms were observed to be relaxing in the communal areas or in their bedrooms. Staff were observed regularly checking in on these residents and were heard by the inspectors encouraging and supporting them to engage in various activities that interested them in their bedrooms. Two residents were availing of one-to-one staff for 16 hours each week to support them with continuing to enjoy socialising in the local community. A wheelchair-accessible bus was available to the centre, and residents were being supported to go on regular outings, including to places of interest in the local town. In line with the residents' wishes, they were facilitated to enjoy regular fish and chip takeaways and to have an ice cream from a mobile ice-cream van that came to the centre every month. A small number of residents liked to go for walks on the grounds of the centre. The inspectors observed staff and family members supporting two residents to go outdoors in their wheelchairs for a walk along the roadway surrounding the premises.

The inspectors observed that the ancillary facilities generally supported effective infection prevention and control. There were storage rooms for the preparation of medications, and clean and sterile supplies such as needles, syringes and dressings. Staff also had access to a sluice area on each unit and a dedicated housekeeping room for storage and preparation of cleaning trolleys and equipment. These rooms were observed to be clean and tidy. However, the inspectors observed that a clinical storage room with supplies of clinical equipment and personal protective equipment also provided storage space for a specimen collection refrigerator in close proximity to clean supplies. Furthermore, there was storage of boxes of supplies directly on the floor in this room.

Residents' personal laundry and linen were washed off-site in a laundry facility. Residents' laundry was collected and returned to them, and residents confirmed they were satisfied with this service.

Residents told the inspectors that they felt safe and secure in the centre and that they would speak to a staff member or their relatives if they had any concerns or were dissatisfied with any aspect of the service they received.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered. Areas

identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, this inspection found that improvements were made regarding management oversight of the service, and although delayed, progress with completing a programme of works to address significant fire safety risks identified in a fire safety risk assessment report dated 17 January 2024 was nearing completion. However, not all identified fire safety risks were addressed, and residents' fire safety was not assured.

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

Due to the provider's previous failure to address known fire safety risks to residents in a timely manner and ongoing non-compliance with Regulation 28: Fire Safety, the Chief Inspector attached a restrictive condition to the designated centre's registration to cease admission of new residents. Notwithstanding the works that have been completed by the provider to improve fire safety, this inspection found that necessary works were not completed to protect residents from the risk of fire. These findings are discussed under Regulation 28: Fire Precautions.

The registered provider of St Joseph's Community Hospital is the Health Service Executive (HSE), and a service manager was assigned by the provider to represent them. As a national provider involved in operating residential services for older people, St Joseph's Community Hospital benefits from access to and support from centralised departments such as human resources, information technology, fire and estates, staff training and finance.

The centre's local management structure consisted of a person in charge supported by an assistant director of nursing (ADON) and clinical nurse managers (CNMs) on each of the units. The management team oversaw the work of a staff team of nurses, health care assistants, activity staff and catering and cleaning staff. The quality assurance systems in place included monitoring and auditing of key clinical indicators such as falls and wounds, which were being effectively addressed. Although delayed, the provider was closely monitoring the completion of the works to address the fire safety risks still outstanding. Residents' feedback was sought and was used to inform quality improvement plans including an annual review of the quality and safety of the service.

The provider ensured there were adequate numbers of staff available with appropriate skills to ensure consistency of the staff team, and continuity of care for the residents. The person in charge had a system in place to monitor staff training and all staff were facilitated to complete mandatory and professional development training. A programme of professional development training was made available to all staff to ensure that they had the necessary skills and competencies relevant to their roles, to meet the complex needs of residents. The inspectors were assured from their observations of staff practices and from discussions with staff that they were familiar with residents' needs. Staff were appropriately supervised according to their roles.

Records reviewed by the inspectors included a sample of staff employment files, which showed that staff had appropriate Garda vetting in place before they commenced working in the designated centre. Cleaning schedules were completed as required, and residents' care and support documentation and records were completed to a satisfactorily standard.

Arrangements for recording accidents and incidents involving residents in the centre were in place. Statutory notifications and quarterly reports were submitted as required by the regulations to the Health Information and Quality Authority within the specified timeframes.

Regulation 14: Persons in charge

The person in charge commenced in this role in August 2023. The person in charge is a registered nurse and has clinical and management experience and qualifications as required by the regulations.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient numbers of staff with appropriate skills rostered and on-duty on the day of the inspection to meet the care and social needs of the residents, including residents who chose not to attend the social activities taking place in the communal rooms. Staff were knowledgeable regarding residents' needs and usual routines, and responded without delay to residents' needs for assistance.

Judgment: Compliant

Regulation 16: Training and staff development

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

Staff were appropriately supervised according to their individual roles.

Judgment: Compliant

Regulation 21: Records

Records as set out in Schedules 2, 3 and 4 were kept in the centre and were made available for inspection. A sample of staff files reviewed showed that they met the requirements of Schedule 2 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider's oversight and management of risk in the centre was not effective regarding the following;

- The risk of unauthorised persons entering the designated centre was not identified and effectively mitigated. This arrangement did not ensure residents were appropriately safeguarded from the risk of abuse. The inspectors observed that access was uncontrolled into the designated centre from the short stay unit.

The oversight of fire safety in the centre was not robust, and it did not adequately support effective fire safety arrangements and keep residents safe. For example:

- The providers' in-house fire management systems, such as audits, the fire register and fire safety checks had not recognised fire risks. This was evidenced by poor oversight of fire precautions, the means of escape, and emergency lighting, all of which were impacting on fire safety. These fire risks are detailed under Regulation 28: Fire Precautions.

Judgment: Not compliant

Regulation 31: Notification of incidents

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

Judgment: Compliant

Regulation 34: Complaints procedure

A centre-specific complaints policy was in place and had been updated in line with recent legislative changes. The complaints policy identified the person responsible for dealing with complaints and included a review officer, as required by the legislation. A summary of the complaints procedure was displayed, and was included in the centre's statement of purpose document.

Procedures were in place to ensure all expressions of dissatisfaction with the service were recorded, investigated and the outcome was communicated to complainants without delay. Complaints received were reviewed as part of the centre's governance and management process, and agreed actions to address the issues raised were implemented. Access for residents to advocacy services to assist them with making a complaint was in place, and residents were informed about this service.

Judgment: Compliant

Quality and safety

Overall, this inspection found that residents were provided with good standards of nursing and social care. Residents' care and support were person-centred and were informed by their needs, usual routines and individual preferences and wishes. Residents' rights, including their privacy, and their access the communal areas as they wished, were respected. Residents were supported to participate in meaningful social activities as they wished, and in line with their interests and capacities.

It is acknowledged the provider had completed a significant quantity of fire safety works identified in the provider's own Fire Safety Risk Assessment dated 17 January 2024. The provider had committed to have all fire safety-related works completed by the 31st March 2025. This date had been further extended by the provider to 05 May 2025.

This inspection found that three red-rated fire risks were outstanding and were in the process of being completed. The person in charge provided assurances that these remaining fire safety works would be completed as planned by 05 May 2025. Overall, fire safety systems and the fire safety aspects of the physical premises had significantly improved.

Notwithstanding the above, this inspection found that the management of fire safety did not fully ensure the safety of residents, staff and visitors. The inspectors found areas of non-compliance. For example, the inspectors reviewed the fire safety register and noted that parts of it were well organised. In-house periodic fire safety checks were being completed and logged in the register as required. However, the inspectors observed deficiencies in regards to fire precautions, emergency lighting and means of escape. These fire risks had not been identified in the in-house routine checks. These are detailed further under Regulation 28: Fire Precautions.

There was an emergency fire action plan and policies in place. However, the fire policies and records did not take into account the adjoining Drogheda unit that was not registered as part of the designated centre, and the scenario of a fire emergency occurring in this unit or in the designated centre.

Service records were available for the various fire safety and building services and these were all up-to-date. However, recommended actions for a kitchen suppression system dated 20 November 2024 had not been actioned.

The necessary works to address the identified fire safety risks were carried out concurrently with works to refurbish and upgrade the residents' private and communal spaces in each of the three units. The refurbishment works in the three units were completed at the time of this inspection and terminal cleaning was taking place in Barnesview unit. Barnesview unit was not occupied by residents on the day of this inspection. The works reduced the occupancy in most of the multi-occupancy bedrooms and overall occupancy to 43 residents. Further to completion of the refurbishment works, residents' bedroom accommodation is provided in six single bedrooms, 10 twin bedrooms, four bedrooms with three beds and two bedrooms with four beds in each. An additional single bedroom is kept available in Woodville, Finnview and Barnesview units to care for residents with palliative care or infection prevention and control needs in these units. A variety of communal rooms are available in each unit to meet residents' needs.

The works reduced the occupancy in most of the multi-occupancy bedrooms and overall occupancy to 43 residents. Further to completion of the refurbishment works, residents' bedroom accommodation is provided in five single bedrooms, 10 twin bedrooms, four bedrooms with three beds and two bedrooms with four beds in each. One of the single bedrooms in the Woodville unit is an additional bedroom kept available to care for residents with palliative care or infection prevention and control needs in this unit. A variety of communal rooms are available in each unit to meet residents' needs.

While measures were in place to protect residents from risk of abuse and residents told the inspectors that they felt safe and could talk with staff if they were worried

about anything. An arrangement where access by unauthorised persons into the the designated centre from the short-stay unit, which is operated by the acute hospital services did not ensure residents' safeguarding needs were effectively protected. A senior manager representing the provider assured the inspectors that this arrangement would be risk-assessed and addressed as a priority. All staff interactions with residents, as observed by the inspectors were respectful, resident-centred and kind.

The residents were facilitated to access the enclosed outdoor areas as they wished, the garden furniture and ornaments were in need of repainting and repair to ensure residents' comfort and safety.

The provider had effective measures in place to protect residents from the risk of infection, including regular staff. As part of the refurbishment, the provider had installed staff hand hygiene sinks that were conveniently located to residents' bedrooms and where residents' care was being delivered. Cleaning schedules were in place for all parts of the premises and were consistently completed. However, this inspection found that actions were necessary to ensure cleaning of the floor in a storeroom was not hindered by storage directly on the floor. Additionally, a risk assessment was necessary to ensure the location of a specimen refrigerator in a sterile clinical equipment storeroom was appropriate and did not pose a risk of cross-contamination to residents.

Residents were provided with good standards of nursing care and support to meet their assessed needs. Residents' records and their feedback to the inspectors confirmed that they had timely access to their general practitioners (GPs), specialist medical and nursing services, and health and social care professionals as necessary. Effective arrangements were in place to ensure treatments and recommendations for residents' care made by members of the multidisciplinary team (MDT) were implemented and monitored. Residents' care plans were sufficiently detailed to guide staff regarding each resident's care and support needs in line with their individual preferences and usual routines. Residents' care plans were regularly updated in consultation with residents or their representative, as appropriate.

There was a positive approach to care of residents predisposed to experiencing episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). A minimal restraint environment was promoted, and the procedures in place were in line with the national restraint policy guidelines.

Residents were provided with opportunities to participate in a variety of meaningful social activities to meet their interests and capacities. Residents who remained in their bedrooms had equal access to social activities that interested them. Residents were supported to go on outings to places of interest to them in their local community.

Residents were supported to maintain contact with their families and friends, and their visitors were welcomed into the centre. Residents had access to local and national newspapers, radio and televisions. However, as only two televisions were

available in some of the bedrooms with three and four beds, not all residents in these bedrooms could make choices regarding their personal television viewing and listening.

Residents had access to religious services and were supported to practice their religious faiths in the centre. Residents' meetings were regularly convened and their views on the service were welcomed. Issues raised or suggestions made by residents regarding areas they felt needed improvement in the service were addressed. Residents had access to an independent advocacy service. Information about this service was displayed in the reception area of the centre and the record of the residents' committee meeting confirmed that the purpose and availability of this service was discussed at this forum.

Regulation 10: Communication difficulties

Residents with communication difficulties were supported to communicate freely, and staff were aware of their needs. Each resident's communication needs were regularly assessed and a person-centred care plan was developed for residents who needed support to communicate effectively. Residents were referred for speech and language therapy assessment, including assessment for assistive communication technology equipment to support their communication needs.

Judgment: Compliant

Regulation 11: Visits

There were no restrictions in place on residents' family and friends visiting them, and visitors were observed visiting residents in the centre throughout the day of the inspection. Residents told the inspectors that their visitors were always welcomed and that they were able to meet with them in a private area outside of their bedrooms as they wished.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were provided with adequate storage space for their belongings and could access and maintain control of their personal possessions and clothing in their wardrobes and in their bedside lockers. Residents' clothing was laundered by an

external laundering service as necessary, and their clothes were returned to them without any reported delays.

Judgment: Compliant

Regulation 17: Premises

Notwithstanding the significant improvements made to upgrade the residents' living environment, some areas of the premises did not conform to the requirements set out in Schedule 6 of the regulations as follows;

- The enclosed outdoor courtyards accessible from Barnesview and Woodville units did not provide residents with a comfortable and safe outdoor space. For example, the surfaces on the outdoor furniture, garden ornaments and artificial hedging were scorched and damaged by the weather. Furthermore, the enclosed garden was being used as a storage area for cardboard boxes and building items.
- The curtain rails in a number of the residents' bedrooms were not reconfigured following the reduction in the maximum occupancy of these bedrooms.
- Small holes were visible in the wall surfaces in some areas.
- The paint was damaged and missing on some door surfaces.

Judgment: Substantially compliant

Regulation 27: Infection control

Actions by the provider were necessary to ensure residents were protected from the risk of infection and that the centre was in compliance with Regulation 27.

- There was storage of boxes of supplies directly on the floor in a clinical storeroom and did not support effective floor cleaning.
- Assurances were not available that storage of potentially infected specimens in a refrigerator beside sterile clinical supplies in the clinical storeroom did not pose a risk of cross contamination.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had completed a significant amount of fire safety works to the centre and was working towards bringing the centre into compliance. Notwithstanding this, some areas required improvement and other services were non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

- A timber shed used for smoking purposes was located against a wall of the centre. A fire extinguisher and fire detection were missing. This created a risk of a fire in the timber shed developing without staff being aware or having access to firefighting equipment, which would impact on the designed centre and the safety of the residents.
- The underneath of a protected escape staircase was being used for the storage of building materials. These were in the process of being removed on the day by staff. Notwithstanding this, inappropriate storage practices were found which compromised the protected vertical means of escape for residents in the event of a fire.
- Designated fire assembly points required a review. The inspectors noted an assembly area was located in an area obstructed by parked vehicles, and its location was not clearly visible.
- While the fire register and fire policy documents were being kept up-to-date, areas of the adjoining day hospital were intrinsically linked to the fire evacuation strategy of the designated centre. For example, inspectors were informed that staff in the adjoining Drogheda unit (unregistered unit) joined in fire evacuations in the designed centre if the fire alarm was activated. However, the fire policies and records did not take into account the adjoining Drogheda unit and the scenario of a fire emergency occurring in this unit or the designated centre. This procedure was not reflected in the fire register or fire policy, and as such, there was a lack of management and fire safety oversight.

Adequate means of escape for residents and emergency lighting in the event of an emergency in the centre were not provided. For example:

- An external escape route from a fire exit was found to be obstructed by the presence of bags of composite.
  At the side of the centre the inspectors identified an external evacuation route that was not suitable to evacuate residents to the fire assembly point. This was evidenced by; the lack of emergency lighting to illuminate the path in the event of a night time evacuation, the gradient was too steep for residents with mobility issues. Furthermore, it was not clear where the fire assembly point was located from these fire exits.
- Adequate external emergency lighting was missing from escape routes to the rear and side of the designed centre and above a fire exit in order to provide illumination in the event of a night time evacuation, and ultimately, the safe placement of residents at the designated fire assembly point.
- Works to widen two fire exit doors had originally been recommended in the provider's Fire Safety Risk Assessment. This red risk had subsequently been

agreed between the provider and their fire consultant to be omitted as it was not structurally possible to carry out these works without compromising the structural integrity of the building. However, as the two fire exits were not going to be widened, assurances were required that all fire evacuation equipment and aids for residents would fit through these narrow fire exits.

The provider needs to improve the maintenance of all fire equipment, means of escape, building fabric and building services. For example:

- Minor deficiencies were observed to some of the fire doors. This was evidenced by a cross corridor fire door where a magnetic hold-open device did not release the door when tested, and the double doors did not align when in the closed position. A smoke seal had partially detached from the same door and from a store room door. Furthermore, a smoke seal was missing from a fire door into the staff dining room.
- Some damage was noted to a kitchenette and sluice room fire door that compromised the integrity and performance of the fire doors.
- Maintenance records for an Ansul suppression system dated 20 November 2024 were reviewed. A recommended action was for the system to be connected to the main fire detection and alarm system and for the automatic shutdown of power to the main cooker serving the kitchen. This recommendation had not been carried out by the provider and was yet to be resolved.

The displayed procedures to be followed in the event of a fire required a review by the provider:

- Fire action notices for visitors and staff to follow in the event of a fire were missing throughout the designated centre.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

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

These assessments informed residents' care plans, which detailed each resident's care and support needs, and the care interventions staff should complete to meet residents' needs. The information in residents' care plans was person-centred and clearly described each resident's individual care preferences and usual routines.

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

Judgment: Compliant

Regulation 6: Health care

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

Residents were appropriately referred to health and social care professionals, specialist medical and nursing services, including psychiatry of older age, community palliative care and tissue viability specialists and their recommendations were implemented.

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

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

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

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

Judgment: Compliant

Regulation 8: Protection

Access by unauthorised persons into the designated centre from the short-stay unit, which was not part of the designated centre was not effectively managed. The system in place facilitated members of the public with uncontrolled access to the residents' environment through the door between the designated centre and the short-stay unit. There was no evidence available to provide assurances that the risk to residents' safety posed by this arrangement was appropriately risk assessed and effectively mitigated to ensure residents' safeguarding needs were met at all times.

Judgment: Not compliant

Regulation 9: Residents' rights

The provision of two television sets in the bedrooms with three and four beds did not support each resident's choice of programme viewing and listening.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Joseph's Community Hospital OSV-0000625

Inspection ID: MON-0045807

Date of inspection: 01/05/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The register provider will ensure compliance with Regulation 23 by the following actions:

1. There is a separate external entrance provided for entry to the short stay unit which ensures that members of the public cannot enter the designated centre. Access to the Residential Care Facility is restricted to staff members through the use of Key Fobs. The previous press – button mechanism has been removed to enhance security. This control measure is documented in the facility's risk register.
Oversight of these access control measures is maintained by the Registered Provider Representative and Person In Charge. The implementation of this measure was completed on 1/7/2025
2. All Fire safety risks identified on the Fire Risk assessment have all been completed as of May 2025. Additional emergency lighting is being installed along the external evacutation route to the side of the Centre which will be completed by 25/07/25. In the interm in the event of a fire staff have been briefed and are aware of the external fire escape route to the relevant assembly point and will support and guide all residents to evacuate the building as appropriate. All audits , risk assessments and quality improvement plans are reviewed monthly by the Person In Charge and The Registered Provider Representative. These are also discussed at the quarterly QPS Older Persons Governence meetings, held by the Head of Service and General Manager for Older Persons for CHO1 and any actions required are implemented . The Registered Provider Representative maintains a risk register specific to each Residential Care Faciltiy to ensure good oversight and governence with the local older person service.

3. In line with governance practices across all CHO1 Older Persons Units, the Person in Charge continues to receive the full support of the Service Manager, General Manager and Head of Service in maintaining high standards of oversight and goverence.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The register provider will ensure compliance with Regulation 17 by the following actions:

1. The garden area between Woodville and Barnesview has been upgraded and is available to all residents in Barnesview
2. Ongoing painting and decoration works remain ongoing as part of the centres refurbishment plan
3. All items which were being stored within the garden were removed on the day of inspection
4. All residents dignity and respect is maintained by the use of privacy curtains. The reconfiguration of curtain rails remains ongoing.
5. Any small holes in the surface of the walls that were visible on the day of the inspection have been remediated as of the 20/06/2025
6. The painting of doors have been addressed as part of the centres ongoing refubishment plan. This has been completed as of the 05/06/25
7. The Registered Provider Representative has oversight arrangements in place for all of the matters set out in Schedule 6 of Regulation 17. All audits and risk assessments are reviewed monthly by the Registered Provider Representive along with the Person In Charge and any necessary Quality Improvement Plans are developed and promptly implemented.
8. Audits results and risks are communicated by the Registered Provider Representative to the General Manager and the Head of Service for Older Persons during the Quarterly Quality Patient Safety meetings.
9. A dedicated risk register is maintained by the Registered Provider Represnetative for each Residential Care Facility. This risk register is reviewed monthly to ensure robust oversight, effective risk management and strong governance of all identifed concerns.
10. In line with governance practices across all CHO1 Older Persons Units, the Person in Charge continues to receive the full support of the Service Manager, General Manager and Head of Service in maintaining high standards of oversight and goverence.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The register provider will ensure compliance with Regulation 27 by the following actions:

1. All items within the clinical room are stored appropriately which supports effective floor cleaning
2. The Specimen fridge has been relocated to an alternative area recommended by infection prevention and Control. This was completed as of the 18/06/2025
3. All IPC audits, risk assessments and Quality Improvement Plans are reviewed monthly by the Registered Provider Representaive in collaboration with the Persons in

Charge (PIC). This process ensuresthat infection prevention and control procedures and practices are in line with the established standards and are effectively implemented by the staff.
4. Audits outcomes and identified risks are communicated by the Registered Provider Representative to the General Manager and the Head of Service for Older Persons during the quarterly Quality Patient Safety meetings.
5. The Registered Provider Representative maintains a risk register, specific to each Residential Care Facility (RCF). This risk register is reviewed monthly to support strong oversight, effective risk management and good governence.
6. In line with governance practices across all CHO1 Older Persons Units, the Person in Charge continues to receive comprehensive support from the Service Manager, General Manager and Head of Service in maintaining high standards of oversight and governance.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The register provider will ensure compliance with Regulation 28 by the following actions:

1. The timber shed located against a wall of the centre was removed on the 03/05/2025
2. All items stored under the staircase were removed on the day of inspection 01/05/2025. The Person in Charge supported by the management team ensures that the day to day storage of equipment is appropriate
3. Fire Assembly points are now visible with no parking permitted. This was completed on 02/05/2025.
4. The Fire policy has been updated to reflect the adjourning Drogheda unit. This was completed on the 01/05/2025
5. All Fire escape routes are kept clear at all times. The Person in Charge supported by the management team monitors and ensures that escape routes are kept clear at all times
6. The HSE Fire Officer and an external fire specialist team have reviewed the external evacuation route at the side of the centre. Additional emergency lighting and a number of twin- spot lights have and will be provided along this route to illuminate the escape route towards the assembly point.This will be completed by 25/07/2025. In the event that this escape route has to be used staff will assist and guide residents to the assembly point.
7. The designated Assembly Point (Assembly Point A) is located at the rear of the centre. The external slope, adjacent to the nursing units has been assessed and will remain out of use. This decision eliminates the risks previously identified with its use. Functionally the slope serves as an access route similar to a service road and is not required for evacuation purpose.
The sole escapees using the area to the top of the slope/ramp at any one time will be residents aided by staff evacuating the Woodville wing. External evacuation will only be required as a last resort. Alternatively a resident from a single bedroom nearest the exit from Barnes view that may be transferred via the external garden to the garden exit

gate. There is also another exit from the main central non bedroom area of the unit that enters the external garden area prior to exiting via the garden gate.
It is important to note that these three exits originate from separate independent compartments within the unit. Each compartment also have alternative multi – compartment routes and final exits available. Therefore, not all areas of the nursing unit would be evacuating through the garden gates simultaneously.
Once outside the external garden gate, residents evacuating will be guided by staff along the designated escape route towards Assembly Point A. This route forms the basis of the current evacuation training protocol and will continue to be used for all future training.
8. These evacuation routes have been clearly mapped and assessed to ensure safety and complaince with emergency procedures
9. The existing two number fire exit doors from the Barnes View/Finn View have not been widen as agreed by the provider and the fire consultant due to it structurally not being possible. The provider and the person in charge have ensured that all fire evacuation equipment (e.g. evac. chair and aids) can safely fit via this exit. The Person in Charge has completed a stimulated fire evacuation via this exit and staff are aware of that this exit is narrow. This is communicated to staff via the centes safety pause and this risk has been placed on the centres risk register .
10. All Fire Doors including the magnectic hold-open device to the cross-corridor and smoke seal to the same door and the staff dining room were reviewed and remedial works completed to same since day of inspection. This was completed on 02/05/2025.
11. The 2 no. new fire doors have been ordered to replace the kitchenette and sluice room doors. These will be fitted by 7 th July. The HSEs fire officer has ensured that the current doors provide the appripriate protection at present
12. The ansul suppression system provides fire protection to the hot fats cooking facility within the kitchen canopy. The ansul suppression system has been connected to the main fire detection and alarm system. This was completed on the 15/04/2025
13. Fire action notices are now available throughout the unit. Completed 06/05/2025.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The register provider will ensure compliance with Regulation 8 by the following actions:

1. There is a separate external entrance provided for entry to the short stay unit which ensures that members of the public cannot enter the designated centre.
2. Access to the Residential Care Facility is restricted to staff members through the use of Key Fobs. The previous press – button mechanism has been removed to enhance security. This control measure is documented in the facility's risk register.
3. Oversight of these access control measures is maintained by the Registered Provider Representative and Person In Charge. The implementation of this measure was completed on 1/7/2025

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The register provider will ensure compliance with Regulation 9 by the following actions: 1. Each resident in the Designated Centre will be provided with their own television. This will be completed by 31/08/2025.	

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	20/06/2025
Regulation 23(1)(d)	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	25/07/2025
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the	Substantially Compliant	Yellow	18/06/2025

	Authority are in place and are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	25/07/2025
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	25/07/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	25/07/2025
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	06/05/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	01/07/2025

Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/08/2025