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:	Baltinglass Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Newtownsaunders, Baltinglass, Wicklow
Type of inspection:	Unannounced
Date of inspection:	19 July 2023
Centre ID:	OSV-0000485
Fieldwork ID:	MON-0040911

About the designated centre

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

The centre caters for a maximum of 60 residents and provides care to both male and female residents over 65 years of age. The centre provides 54 residential beds; 12 of these beds (including one respite bed) are specifically dedicated to dementia care and will accept residents under 65 years of age with a diagnosis of dementia. There are six respite beds in total in the centre. Managers and staff aim to provide high quality individualised care to residents and to support their families and friends. The centre's philosophy is to meet the social, psychological, physical and spiritual needs of residents in a manner that reflects their right to respect, dignity, privacy and independence. Accommodation is divided into three units. Ceidin unit accommodates 28 residents in twin and single bedrooms providing a mix of en suite and communal wheelchair accessible toilet, shower and bathing facilities. There is a large communal lounge and dining room and two smaller seating areas. Primrose unit is a specialist 12 bed unit which provides accommodation for residents with a diagnosis of dementia. The unit comprises seven bedrooms providing single and twin bedroom accommodation, one with en suite and communal toilet and bathroom facilities. There is a communal lounge/dining room which leads out to the enclosed dementia friendly garden area and an additional smaller communal room. Willow unit accommodates 20 residents in single and twin bedrooms with a mix of en suite and communal wheelchair accessible bathrooms and toilets. There is a large communal lounge/dining room a small chapel and smaller seating areas leading out to the garden and gazebo. The centre has recently extended the entrance area to provide a pleasant cafe and meeting area which welcomes residents and their visitors.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	52

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
Wednesday 19 July 2023	09:00hrs to 18:50hrs	Bairbre Moynihan	Lead
Wednesday 19 July 2023	09:00hrs to 18:50hrs	Mary Veale	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place over one day. Based on the observations of the inspectors, and discussions with residents, staff and a small number of visitors, Baltinglass Community Hospital was a nice place to live. There was a welcoming and homely atmosphere in the centre. Residents' rights and dignity were supported and promoted by kind and competent staff. Residents appeared to enjoy a good quality of life and had many opportunities for social engagement and meaningful activities and they were supported by a kind and dedicated team of staff.

On arrival inspectors were greeted by a member of the centres' administration team and signed the centres visitors' book. Following an opening meeting with the person in charge to discuss the format of the inspection, the person in charge and assistant director of nursing accompanied inspectors on a walkabout of the premises.

A number of residents were living with a cognitive impairment and were unable to fully express their opinions to the inspectors. However, these residents appeared to be content, appropriately dressed and well-groomed. A small number of visitors who spoke with inspectors were complimentary of the care and attention received by their loved ones. Residents who could express their opinion were complimentary of the staff and services. Residents' said they felt safe and trusted staff.

Baltinglass Community Hospital comprised of three units Ceidín East and West, Primrose and Willow way. Bedroom accommodation comprised of single and twin rooms, many bedrooms had ensuite facilities and wash hand basins. Bedrooms were personal to the resident's containing family photographs, art pieces and personal belongings. Pressure relieving specialist mattresses, cushions and fall prevention equipment were observed in residents' bedrooms. On the day of inspection two single rooms were vacant and the inspectors were informed by staff that the single rooms were used for residents who were at end of life or to isolate residents on admission to the centre. Communal areas included open plan sitting and dining areas on each unit. A partition had been installed in the day room on Willow way which could be pulled over to divide the room if additional privacy was required. Additional sitting areas were available in Ceidín and Willow Way with one of the rooms containing a pool table and a large screen which was used for movie nights. A family room in Ceidín was in use as a staff room at the time of inspection due to the COVID-19 outbreak.

Residents had access to large enclosed courtyard garden areas from each unit. There was an outdoor space to the front of the building and a large mature garden to the rear of the centre. The courtyards had level paving, comfortable seating, tables and raised flower beds. Residents were observed mobilising in the enclosed areas during the day of inspection.

Activities were available for residents seven days a week. Inspectors were informed

that there were four activities co-ordinators in post which was an increase of one since the inspection in July 2022. The activities programme was displayed in the centre. On the day of inspection residents were observed playing a one to one activity with staff, walking, trips on the trishaw within the grounds of the hospital and enjoying bingo. A staff multi-cultural summerfest was scheduled for the end of July and a family day was scheduled for 5 August 2023. A quarterly newsletter was produced and available at the entrance to the centre. This detailed activities and events that had taken place in the centre for example; flower arranging. It contained details of advocacy services for residents and crosswords. WiFi had been installed in the centre since the last inspection and all units had communal smart televisions. Newspapers were available for residents and a number of residents were observed reading them on the day of inspection. Residents were facilitated to access the local community. A resident informed an inspector that there were no restrictions on the resident leaving the centre and going to the local town and inspectors were informed that residents were facilitated to access the local men's shed if they wanted to attend. Spiritual advisors attended the centre once weekly and Roman Catholic mass and a Church of Ireland service were celebrated onsite on a weekly basis.

The dining experience was observed by inspectors. The majority of residents attended the dining areas other than those residents that were isolating with COVID-19. The menu was on display on a white board in the dining areas. A resident informed an inspector that the "food is 100%" . Residents were provided with a choice and residents on a modified diet were provided with the same choice. Staff were available to assist residents that required it both in the dining room and in resident's rooms if required.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection carried out to monitor ongoing compliance with the regulations and standards. The inspectors followed up on the compliance plan submitted following the inspection in July 2022 and notifications submitted to the office of the Chief Inspector of Social Services since the last inspecton. The provider had progressed the compliance plan following the previous inspection and improvements were found in Regulation 9: Residents rights, Regulation 23: Governance and management and Regulation 27: Infection prevention and control. On this inspection, the inspectors found that actions was required by the registered provider to address Regulation 17: Premises and areas of Regulation 5: Individual assessment and care planning, Regulation 7: Managing behaviours that are challenging, Regulation 16: Training and staff development, Regulation 19: Directory of residents and Regulation 34: Complaints procedure. Additional improvements

were required in Regulation 23: Governance and management and Regulation 27: Infection control.

The registered provider had made changes to the footprint of the centre as per condition 01 of the registration for Baltinglass Community Hospital and had not informed the office of the Chief Inspector of Social Services. The provider had made changes to the oratory and duty room on Willow way. The oratory room and duty room were interchanged, reducing the size of the oratory from 21 sq to 10 sq in size. An ensuite toilet had been added to room 029 and the family room on Primrose unit had interchanged with the dining area. The current location of the dining room enhanced the dining experience for residents on Primrose unit.

The centre is registered to provide care for 60 residents and there were 52 residents living in the centre on the day of inspection. There are a total of 52 continuing care beds and 2 respite care beds in the centre. Inspectors' were informed that the centre was running at a reduced occupancy in order to comply with regulations however, the six beds had not been deregistered with the office of the Chief Inspector. Additionally, the floor plans and statement of purpose had not been updated to reflect the changes.

This centre is operated by the Health Service Executive (HSE), who is the registered provider. The person in charge (PIC) had sole responsibility for this centre and was supported in the role by two assistant directors of nursing who were supernumery, clinical nurse managers (CNM's), nursing staff, health care assistants, activity staff, kitchen staff, housekeeping, maintenance, and administration staff. The person in charge reported to the general manager for older person's, and who was also the registered provider representative. The general manager provided support to the person in charge. Inspectors were informed that there were two vacant clinical nurse manager posts, however these posts were temporarily filled by staff in an acting capacity on the day of inspection. Inspectors reviewed the staffing rosters and, while there were vacancies for 1.5 wholetime equivalent (WTE) staff nurses and a number of healthcare assistant posts, the provider had a staffing and recruitment plan in place to ensure that staffing levels remained stable and residents care needs were met. There were sufficient staff on duty to meet the needs of residents living in the centre on the day of inspection. Notwithstanding this rosters reviewed indicated an over reliance on agency staff in the centre. On the day of inspection three out of the five healthcare assistants in Ceidín unit were agency healthcare assistants. At the time of inspection an additional health care assistant was rostered on night duty to provide cohorted care to residents during an outbreak of COVID-19.

Staff had access to education and training appropriate to their role. The centre had two, train the trainers in managing actual and potential aggression onsite. There were, however, gaps identified in staff training matrix. This is discussed further under Regulation 16: Training and staff development. Staff with whom the inspectors spoke with, were knowledgeable regarding fire evacuation procedures and safe guarding procedures.

There was a comprehensive annual review of the quality and safety of care

delivered to residents completed for 2022. The review was undertaken against the National Standards. It set out an improvement plan with timelines to ensure actions would be completed. The centre had an extensive suite of meetings such as quality and patient safety meetings, clinical nurse manager meetings, staff ward meetings and recently established falls prevention, restrictive practice and medication management meetings. Meetings took place quarterly in the centre. Minutes of meetings detailed items discussed, discussion type and owner. There was evidence of governance meetings every second month. Key performance indicators (KPI's) were collated for each unit. Improvements were found in the centres auditing system since the previous inspection. The centre was using a quality care metric platform to measure nursing care processes which monitored and assessed performance against evidenced-based standards. The results of these were on display on the corridor to Ceidín unit. Along with the quality care metric platform there was evidence of an ongoing schedule of audits in the centre. The schedule of audits included restrictive practice and infection prevention and control audits. Management had good oversight of falls in the centre. A falls report was completed at the end of 2022 and falls were reviewed at a falls committee meeting which met on a quarterly basis. Improvement were required in the centres audit action plan process to monitor and improve the quality and safety of care. This is discussed further under regulation 23: Governance and management.

Inspectors requested the incident log in the centre, however this was incomplete with August 2022 to December 2022 and May and June 2023 unavailable. An inspector was informed that these were managed by a person who was on leave. Of the incidents provided to inspectors, those that required notification to the Office of the Chief Inspector were notified within the required timelines.

A directory of residents was provided to inspectors. However, the directory provided was incomplete. This will be further discussed under regulation 19.

The registered provider had integrated the update to the regulations (S.I 298 of 2022), which came into effect on 1 March 2023, into the centre's complaints policy and procedure. The management team had a good understanding of their responsibility in this regard. Inspectors reviewed the records of complaints raised by residents and relatives. The complaints procedure was not displayed in the centre during the inspection but was made available at the main reception notice board prior to the completion of the inspection. The complaints procedure provided details of the nominated complaints and review officers. Inspectors were informed that the nominated persons had received suitable training to deal with complaints. Details of the investigation completed, communication with the complainant were included. However, there was no documentary evidence to confirm the complainant's satisfaction of the concern raised.

Regulation 15: Staffing

Staffing was found to be sufficient to meet the needs of the residents on the day of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Not all staff had access to appropriate training to support them to perform their respective roles. For example:

- 5 staff training in safeguarding was out of date.
- 50 staff had not completed training in restrictive practices or their training was out of date.
- Training on managing behaviours that challenge is discussed under Regulation 7.

Judgment: Substantially compliant

Regulation 19: Directory of residents

Gaps were identified in the directory of residents provided to inspectors on the day of inspection. For example;

- The medical officers details for the majority of residents was not included in the directory.
- There were gaps in the contact details for next of kin and the marital status of residents.
- None of the records viewed contained a cause of death.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems required improvement to ensure that the service provided was safe, appropriate and effectively monitored. For example;

- The audit action plans viewed were a list of identified tasks or a list of outstanding documentation required for individual residents nursing documentation. Audit action plan processes required review to include specific, time bound action plans to inform ongoing quality and safety improvements in the centre.

- The registered provider had made changes to the footprint of the centre without informing the Office of the Chief Inspector by submitting an application to vary condition 1 of the centres' registration.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All incidents provided to inspectors were reviewed and were notified to the Office of the Chief Inspector in line with guidelines. However, inspectors were unable to fully assess this regulation as seven months of incidents were not provided to inspectors.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints register was reviewed by an inspector. It was not consistently recorded if the complainants were satisfied or otherwise with the outcome of the complaint as required by the regulations.

Judgment: Substantially compliant

Quality and safety

Overall, residents and visitors expressed satisfaction with the care provided and the quality of life in the centre. Improvements had been noted in the area of residents rights and some areas of infection prevention and control since the last inspection.

At the time of inspection, the centre was experiencing a COVID-19 outbreak and a number of residents were isolating in their bedrooms on Ceidín and Willow Way. Public health guidelines on visiting were being followed. Residents experiencing COVID-19 could receive visits from their nominated visitor and there were no visiting restrictions in place for the residents on Primrose and residents who were not isolating on Ceidín and Willow way. Visits and outings were encouraged and practical precautions were in place to manage any associated risks. Visitors were observed coming and going over the course of the inspection.

Improvements were found in some areas of the premises since the previous inspection, for example; areas in the centre had been painted. There were an ongoing plan of preventative maintenance works which included ongoing painting

and redecorating areas. Efforts had been made to de-clutter the centre and the storage areas were observed to be clean, tidy and organised. Grab rails were available in all corridor areas, toilets and en-suite bathrooms. The registered provider had identified an infection control nurse. The role equated to one wholetime equivalent and the person had completed post-graduate qualification in the area. The infection prevention and control nurse completed training with staff and was carrying out ongoing audits. Audit results were available in each unit for staff to view. Audits were identifying issues and there was an accompanying action plan. In addition, the centre had support from an infection prevention and control nurse from CHO7. Inspectors were informed that training in standard and transmission based precautions was not mandatory in the centre. 18 staff had not completed training in the area. While this training was not mandatory, in the context of a COVID-19 outbreak on the day of inspection, this is a significant gap. Notwithstanding this, face to face training was planned for one day a month until the end of 2023. The registered provider had an infection prevention and control plan in place. One of the items for action was the replacement of three hand hygiene sinks which will be in line with recommended specifications. Improvements were required in relation to the centres premises and infection control which are discussed under Regulations 17 and 27.

Systems were in place for monitoring fire safety. The fire detection and alarm systems and emergency lighting had preventative maintenance completed at recommended intervals. Fire doors were checked on the day of inspection and all were in working order. There was evidence that fire drills took place monthly. There was evidence of fire drills taking place in compartments with stimulated night time drills taking place in the centre. Fire drills records were detailed containing the number of residents evacuated, how long the evacuation took, and learning identified to inform future drills. There was a system for weekly checking of; means of escape, fire safety equipment and fire doors. All fire safety equipment service records were up to date. Each resident had a personal emergency evacuation plan (PEEP) in place which were updated regularly. The PEEP's identified the different evacuation methods applicable to individual residents and supervision required at the assembly area. Staff spoken with were familiar with the centres' evacuation procedure. There was evidence that fire safety was an agenda item at meetings in the centre. The centre had automated door closures to all compartment doors, and bedroom door. Since the previous inspection improvements were found in fire safety training for staff in the centre and there was evidence of an on-going schedule for fire safety training On the day of the inspection there were two residents who smoked and detailed smoking risk assessments were available for these residents. A call bell, fire aprons, fire blanket, fire extinguisher and fire retardant ash tray were in place in the centre's smoking area. However; improvements in fire safety were required, this is discussed further in the report under Regulation 28.

A detailed individual assessment was completed prior to admission, to ensure the centre could meet residents’ needs. Residents' needs were comprehensively assessed by validated risk assessment tools. Care planning documentation was available for each resident in the centre. Further improvements were required to residents care plans which is discussed under Regulation 5: Individual assessment

and care planning.

Residents had access to medical care through the medical officer in the centre. Residents' health and well-being was promoted and residents had timely access to specialist services and health and social care professionals, such as psychiatry of old age, physiotherapy, occupational therapy, dietitian and speech and language, as required. Inspectors observed a medical officer attending the centre on the day of inspection. Residents had access to a consultant geriatrician and a psychiatric team. Residents accessed dental treatment through the local dentist and optical services were accessed locally. Residents who were eligible for national screening programmes were supported and encouraged to access these.

Some residents had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Responsive behaviours were well managed in the centre by a person centred approach to care. Behavioural trigger charts were regularly completed, identified the trigger and the learning from these assessments was transferred to the care plans. The use of bed rails in the centre was low but there was a high usage of mattress and floor sensor safety alert devices. There were low beds and crash mats available to support the reduction of restrictive practices. There was open access to the centre's internal courtyards and residents enjoyed accessing this space when the weather allowed. The centre maintained a weekly restrictive practice log and staff had access to a local restrictive practice guideline. Improvements were required in the documentation of restrictive practice to ensure staff were in line with best practice as set out in the national guidance on restrictive practice.

The registered provider had systems in place to protect residents from abuse. Staff were knowledgeable about what constitutes abuse and described the escalation pathway for their concerns. There was evidence that potential concerns were reviewed by management. Residents could freely access their money and could attend a hatch at the administration office to access this money or request a balance. Additional good practices are outlined under the regulation.

Residents' rights were protected and promoted in the centre. Choices and preferences were observed to be respected. Two monthly resident meetings were held which provided a forum for residents to actively participate in decision-making and provide feedback in areas regarding social and leisure activities. Minutes of these meetings were documented, with action plans assigned and followed up on. For example, a resident requested a garden hose which was installed. In addition, residents were informed about ongoing painting in the centre with a plan to "revamp the dayroom" in 2023.

Regulation 11: Visits

The centre had a COVID-19 outbreak at the time of inspection and visitors to those residents were restricted to the nominated visitor. Otherwise, visiting had resumed

as normal in the centre. Residents confirmed this to inspectors.

Judgment: Compliant

Regulation 17: Premises

The registered provider had failed to notify the office of the Chief Inspector of Social Services of changes to the footprint of the centre as per condition 01 of the registration for Baltinglass Community Hospital. The provider had made changes to the oratory and duty room on Willow Way. The oratory room and duty room were interchanged, reducing the size of the oratory from 21 m2 to 10 m2 in size. An ensuite toilet had been added to room 029 and the family room on Primrose unit had interchanged with the dining area. An application to vary condition 01 was not submitted to the Chief Inspector of Social Services prior to the commencement of works. Furthermore, the statement of purpose and floor plans were not in line with what inspectors observed on the day of inspection.

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example;

- A review of the centres call bells was required as a significant number of residents did not have access to their call bells as a mattress sensor safety monitor device was plugged into the call bell system or a call bell attachment was not available. Residents in bedrooms 13,16, 21, 23 and 29 on Primrose unit, bedrooms 126, 130 and 140 on Willow way unit and 5 on Ceidín West unit did not have access to a call bell.
- Room 199 in Ceidín unit was a throughfare from one corridor to another. The door was a push door and contained no handle and therefore there was no facility for the resident to fully close the door or lock the door if they so wished. Management stated that it was not used as such, however, the potential for this to occur was there.
- Due to the COVID-19 outbreak in the centre on the day of inspection a family room and a bedroom were set up and used as a room for staff to take their break.
- A single room in Primrose had recently had a leak. While the leak was identified and fixed the repair and repainting of the area was not completed.

Judgment: Not compliant

Regulation 27: Infection control

Inspectors observed that the centre was generally clean on the day of inspection, however, improvements were required in order to ensure procedures are consistent

with the national standards for infection prevention control in community services. For example;

- Communication systems between management and staff required strengthening during the outbreak as more than one staff member informed an inspector that two residents were in their room as they were isolating for 24 hours as they were a contact with a resident who was COVID-19 positive. However, management stated that this was not the reason for resident's remaining in their room.
- Staff in Primrose unit informed an inspector that the single en-suite room in the unit was used to isolate residents on admission to the centre. This is not in line with current guidance.
- A small number of hand hygiene sinks in the centre were not compliant with the required specifications, including the clinical room in Ceidin and sluice rooms. Management stated that they were going through a tendering process with other centres for the replacement of sinks.
- There was a break in the integrity of a chair in the smoking room.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required in relation to fire safety management systems in the centre. For example:

- A fire evacuation map was displayed at the main fire panel in the centre, however; there were no fire evacuation maps displayed on Ceidín, Primrose or Willow Way units in the centre which posed a risk to the safety of the residents and staff as there was no evacuation procedure to follow in the event of a fire.
- An outdoor area observed in use by two residents who smoked required review as it had no fire blanket, call bell or access to a fire extinguisher.
- Personal Emergency Evacuation Plans on two residents had not been updated since February 2023.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- Two residents on Primrose unit and two residents in Ceidín Unit did not have all their care plans reviewed at intervals not exceeding 4 months.
- Of the sample of resident files viewed by inspectors it was not always documented if the resident or their care representative were involved in the reviews of the residents care plans in line with the regulations.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. The centre had a medical officer who routinely attended the centre and was available to residents. Allied health professionals also supported the residents in the centre where possible and remotely when appropriate. There was evidence of ongoing referral and review by allied health professional as appropriate.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Not all staff had up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging. For example:

- 42 staff had not completed training in the management of behaviour that is challenging.

Improvements were required in the documentation of restraint use in accordance with the national policy, for example:

- The centres did not have a consent form for restrictive practice as outlined in section 7.4.14 of the local policy. Restrictive practice mutli-disciplinary team (MDT) discussion forms were viewed on the day of inspection. This form had a residents' consent signature section but did not include the type of restrictive device in use and the risks associated with the device in use were not recorded.
- Training was required for staff in the risks and safe use of bed rails as outlined in the centres' restraint policy. This was discussed under regulation 16: Training and staff development.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had assurances in place to safeguard residents and protect them from abuse.

- Staff had access to safeguarding training of which the majority of staff had completed it. This was discussed under Regulation 16: Training and staff development.
- Staff spoken with were knowledgeable about what constitutes abuse, the different types of abuse and how to report any allegation of abuse.
- Garda vetting records indicated that all staff had a garda vetting disclosure in place. Management assured inspectors that this was in place prior to commencing employment in the centre.
- The registered provider was a pension agent for 12 residents. Systems were in place for the management of residents' finances through the HSE central system and a local client account.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected within the confines of the centre. Activities were provided in accordance with the needs' and preferences of residents and there were daily opportunities for residents to participate in group or individual activities. Facilities promoted privacy and service provision was directed by the needs of the residents.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not 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	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Baltinglass Community Hospital OSV-0000485

Inspection ID: MON-0040911

Date of inspection: 19/07/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: · The designated centre has a training tracker in place to monitor the training records of all staff. Staff are notified 1 month in advance of expiry of any mandatory training through nursing administration and their line manager. It is the responsibility and over sight of the ADON office to manage this. · Staff identified with outstanding safeguarding training related to individuals on longterm leave. A notification asterisks is now placed on the training tracker to identify staff with training non-compliance relating to longterm absence status as appropriate. · Staff engage with nursing administration when they are deemed fit to return to work by their medical officer and Occupational Health department. Once a return to work date is established the staff member is requested to complete any mandatory training that is out of date prior to the agreed return to work date. Nursing administration have a return to work discussion with staff on return from leave of absence to the designated centre as part of local policy and HSE Managing Attendance Policy and Procedures. · Staff with outstanding restrictive practice training are (includes safe use and risks associated with bed rails use) have been scheduled to complete this training in Q4 2023 with dates scheduled from Sept to December inclusive. · Training on managing challenging behaviours is outlined in regulation 7 7	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents:	

Schedule 4 (paragraphs 7-9)
The directory of residents is updated from 24th July 2023 on nursing administration shared folder excel template (nominate staff access only) with the following information as per Schedule 4

- Name address DOB gender marital status of resident
- Main address and contact details of the residents NOK or representative
- Name and address and contact details of GP
- Date of admission to designated centre
- Name address of any authority, organisation or other body which arranged the residents admission
- If the resident was discharged and the date
- If the resident was transferred to another designated centre or to a hospital and the date
- Any dates during which the resident was not residing at the centre , excluding overnight visits home
- Date and cause of death

Regulation 23: Governance and management	Substantially Compliant

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

- Update statement of purpose to reflect changes to footprint of designated centre; change to staffing levels; changes to the maximum number of residents and complaints procedure as per updated guidance document June 2022 to include access to advocacy service (S.1 298 2022)
- Completion of an Application to Vary for condition 1 and condition 3 (oratory change and room 29 supported by updated floor plans to reflect changes to condition 1 & 3
- Audit action plans from incident management such as Falls Management / Medication Management / Restrictive Practice Management will have SMART focused action plans in response to audit results. This will inform quality and safety of care for the residents in the designated centre. This will be done as part of the relevant committee meetings from Sept 2023 such as the Falls Committee/ Medication management/Restrictive practice to assess progress and evaluate the impact on the resident and share what works best.
- Quality Care Metrics have to date since the implementation in the designated centre in Jan 2023 being part of a quantifiable measurement system in terms of an agreed standard of care. As part of this new QCM introduction the process of auditing and measurement is for the data collectors (Nurse Managers) to assign the same score across all the residents care plans. Once this introductory phase on all care plans is completed in Dec 2023. The next timeline will be the interpretation and developing of action plans on the platform – Create Your Own Report on TYCHSE .This will be done using a collaborate approach with SMART goals having identified metrics/ indicators to tackle or focus on from Q1 2024.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
· The designated centre has implemented (August 2023) an incident management tracker in conjunction with the HSE incident management reporting system IMF for ease of access for nursing administration.
· The live tracker will record Category 1/ Category 2 or Category 3 incidents with outcomes in line with HSE IMF to give an overarching practical approach to the designated centres recording of incidents.
· The designated centre have applied for 2 other staff members to have access to NIMS National Incident Management System to ensure timely access to data.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
· The designated centre (July 2023) has added to the complaints log a tick box to denote the complainant was satisfied with the outcome of the review of the complaint in line with best practice and Regulation 34 and updated guidance S.1 298 2022 . The outcome section of the log is used to document the review of the complaint and if the complainant was satisfied.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
·· All residents residing in the designated centre have access to the call bell alert system which is implemented and rectified on day of inspection 19th July 2023
· Room 199 in Ceidin unit. Even though this area is never used as a communal access to other areas of Ceidin unit, the designated centre takes on board the inspectors concerns and have asked for a review of this area by the HSE Fire Officer/Estates to review the potential to install a lock on this door.
· The designated centre will ensure staff have staggered breaks during unprecedented times such as outbreaks so as not to occupy any of the resident space. Implemented

with IPC and line managers in August 2023
· Repainting to an area of a single room in Primrose unit will be completed in Dec 2023 as part of a schedule of HSE maintenance works

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
· Staff have access to the latest HPSC guidelines and ongoing updates from IPC nurse on the management of C19 outbreaks . The designated centre is aware that residents are not isolated in the event of what is deemed a close contact or the admission of transfer of a resident. This is not in line with guidance and is obsolete practice. The IPC nurse highlighted this to all staff at face to face updates since the date of the inspection in July 2023.
· Hand hygiene sinks are on a schedule for replacement with HSE estates to be completed by March 2024
· Chair in smoking room was removed in July 2023 due to break in the integrity of the covering

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Regulation 28

· Fire evacuation plans are in position beside one of the main panels at Ceidin
· Fire evacuation plans are in position beside the panel in Primrose
· Fire evacuation plans were off the wall in Willow due to recent painting and are now back on the wall
· All three sets of Fire Plans will be reviewed by the HSE fire officer review to identify a clear route to evacuation with - YOU ARE HERE denoted on them Q1 2024
· Review the existing residents' usage of the designated outdoor smoking area to ensure fire safety by maintaining ongoing provision of fire blanket, fire extinguisher and portable alarm bell
· Review and update the existing risk assessments for the residents' observed smoking on the day of inspection. Update of care plans for these residents' based on the any amendment risk assessment.
· All line managers are requested to audit and monitor the PEEPS of residents on each unit in line with Regulation 28 and best practice. This was implemented in August 2023 managers meeting

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:
· Nurse managers are reminded at August 2023 managers meeting as part of ongoing promotion person centred care and best practice to ensure all residents care plans are kept updated and have a documented evidence of resident or representative input .
· Care plans will be audited as part of local QCM quality care metrics on a monthly ongoing basis and results monitored to ensure person centred care

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
· · Staff with outstanding management of challenging behaviours training are schedule for this training between Oct 2023 until Dec 2023 with onsite MAPA/CPL safety intervention trainers
· Any staff returning from long term leave will be facilitated with this additional training on return
· The designated centre restrictive practice committee will review local policy with a particular focus on the utilization of the restrictive practice consent form at the Sept 2023 meeting to discuss the inspectors concerns and in line with the National policy on Towards a Restraint Free Environment in Nursing Homes and best practice.
· Training in the risks and safe use of bed rails is included in the designated centre restrictive practice training. This will be added to the local policy for clarification and inform staff reading the policy.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/12/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2023
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	31/07/2023
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Substantially Compliant	Yellow	31/03/2024

	consistent and effectively monitored.			
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	31/03/2024
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.	Substantially Compliant	Yellow	31/12/2023
Regulation 28(2)(ii)	The registered provider shall make adequate arrangements for giving warning of fires.	Substantially Compliant	Yellow	31/03/2024
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	31/12/2023
Regulation 31(1)	Where an incident set out in	Substantially Compliant	Yellow	30/09/2023

	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.			
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	31/07/2023
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	05/09/2023

Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	31/12/2023
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/09/2023