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:	New Houghton Hospital
Name of provider:	Health Service Executive
Address of centre:	Hospital Road, New Ross, Wexford
Type of inspection:	Unannounced
Date of inspection:	22 June 2023
Centre ID:	OSV-0000603
Fieldwork ID:	MON-0039753

About the designated centre

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

New Houghton hospital is situated in the town of New Ross. The building was erected in 1936 and became the fever hospital for the counties Waterford, Wexford, Carlow and Kilkenny. In 1984 the building became a care of the older person's facility. While there have been many changes, renovations and some improvements since then the design and layout of the premises is largely reflective of a small hospital from the period in which it was built. The registered provider of the centre is the Health Service Executive (HSE). The centre is registered for 42 residents over the age of 18 years, both male and female for long term care. Services provided include 24 hour nursing care with access to community care services via a referral process including, speech and language therapy, dietetics, physiotherapy, occupational therapy, chiropody, dental, audiography and opthalmic services. All admissions are planned. Residents and relatives are welcome to visit the site in advance of the placement. Residents being admitted will have been assessed by the Geriatric Assessment team and placed on a waiting list for admission. Once a bed becomes available the resident and or relative is informed and is requested to arrive to the unit before 4pm Monday to Friday. The hospital accepts all levels of dependency from level 1 (full dependency) and including residents living with dementia. The services are organised over two floors with 21 residents accommodated on each floor with a passenger lift provided. Residents' accommodation on the ground floor comprises of four, four-bedded rooms, one three-bedded room, one twin-bedded room, and one single-bedroom (end of life suite) with adjacent family/community room. All bedrooms have hand washing facilities. Residents' accommodation on the first floor also consists of four, four-bedded rooms, one three-bedded room, one twin-bedded room, and one single-bedroom (end of life suite) with adjacent family/community room. There is access to an outside suitable secure garden area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	40

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 22 June 2023	09:20hrs to 18:30hrs	Bairbre Moynihan	Lead

What residents told us and what inspectors observed

On the day of inspection, the inspector observed staff being kind, caring and attentive to residents' needs. Residents were complimentary about the staff and the centre and the majority of residents were complimentary about the food.

The inspector arrived in the morning to carry out an unannounced inspection to monitor ongoing regulatory compliance with the regulations and standards. The inspector was greeted by the person in charge and following an introductory meeting was guided on a tour of the premises. During the inspection,the inspector took the opportunity to speak to a number of residents to gain feedback about the centre and spent time observing practice. The centre had a relaxed atmosphere and residents were observed freely mobilising around their unit and chatting to other residents and staff.

New Houghton Hospital is registered to accommodate 42 residents with 2 vacancies on the day of inspection. It contained two units: Abbey unit on the ground floor and Brandon unit on the first floor. Each unit was connected by a lift and a stairs. Both units mirrored each other and accommodated 21 residents each. Each unit contained four, four bedded rooms, a three bedded room, a two bedded room and a single room on each floor. None of the rooms contained en-suite accommodation. Each floor had shared showering and toilet facilities. Residents had personalised their bed space with personal belongings and photographs of family and friends and their bed space contained a television and radio. Communal space included an open plan dining and sitting room in Abbey unit and a sitting room and separate dining area in Brandon unit. The dining room in Brandon was not in use during the last inspection and since then it was repainted and blinds and pictures were put on the windows and walls respectively. Residents were observed enjoying their lunch in the dining room. Abbey unit's sitting room opened out onto a sensory garden. The garden was blooming with flowers on the day of inspection. The residents in Brandon unit had access to the garden through Abbey unit. The registered provider had created an additional outdoor area for residents in Abbey at the front of the centre. Seating was installed and the registered provider was awaiting the delivery of flowers. The inspector was informed that this area was created as an additional area that can be used if there is an outbreak of infection in Abbey unit as residents from Brandon would be unable to transverse through it.

The registered provider had employed one activities co-ordinator and four activities assistants equating to approximately 2.5 WTE. Residents were observed in the garden with the activities co-ordinator and taking part in an exercise class in the morning and a number of residents were doing art in the afternoon. Management informed the inspector that activities had been reviewed since the last inspection and that outings had recommenced. On the day prior to inspection the centre had a garden party. A number of residents informed the inspector about the party and how much they enjoyed it. They spoke about how good the weather was, the ice-cream van, the Wexford strawberries and live music. Family members were invited

and a number attended. In addition, a number of residents had recently attended an outing to a local cafe. The inspector observed that this was a routine trip that occurred fortnightly and was rotated between residents. The registered provider had created a newsletter with pictures included of recent events such as St Patrick's day. The newsletter was available in the lobby at the entrance to the centre. Mass was celebrated onsite once monthly. Residents had access to WiFi and daily newspapers on each unit.

Residents were consulted about the centre through residents' meetings which were held one to two monthly. Meeting minutes for these meetings were not available for review, however the inspector viewed the family and residents' meeting minutes which occurred three monthly. Items discussed included the activities timetable, gardening and the day centre. A resident survey was completed in May 2023 with an associated quality improvement plan; for example; 20% of residents indicated that they did not know what medications they were on. An associated action plan included a site visit from a pharmacist.

The dining experience was observed in both dining areas. Residents were no longer required to sit at their bedside for meal times on alternate days. The registered provider now had two sittings for lunch and this was observed by the inspector. There were a number of staff present to provide assistance to residents that required it. It was evident that staff were familiar with residents likes and dislikes.

There were no restrictions on visiting in the centre and visitors were observed during the day of inspection. Visitors confirmed this.

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

Capacity and capability

This was an unannounced inspection to assess the overall governance of New Houghton Hospital and to identify if actions outlined in the compliance plan from the inspection in August 2022 had been completed and actions sustained. Overall, the inspector identified that a number of actions had been implemented and sustained, for example; as discussed earlier, the Brandon dining room was now in use by residents. In addition, racking had been installed in all sluice rooms. Management informed the inspector that a pharmacist attended onsite every three to four months.

The registered provider is the Health Service Executive (HSE). There was a clearly defined management structure with identified lines of accountability and responsibility. The person in charge reported to a manager for older person services in CHO5. The manager for older person services attended the feedback meeting at the end of the inspection. The manager for older person services reported to the

general manager for older person services and upwards to the chief officer. The person in charge was supported in the role by two clinical nurse manager (CNM) 2 (one for each unit) and two CNM 1s with no supernumery hours allocated, staff nurses, healthcare assistants, activities, household, catering and laundry staff. Management stated that at present there is one staff nurse and one healthcare assistant on nights on each unit and that due to feedback from a residents and relatives meeting they were reviewing rosters to add an additional healthcare assistant on nights. The registered provider had two staff nurse vacancies at the time of inspection, one staff nurse was due to commence imminently. Both posts were covered by agency staff. In addition, there was one wholetime equivalent (WTE) vacancy for practice development.

Staff had access to mandatory training including safeguarding, fire and hand hygiene. The training matrix was not completed at the time of inspection and no training records were available for review. This was submitted following the inspection. This indicated that all staff had completed fire and safeguarding training. Improvements were identified in training in managing behaviours that challenge since the last inspection with further improvements required. In addition, the uptake in medication management training required action.

The inspector requested a sample of staff files. Management stated that since the last inspection all staff files were removed from the premises for uploading onto an information technology system. Of the five files requested, one file was on the new system. Evidence of the professional registration of nursing staff and garda vetting was held within the centre. Of the files requested the professional registration was in place and up to date, however, garda vetting was not available on one staff member. Management provided an explanation for this however, this is not in line with the regulation. This and further gaps will be discussed under regulation 21: Records.

The registered provider had completed the annual review for 2022 aligned to the National Standards for Residential Care Settings for Older People in Ireland with an associated action plan. Actions included an extension of residents' meaningful activities timetable and improvement of storage within the centre. A monthly quality and safety meeting took place which was attended by management from within the centre. One set of minutes was provided to the inspector from May 2023. Items discussed included incidents from the previous month. The inspector was informed that the person in charge attended a meeting with other HSE centres from within CHO5. This had commenced in June 2023. A daily safety pause took place on each unit. Staff discussed, for example; diet, residents on antibiotics and falls. The registered provider had a system of audits in place. Audits completed included hand hygiene facilities audit, general environment audit and medication audit. Audits included action plans. The general environment audit was comprehensive and was identifying issues, some of which were identified on inspection. The centre had a risk register in place. This was updated since the inspection in August 2022.

Management were maintaining a log of incidents within the centre. 43 falls were reported on the national incident management system in 2022. however, there was no evidence provided to the inspector that trending of the falls or other incidents

had occurred. This was a missed opportunity for learning. Notwithstanding this the majority of incidents meeting the criteria for reporting to the office of the chief inspector were notified within the required timelines with the exception of one incident.

The inspector reviewed a sample of complaints. These were maintained in a complaints log on each unit. Complaints were investigated and contained the outcome of each complaint. The person in charge was the nominated complaints officer, however, at the time of inspection had not completed suitable training to deal with complaints in accordance with the designated centre's complaints procedures. The complaints procedure was on display in the centre.

Schedule 5 policies were reviewed on the day of inspection. A small number of policies had been reviewed since the last inspection in August 2022 for example; medication management policy and the fire safety management policy, however, a number of policies were still outstanding. These are discussed under regulation 4: Written policies and procedures.

Regulation 15: Staffing

The centre had sufficient staffing on the day of inspection taking into account the assessed needs of the residents and the size and layout of the centre. For example: on the day of inspection the person in charge was on duty, a CNM2 in Abbey unit and a CNM1 in Brandon unit, four staff nurses and 6 healthcare assistants, four of whom worked until 2030hrs and two until 1800hrs. Each unit had a member of the housekeeping team and member of the catering staff on duty.

Judgment: Compliant

Regulation 16: Training and staff development

Similar to findings from the inspection in 2022 the training matrix was not available for review on the day of inspection. Records received following the inspection identified that:

- 7 staff who administer medications had not completed medication management training within the last year.
- 12 staff had not completed training on managing behaviours that challenged within the last three years. Four of these staff had training booked for early July.

Judgment: Substantially compliant

Regulation 21: Records

The inspector requested five staff files. Significant gaps were identified in the staff files requested:

- Four of the files reviewed contained no information on the IT system.
- One staff member had no garda vetting completed.
- The one file on the IT system contained no evidence that the staff member had received an induction.
- The inspector was informed that the file for the person in charge was not kept on the IT system or onsite but was maintained in another site.

Judgment: Not compliant

Regulation 23: Governance and management

Areas requiring action were identified to ensure the service provided is safe, appropriate and effectively monitored:

- Oversight of staff training, staff personnel records and residents' pensions was required by management so that any gaps could be actioned in a timely fashion.
- Trending of incidents was not taking place.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

One incident meeting the criteria for notification to the office of the chief inspector was not notified as required. This was submitted following inspection.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Actions were required in order to ensure compliance with the regulation. For example;

- The complaints procedure was under review at the time of inspection in order to ensure it was in line with the updated regulation. The policy was in a draft format and had not been approved at the time of inspection.
- The nominated complaints officer had not received suitable training to deal with complaints in accordance with the designated complaints procedures.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

A number of policies which are required under regulation 4, required review in 2020 but this had not been completed. For example; Staff training and development. In addition, three polices were not included in the schedule 5 policies for example; the use of restraint. Furthermore, two policies were included which were national policies on safeguarding and had no date in the version that was included with schedule 5 policies.

Judgment: Not compliant

Quality and safety

Overall, residents had a good quality of life in New Houghton hospital and were supported to live their lives to their own capabilities. Residents were supported to access appropriate health care services in line with their assessed needs and preferences. Residents had timely access to a medical officer and health and social care providers as required. In addition, residents had access to a day centre onsite and all residents were offered a choice on whether they would like to attend it. A number of residents attended for at least one day a week and were transported via a mini bus to the day centre.

New Houghton hospital was built in the 1930s and required ongoing maintenance. As discussed earlier in the report since the inspection in August 2022 the dining room in Brandon unit was painted and new blinds installed. In addition, the open plan dining and sitting room in Abbey unit was repainted. The centre was bright and airy with assistive handrails throughout. However, the centre was challenged for storage space. This was identified on the last inspection and in the annual report for 2022 and again on this inspection. Maintenance staff attended from a local acute hospital on request. The centre was generally clean on the day of inspection with few exceptions. A housekeeper was on duty on each unit on the day of inspection. The centre had good access to infection prevention and control advice from CHO5 and had identified two nominated infection control link nurse who had completed the required training. Five hours per week each was allocated to them to perform

this role which included undertaking infection control audits. Hand hygiene sinks were identified throughout the centre and were in line with the required specifications. The registered provider had a hand hygiene awareness programme in the centre on the week prior to inspection which outlined the importance of hand hygiene for staff, residents and visitors. This was highlighted in the local paper. However, in line with findings from the inspection in August 2022, the housekeeping room did not contain a janitorial sink and hand hygiene sink. Notwithstanding the improvements identified under regulations 17 and 27 since the last inspection, areas for action remained which is discussed under the regulations.

Fire safety management records were reviewed by the inspector. Appropriate certification was evidenced for servicing and maintenance. Records confirmed that daily checks of for example; means of escape were generally carried out. A sample of fire doors were checked by the inspector and were closing, however, records reviewed indicated that staff were identifying issues with fire doors during fire drills and escalating it to maintenance. The registered provider had an unannounced inspection from the local county council in April 2023. This inspection identified a number of areas for action. A time bound action plan was devised. At the time of inspection a number of areas were outstanding that required addressing. For example; the registered provider needs to identify if the grilles in the fire doors are at least 30 minute fire rated. Fire drills were taking place, however, the record of the fire drill was not comprehensive enough to identify the number of residents in the compartment requiring evacuation and the number of staff who took part in the evacuation. It was unclear if fire drills were taking place of the largest compartment with night time staffing levels.

The standard of care planning was generally good and described person-centered care interventions to meet the assessed needs of residents. Validated risk assessments were regularly and routinely completed to assess various clinical risks including risks of malnutrition and falls. However, action was required which is discussed under Regulation 5.

All staff in the centre had completed safeguarding training. Staff were knowledgeable about what constitutes abuse, the different types of abuse and how to report suspected abuse in the centre. The registered provider was a pension agent for four residents. The inspector was informed that this money was managed through a separate client account. This is further discussed under regulation 8: Protection.

Residents provided positive feedback regarding life and care in the centre. The inspector observed staff interactions with residents and it was evident that they knew the residents well. Residents could move freely around their respective unit however, a resident informed the inspector that no activities took place at weekends and as a result residents in Brandon unit could not access the garden at weekends. Management stated that activities were provided on alternate Saturdays but there were no activities on a Sunday. This is discussed further under Regulation 9: Resident's Rights.

Regulation 17: Premises

Improvements were required in order to ensure compliance with schedule 6 of the regulations. For example;

- Storage in the centre remained an issue. This was identified in a number of audits and observed on the day of inspection. For example; wheelchairs, hoists and commodes were stored in communal bathrooms.
- Updated floor plans outlining the storage areas in the centre had not been received as outlined in the compliance plan from the inspection in August 2022.
- In addition, the laundry was not outlined on the floor plans.

Judgment: Substantially compliant

Regulation 27: Infection control

Improvements were required in order to ensure that procedures are consistent with the national standards for infection prevention control in community services. For example;

- The cleaning practices and procedures in the centre required review so that they were in line with the community health organisation (CHO) policy provided to the inspector. For example; a chlorine based solution was routinely used on floors and sluice rooms when there was no indication for its' use.
- The housekeeping room did not contain a janitorial sink. Housekeeping staff filled and disposed of the water in the sluice room. This posed a risk of cross contamination. Furthermore, this is not in line with the policy from the CHO.
- The registered provider had yet to introduce new linen trolleys which were available in the centre during the inspection in August 2022. The registered provider was awaiting labelled linen bags from an external provider. The inspector was informed that they were due for delivery the following week and would be introduced then.
- A number of bedside tables were observed in a state if disrepair. This did not aide effective cleaning. The bedside tables was identified as an issue in a number of infection control audits completed. Management stated that the bedside tables were ordered and they were awaiting delivery.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Actions were required in fire precautions so that the registered provider is assured that residents could be safely evacuated in a timely manner. For example;

- Fire drill records reviewed did not indicate the number of residents in the compartment being evacuated and the number of staff involved in the evacuation. Furthermore, records indicated that fire drill was taking 16-20 minutes. The inspector was informed at feedback the largest compartment with night time staffing levels was simulated, however, this was not evident from records reviewed. In addition, staff spoken to were not clear on the compartments and horizontal evacuation.
- Repeated issues with fire doors were identified in fire drills. There was evidence that these were escalated to the maintenance department, however, the issues remained in subsequent fire drills.
- A number of areas were outstanding on the action plan that was devised following the inspection from the local county council.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A sample of care plans and validated assessment tools were reviewed. A number of care plans on one resident were last updated in September 2022.

In addition, a smoking care plan and risk assessment had not been completed on resident that smoked.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider had a medical officer who was contracted for 20 hours per week. Residents had access to health and social care providers through the HSE with management stating their were minimal waiting times. A chiropodist attended onsite once monthly. Residents had access to old age psychiatry if required, a day hospital in a local acute hospital and a consultant geriatrician attended onsite once monthly.

Judgment: Compliant

Regulation 8: Protection

The registered provider was a pension agent for four residents. The inspector was unable to assess the processes in place for the management of residents' finances as this was managed by a person who was on leave on the day of inspection. Notwithstanding this, the policy outlines that the responsibility lies with the director of nursing for overall oversight of residents' finances. This required strengthening to so that the registered provider was assured that processes were adhered to in the centre.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Action is required to ensure the registered provider is in compliance with Regulation 9: Residents' rights:

- Activities were not available to residents on weekends except for alternate Saturdays. Residents in Brandon Unit could not access the garden at the weekend as there was no staff member available to accompany residents.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for New Houghton Hospital OSV-0000603

Inspection ID: MON-0039753

Date of inspection: 22/06/2023

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: Medication Management Training: • At the time of inspection 7 employees required updated training • 5 employees have completed training • 2 employees are on long term absence. Their updated training records will be part of their return to work requirements. Managing Behaviours that Challenge: • At the time of inspection 12 employees required updated training. • 10 employees have completed training. • 2 employees are on long term absence. Their updated training records will be part of their return to work requirements Onsite compliance reached : 31/07/2023	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • Staff files including Garda Vetting have been uploaded to the HSE IT system. • Each staff member receives an induction pack on commencement of new post. On completion of the induction, the document is then uploaded on to the IT system.	

Completion date: 31/08/2023

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• PIC will now oversee the staff training, staff personnel files.
• Process in place for PIC to provide oversight of resident's pensions on a weekly basis.
• Commenced tracking and trending analysis of incidents.

Completed: 31/07/2023

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The outstanding notification was sent to HIQA post inspection on 26/06/2023.

Completed 26/06/2023

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Complaints Policy is updated and approved. Has been submitted to Inspector 09/08/2023

• The nominated complaints Officer/PIC will complete two modules of online training
• Complaints handling, guidance for clinical staff, cover your service, your say
• HSE effective complaints investigation
• PIC will attend further training if required for the role of complaints officer

Completion Date: 11/08/2023

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Schedule 5 policies under regulation 4 are now being reviewed and updated
• Staff training & Development – Date of completion- 31/08/2023
• Use of restraint Date of completion – 31/08/2023
• Safeguarding Date of completion – 31/08/2023

Completion Date:

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A number of areas are being examined to reallocate for storage purposes, in order to utilize what is available to the maximum benefit.

Completion Date: 30/09/2023

• Updated Floor plans are available and sent to HIQA on 21/08/2023

Completed-21/08/2023

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• A training schedule is in place for the housekeeping staff to educate and improve the practices and to be in line with Community Health Organization Policy.
Training Dates: 28/09/2023, 12/10/2023, 19/10/2023 and 26/10/2024.
This Training will be provided by the New Houghton Hospital IPC Leads in

Conjunction with the IPC Leads
• Housekeeping rooms were reviewed and maintenance personnel indicated that the rooms currently in use are not spacious enough to contain a janitorial sink however, they are now in the process of sourcing a smaller janitorial sink.
• Replacement of bedside tables will be complete by 30/09/2023.
• New Linen/ Laundry trolleys are now in use at both units since 24/06/2023.

Completion Date: 26/10/2023

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Fire Drill record is updated to reflect the actual number of staff participating in the evacuation and the number of residents being evacuated. Monthly fire drill/ evacuation drills have commenced in at each unit.
• Fire doors at Brandon Unit were serviced on 21/07/2023. Survey of Fire doors at Abbey unit is completed and remedial works are expected to begin 08/08/2023.
• Action plan following the inspection from Wexford County Council was reviewed by Inspector. Meetings continue and plan updated

Completion Date: 31/10/2023

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:
• A systematic plan is in place for review and updating of all Care records

Completion Date: 31/07/2023

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• Residents' Personal Property and Finances Management policy is being reviewed and updated. • Admin support is now provided to facilitate and support residents which will cover any absences. Completion Date: 31/08/2023.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Social care plan for residents weekend activities has been reviewed
• Staff are allocated to provide same.
• Individual social care plans for each resident
• Access to gardens & outdoor areas – 27/07/2023
• Audit of same by social care team to commence week 04/09/2023

Completion Date: 08/09/2023

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	31/07/2023
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.	Substantially Compliant	Yellow	31/10/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/08/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to	Not Compliant	Orange	31/08/2023

	be safe and accessible.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/07/2023
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	26/10/2023
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.	Not Compliant	Orange	31/10/2023
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is	Substantially Compliant	Yellow	31/10/2023

	reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Substantially Compliant	Yellow	26/06/2023
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Substantially Compliant	Yellow	31/10/2023
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	31/08/2023
Regulation 5(4)	The person in	Substantially	Yellow	31/07/2023

	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.	Compliant		
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	31/08/2023
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/07/2023